Conference Proceedings

"Alcohol Education in Industry – Prevention & Intervention"

10th-12th April, 1981

Great Southern Hotel, Killarney

Health Education Bureau

CONFERENCE PROCEEDINGS

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INTRODUCTION

This publication represents the proceedings of a Conference held in co-operation with the Occupational Health Nurses section of the I.N.O. and the Irish Society of Occupational Medicine. The one hundred and fifty participants comprised those working in industry in the provision of health services.

All the main papers and Group Reports are included. Also included is the paper by John Deacock who was unable to be present. It is hoped that the publication of this report will stimulate those who attended to greater efforts and provide those who could not attend with a useful resource.

Noel Daly
Head of Education and Training
Health Education Bureau.

Conference Programme

FRIDAY 10TH APRIL

Opening Session

Official Opening
Dr. H.D. Crawley,
Director, Health Education Bureau.

Introductory Address
Noel Daly,
Head of Education and Training, Health Education Bureau.

"Towards a Strategy of Prevention and Intervention"
Dr. A. Clare,
Institute of Psychiatry, Maudsley Hospital, London

SATURDAY 11TH APRIL

Second Session

Chairman
Col. J. Adams,
Director, Irish National Council on Alcoholism

"Prevention and Intervention Programmes in Industry"

1. **Dr. Ward Gardner,** Senior Medical Officer, ESSO
2. **Dr. John Aldridge,**Senior Medical Officer, IBM
3. **Mrs. Joy Evans,** Personnel Officer, Bradbury and Wilkinson Ltd.

Third Session

Chairman
Dr. H.D. Crawley,
Director, Health Education Bureau

"An Irish Response"

1. **Dr. Cormac McNamara,** Honorary Secretary, Irish Society of Occupational Medicine
2. **Mary Mulkerrin,** Health and Safety Manager, Warner-Lambert (Irl) Ltd.
3. **Dr. Dan Murphy,** Medical Officer, E.S.B.

Fourth Session

Group discussions

Group 1	—	Leader:	Mary Barrett, Health Services Co-Ordinator, Elanco
		Adviser:	Dr. Ward Gardner
		Rapporteur:	John Condon, Education Officer, Health Education Bureau
Group 2	—	Leader:	Dr. Des O'Byrne, Head of Research and Information, Health Education Bureau
		Adviser:	Dr. John Aldridge
		Rapporteur:	Kathleen Mooney, AnCO
Group 3	—	Leader:	Dr. Cormac McNamara
		Adviser:	Mrs. Joy Evans
		Rapporteur:	Maurice Cashell, Secretary to the Commission on Health, Safety and Welfare at work
Group 4	—	Leader:	Claire Devlin, Librarian, Health Education Bureau
		Adviser:	Dr. Dan Murphy
		Rapporteur:	Stephanie Prior, AnCO
Group 5	—	Leader:	Dr. Joe Cunningham, Medical Officer, C.I.E.
		Adviser:	Col. J. Adams
		Rapporteur:	Sam Docherty, Senior Educationist, Scottish Health Education Group

SUNDAY 12th APRIL
FINAL SESSION

Chairman**A. M. Morris,**
Head of Administration and Finance, Health Education Bureau
"Alcohol Education in Industry — the Future"

Marcus Grant,
Director, Alcohol Education Centre, London. Reports and recommendations from Discussion Groups.

CONTENTS

PROCEEDINGS EDITED BY NOEL DALY, HEAD OF EDUCATION AND TRAINING, HEALTH EDUCATION BUREAU

"ALCOHOL EDUCATION IN INDUSTRY — PREVENTION & INTERVENTION"

INTRODUCTORY ADDRESS:

NOEL DALY, Head of Education and Training, Health Education Bureau

It is increasingly recognised that alcohol abuse does not begin or occur only among school-age youth, therefore prevention programmes must be developed for a variety of other adult populations and settings. In order to reach adults, the world at work is a logical environment in which to situate programmes. This Conference attempts to examine existing employee alcohol education programmes as well as the more generic approaches based on a prevention philosophy currently underway in these settings. It is by no means meant to be a solution; rather, it is intended as an introduction and overview of potentially exciting and powerful new directions for primary prevention.

The aims of this Conference are two-fold:

1. To give information about current alcohol education programmes in industry and to examine them critically;
2. To consider and recommend how educational programmes can be developed within the workplace for all employees.

   The second aim should be considered in the light of early industry efforts being almost exclusively the result of concern for the alcoholic employee and had a single programmatic focus.

HISTORICAL DEVELOPMENT

The first industrial alcoholism programmes attempted to point out the cost to business and industry as well as to society of the abuse of alcohol. Increased absenteeism, poor judgement, reduced efficiency, lost time, morale problems were among the factors cited which caused company losses annually. Another major factor used to persuade company officials to develop procedures was the investment they had in trained, experienced employees who would be an expensive loss in their middle-service years. Initially, several companies pioneered efforts to establish alcoholic worker identification treatment and referral programmes. Most alcoholism procedures originated in the 40's and 50's were narrowly based projects which barely dealt with the full range of ailments and disorders that accompany alcoholism. Management and unions did not work together in these initial alcoholism programming attempts. In fact, it appears that these two groups overlooked or neglected the important role of the other in unionised companies, and consequently reduced potential programmes and impact. The medical departments of companies usually had the responsibility for the implementation of the early programmes. Then in the 1950s research began to show the full impact of alcoholism on job impairment. At that time dependencies of other sorts and emotional disturbances in general, were not addressed in company policies. The use of impaired job performances in rationale for employer intervention grew and in the 1960's programmes became less narrow and widened their focus of attention to other employee problems. In the 1960s new occupational alcoholism projects were developed and the number of programmes increased by more than 800% during that decade. The features of these programmes were *early identification, intervention and treatment.*

While some programmes advertised the inclusion of education and/or prevention as part of their programme, the range of these activities were extremely limited and would be better defined as awareness programmes in the light of new definitions of primary prevention. An example of this type of programme theme can be seen in the alcohol awareness education seminar conducted by the U.S. Airforce. This is an eight hour programme designed to:

> Give information on the entire range of alcohol and its related use; promote a self-awareness of individual drinking habits; and emphasise a concept of responsible drinking.

It was developed in late 1975 and it parallels early school drug education curricula in its emphasis on pharmacological and legal aspects of alcohol use. Information is given about the school and impact of alcohol use in the United States; definitions of problem drinkers and alcoholics; effects of alcohol; stages of alcoholism; ways to use alcohol wisely. However, one of the ten sessions also deals with values clarification, emphasising the development of personal values and knowledge about one's own behaviour in relation to alcohol.

It appears that when the term prevention is used in business or in industry, it means the prevention of greater problems, both personal and job related, for the particular employee. However, the concept of preventing specific problems *before* they occur or of promoting positive life skills, does not seem to be addressed in most employee assistance programmes to this point.

PREVENTION AND INTERVENTION

In your work over the next two days, I contend that one of the things which you have to do is to define what you yourself mean by prevention. I suggest that primary prevention is a constructive process designed to promote personal and social growth of the individual towards full human potential; and thereby inhibit a reduced physical, mental, emotional, social impairment which results in or from the abuse of chemical substances.

Intervention which could also be termed secondary prevention really means the early detection of people with specific problems. Now the advantages of intervention are that it should be possible for it to occur at an early

enough state that treatment as such will be unnecessary and, most important, that it can be carried out by the individual himself.

The idea of prevention is accepted so easily because the advantages appear so self-evident. The actual strategies adopted have never been clarified sufficiently for them to have any real effectiveness. I contend that in order for any specific primary or secondary prevention strategy to be successful, it must have three components:

1. Careful design;
2. Effective communication;
3. Be relevant to the target audience.

Three components must in the first instance be part of an educational spiral which contains three elements:

1. Definition of objectives;
2. Programme implementation;
3. Evaluation.

In relation to educational objectives, it is important to remember that an educational objective is what the individual can do at the end of the learning period that they could not do beforehand. The definition of the objective of a course or a programme is that of the results sought not a description or summary of the programme and that the essential quality of the educational objective is its relevance. If you are not certain where you are, you may very well end up somewhere else (and not even know it). The qualities of a specific educational objective are:

1. To be relevant;
2. To be logical;
3. To be unequivocal;
4. To be feasible;
5. To be observable;
6. To be measurable.

In relation to alcohol education movements in industry, one major barrier is the fact that people working in industry are not very well versed in educational methods and that educators know very little about what happens in the work place. So, I would suggest that in your deliberations you must look at how educators can be educated to understand the constraints and positive conditions that facilitate learning within industry. Also that you as part of occupational health teams in industry should look to educators to assist you in the design and development of generic prevention programmes or specifically alcohol education programmes. In addition, you must consider in the development of alcohol education programmes what teaching approaches are necessary for the particular programme and secondly what resources are necessary to implement these teaching approaches. Are you as Health Professionals equipped to deliver alcohol education programmes within your particular industry? If you are not equipped, what thype of training course do you need to equip you with the skills necessary to undertake a prevention and intervention programme in your industry? Does your particular job allow you to actually fulfil a prevention and intervention role? Is there a need to go outside your industry to develop a team approach to alcohol education or should it be in-house all the time? The message I am trying to get across in relation to the questions I am posing for you to discuss is that 'Nobody plans to fail but many fail to plan.'

To this point, I have not mentioned information programmes, I believe in the results of the research by John Swisher which proved that numerous studies suggest the ineffectiveness of education programmes which utilise information as a primary approach. Providing information using scare tactics has done little to curtail alcohol abuse. Swisher continues:

> "In drug education programmes to date, the focus of attention has been on the physiological or pharmacological affects of drugs on the human body. This emphasis alone provides an important clue to the probable inaffectiveness of numerous programmes. The need is for greater emphasis on the psychological, social and spiritual aspects of the educational programme."

Swisher's remarks support the need to direct more attention to the underlying motivations for alcohol abuse rather than focusing on the substance itself.

CONFERENCE DESIGN

This Conference is designed with the intention that everyone will be able to share in its progress and contribute something of their particular expertise to its outcome. Whatever your background, this is your conference and your active participation will be of value to the other participants. It is hoped that you will find the Conference of practical value to you in implementing alcohol education programmes when you return to your own company.

The first three sessions of the Conference are designed so that you will:

1. Consider the value of and goals for alcohol education in industry;
2. Examine some aspects of current knowledge and opinion about alcohol education as expressed by our distinguished speakers;
3. Hear of actual examples of alcohol education programmes.

The fourth and fifth sessions have been designed so that you will:

1. Identify specific learning objectives for alcohol education on the basis of the preceeding sessions;
2. That you will study the elements involved in planning alcohol education programmes in industry;

3. Consider the special problems of alcohol education programmes;
4. Identify the particular problems in introducing alcohol education programmes into your business or industry;
5. Look ahead to possible solutions to these problems and the implementation of alcohol education programmes in industry.

The Group Discussions are designed so that the topics of the preceeding presentations are applied to real situations you might encounter in your industry. The discussion in these groups is structured and the group leader has been appointed to help the group focus on the exercise, keep to time, produce written conclusions and so on. The Leader is not there to teach the group. In addition, each group has been allocated an adviser who brings to the particular group an expertise in the field of the development of alcohol education programmes.

WHY THE OCCUPATIONAL HEALTH SERVICES?

In the booklet on occupational health nursing service published by the Occupational Health Nurses section of the Irish Nurses Organisation and the National Council of Nurses of Ireland, it is pleasing to note that health education receives generous mention and status. In the section on "functions relating to nursing care and Health Maintenance", the sub-section on the provision of health education on an individual or group basis, states that the occupational health service is responsible for:

1. Identifying health problems and deciding what particular problems need general emphasis;
2. Providing health education to meet the needs of employees;
3. Corrolating health education with nursing care given to individual employees;
4. Promoting the inclusion of health education in training programmes and services provided by community health organisations;
5. Keeping employees informed of community health programmes and services provided by community health organisations;
6. Encouraging employees to initiate good health practices for themselves and their families;
7. Making selected authentic information available: leaflets, pamphlets, posters etc.

I suggest that it is important to use the occupational health service because of its stated objectives of using health education as a natural means of developing the overall health of employees. It is also important that from the point of view of community health education programmes, this booklet encourages occupational health staff to bridge the gap between work and the community and a further dimension is added by the inclusion of the families of workers. This further dimension of family education is to be welcomed and perhaps based on the stated functions in the booklet a three-pronged approach on the workplace, the family and the community might be undertaken using an alcohol education programme as a pilot for such a development. As this book was written as a guide for employers and nurses, perhaps there is one employer or maybe more in this country who would be interested in adapting the health service as a means for developing overall healthier and concerned employees. Perhaps a company would like to consider the possibility of assigning a member of the occupational health team to health education full-time on a project. Maybe this is one way of promoting health in the workplace as distinct from a purely health maintenance function.

In conclusion. . . . before you undertake your task for this Conference, I would like to remind you of a management education principle which states

'Insight without action breeds anxiety,
Action without anxiety breeds confusion'.

"Towards a strategy of Prevention and Intervention".

DR. A CLARE, Institute of Psychiatry, The Maudsley Hospital, London.

Well, Mr. Chairman, Mr. Daly, thank you very much indeed for quoting me absolutely in context. Indeed, I thought when Dr. Crawley mentioned the fact that this Conference emerged as it were out of the last one, that he meant that what went on in the Conference devoted to "Whither Health Education" immediately stimulated the notion of a Conference on Alcohol in Industry. I don't quite know how otherwise to explain my presence here since I am not working in industry and indeed some people might even say I am not really working at all, but be that as it may, in view of the experiences of the last time, which were retailed to you by Noel Daly, I certainly didn't ask questions when invited here again. I certainly would like to take the opportunity on behalf of my visitors from Britain who will address you tomorrow, to express our appreciation of the invitation and the honour indeed of coming here to speak to this gathering and the satisfaction of coming to such a magnificent place. I am only sorry that today is as cloudy as it is, but tomorrow I hope that my visiting friends will see this place for what it truly is.

I want to discuss a topic entitled "Towards Strategies of Prevention and Intervention." I thought I would do this by pausing as it were before we launch into discussions of how we might prevent, identify and treat by putting some of this in historical context. For some of you this will be nothing new, you will know much of this. But for others it is useful to just recall. When Dr. Crawley and I were at University, not too many years ago, such teaching as we got on alcoholism was very straight forward and simple. It was that: an alcoholic is a person who is physicially dependent on alcohol. Take his alcohol away and this man or woman manifests clear-cut withdrawal symptoms of a psychological kind which was called craving. The symptoms of a physical kind were manifested in things like nausea, vomiting, tremor, hallucinations, pink elephants and all sorts of other shameful things that occured usually in the early hours of the morning and were quickly relieved by a drop of the hard stuff. These were a minority of drinkers and they were not like you or me. They certainly were not like any of the Doctors who were asking questions about drinking.

I remember well wandering around wards in St. Vincent's Hospital, the old St. Vincent's, and asking people as part of their history whether they drank — quite a simple thing to do. You just said "how much do you drink?" and they said "about average" and you said "how much was that?" and they would say "A couple of pints" and you would write down "average". I often wondered what would happen if a chap said "I'm a soak" — you would probably write down "exaggerates". By and large we did not ask too many questions about drinking as it was reinforced by our seniors the pointlessness of asking too many questions when you would not get accurate answers.

It is interesting to note that one was working at that stage as a medical student in training, on for example, gastroenterology wards, while at the same time research was being published in Australia and the U.S. and in the United Kingdom showing that perhaps one in five of the patients we were seeing in those wards were there because of alcohol abuse. This only emerged many years later. This model that there was this small group of alcoholics and this much larger group of normal drinkers was of course endorsed by the industry.

At the Health Education Bureau's first Annual Conference, Dr. Dermot Walsh quoted the Managing Director of Irish Distillers who was encouraging the Licensed Vintners Association to resist any measure to increase the price of alcohol. He said "forcing up the price of drink might well reduce overall consumption, but the very small minority who are alcoholics have a craving and they will continue to drink as before." A submission to the Government by the Association of Canadian Distillers pointed out that "alcohol and alcoholism are two entirely different subjects — while alcoholism is a major health problem — alcohol is not, just as sugar is not the cause of diabetes, alcohol is not the cause of alcoholism".

I am not going to bash the industry, at least not now, in a few minutes perhaps. This is an excellent statement of the medical view that held in the 1950s and 1960s. The statement was underwritten unwittingly by a variety of organisations for example Alcoholics Anonymous. Still the view that there was a small group of vulnerable people whether constitutional, genetic, a celtic gene perhaps, which rendered them very sensitive to alcohol. One drink and that was it, whereas the rest of us if we were not in that unfortunate minority, we were not stigmatised by God with that particular cross and could indulge ourselves to our hearts content. As a man's best friend is his dogma, it was summed up in the sort of Churchill story — Winston Churchill (I have got to be careful now, he is a dead M.P. so I don't think I can be slandered outside the House) was a heavy drinker — like you and me, but he was not an alcoholic.

That was the stock answer if you did nail somebody in your clinic about whom you had great suspicions about his drinking. He would quickly turn and tell you that he was drinking no more than his friends. A dangerous alibi in the Republic of Ireland, but one nonetheless, somewhat difficult to circumvent.

Now, this view implied that factors which might influence the consumption levels of social drinkers would have no affect on the pathological drinker and vice versa. As many of you know that particular model of alcohol and alcoholism has been severely dented and indeed it is now largely redundant. In its place, for reasons I won't go into, has been installed an alternative view of the concept of alcoholism. It is still, of course, accepted that there are a number of individuals and perhaps relatively small, who are or have become physically dependent on alcohol. Alcohol, being a psycho-tropic drug can cause the phenomenom of physical dependence. As a result of this dependence, many people show withdrawal symptoms, psychological compulsion, the phenomenon of tolerance i.e. the ability to consume larger amounts and show the same effect — up to a point. It would appear that these people can only be managed in the short term by withdrawing them totally from alcohol and by

maintaining them in an abstaining state. However, this is at the end of a spectrum, a spectrum of drinking running all the way from non-drinking to mild and moderate drinking, through heavy drinking and into severe alcoholism.

The model of disease, if we can call it disease is similar to the model of blood pressure, whereas the first model I mentioned, the largely redundant one is very similar to the model we hold of infectious diseases. Infectious disease is someting you either have or you haven't. Blood pressure everybody has — some people have such high blood pressure that they have symptoms immediately related to it: headaches, kidney disease, heart trouble. Some people have only moderate blood pressure, but from that group may be recruited some of the people who will have difficulties and associated difficulties may respond to stress and diet and to lack of exercise with periodic increases in their blood pressure. Everybody is scattered along that dimension. Anyone can become a severe hypertensive. Some are clearly more at risk than others—there are genetic factors, but nobody can say he/she is immune. As you know from other activities of the H.E.B. and others, we now pay considerable attention to the factors which move people along the blood pressure scale so that we may prevent, deter and intervene before people develop blood pressure problems.

A very similar model is evolving in alcoholism and in the field of alcoholic abuse. Such a model immediately brings into play, issues that I as a medical student never ever heard considered. For example, nobody in the discussions in U.C.D. on the pharmacology of alcohol and on its psychotropic affect — its effects on blood flow, gastic juice, liver enzymes — ever discussed how many people drink; or how much they spend on drink; how it is sold; marketed or advertised; where it is retailed; what values we place on it; or why we drink. Actual motivation for drinking was never questioned because it was assumed we knew why people drink. We all drank for much the same reasons was the assumption. It is perfectly clear now that there are many reasons for drinking, but some of them are more pathological than others.

With the disease model, such questions were irrelevant both to the afflicted and the healthy. Now of course, they are not irrelevant. Straight away we shall take a look at the information we have got on how much we, the Irish are drinking. These figures may well be familiar to you. What they show is that the despairing cries of the harassed Vintners Industry show to to the contrary: the Irish have been steadily doing their bit to bring Irish drinking levels up to the European high (held currently by France). You can see that it is a very dramatic increase in 30 years. When we come to consider altering the behaviour practices and so on, it is very important to note the changes in drinking in the increased direction can take quite some time. It should not be, therefore, expected that changes in the opposite direction won't take some time as well.

The next question concerns how much we spend on alcohol. Again, it has shown a rather remorseless increase and the column on the right, of course, is the technical jargon for saying the amount we spend on alcohol taken from the amount of money we have to spend on things, goods and services.

You will see from the next slide, and our guests from England, if they don't know this already, will quickly get some measure of the extent of certain Irish characteristics that we spend in terms of the proportion of the money we have, quite a significant amount more than most others. I am not sure why the Poles fell out of the statistics, they now have other problems. But, perhaps if we keep going, we might fall out of the statistics as well. You should remember too that the proportion of the disposable income, the base from which this proportion is drawn is much lower than in many other of those other countries. So that of the little money we improverished Irish have, we spend a very substantial amount on alcohol. In fact, we spend from £1m to £1¼m a day. To put that in some context, half of that goes to the Government and in fact 13% of the Government's income comes from alcohol. Indeed, if you add in tobacco, 20% of the Government's income comes from our drug habits.

I mention this again to put into context the extend of the problem you and I are concerned with. Because as I proceed through my discussion, you will become, as befits a psychiatrist addressing you, profoundly depressed. You will stay that way all this evening only to be rescued from it by people tomorrow speaking to you, who know a good deal more about lifting your spirits than I do. The next slide emphasises the extent to which this is important to our economy. It says something about the people who actually produce alcohol. You have got to bear this in mind that some of your erstwhile allies may turn out to be some of your erstwhile opponents in the sense that they may be involved in making their living out of alcohol and alcohol production.

There is considerable discussion in Britain at the moment in the City of Bristol because as a result of Mrs. Thatcher's Budget, sales of cigarettes have significantly fallen. It may of course be one of those temporary falls, but in the meantime people are actually put on short-time. They are not exactly the doctors best friends. Just to give it some kind of international Eurovision comparison, our equivalent to Johnny Logan is doing very well. Our excise duties, Mr. Haughey will be glad to see, are substantial though he may not be glad to see it because it raises problems about how to reduce alcohol consumption without reducing tax revenues, again we will come back to that. The final point is just to remind you about Irish trade in the export of alcohol: Ireland's whiskey is competing with a very inferior Scottish brand, but it has started behind. However, I am told, thanks to the vigorous and competent efforts of Irish industry that it is now making incredible strides so that arm in arm with the Scots we can have the developing world totally incapacitated by the year 2,000; the year which the World Health Organisation has proudly proclaimed the Year of Health for All.

Against that context, drinking is engrained in the heart of Irish society. We talk in terms of prevention, identification and treatment. But before we do that, we have got to start talking in terms of what it is we are talking about preventing since so many people drink and it is an important aspect of life in this society. It is hardly drinking since most of us do that, lets be realistic, so it must be related in someway to the problems related to alcohol misuse and abuse and depedence.

With the earlier model there were no great problems; you left the alcoholic to emerge from society and then the great therapeutic might of the medical profession fell on him, cleaned him out and cured him. For a while,

indeed, the medical profession colluded in that romantic little fantasy but it quickly proved somewhat hollow. But now of course, we are engaged in looking at the social implications and the psychological, as well as the physical implications, the net of identification — first of people who are already established drinkers and then the people at risk and then the community.

I will take them in those three groups. Of course they have implications for those of you working in frontline activities where you are in a position to pick up far earlier than the specialist, the people who are beginning to have problems with alcohol or the people who are well along the road with problems but who have concealed them from society for sometime. I would like to say something about the detection of those people who are for one reason or another misusing alcohol. I mentioned to you that when I was training, very little interest was taken in motivation for drinking. But, in fact, the first interesting development in the 60's related to attitudes to drinking and the reasons for drinking. One of the things that quickly emerged was that people who subsequently go on to develop problems with alcohol are often people who drink for alcohol's direct psychological — so called psychotropic affect i.e. people who drink to relieve anxiety or people who drink to relieve depression, though in the end it works as a depressent. People who start to drink to relieve stress, for example stress at work, at home, stress related to physical ill-health or stress related to recent bereavement slip very gently into an at risk group.

If you analyse your own reasons for drinking,no doubt you will find from time to time you do take a stiff drink to see you through the night as they say. I am not saying that everybody who does that is immediately at risk. Someone whose drinking repertoire starts to show that pattern of drinking as the main reason as distinct from the social and clubable reasons for drinking is the sort of lubricant of social actions — but one who drinks mainly for the psychyotropic affect on him, using alcohol as a medicine, is a man at risk. You may pick that up, people may tell other people that they are using alcohol in that way, it is not, yet anyway seen as an early sign. Though doctors are increasingly being warned to look for precisely that. People will often complain to doctors or to friends, personnel managers that they are under stress. It is a very simple and realistic question to ask: whether they take the odd drink to ease it or what they do in the evenings to relax. You can often ask that question in a colluding way because all of us have done it at one time or another. I hope I am not giving myself away to an even better detector of alcohol abuser than I claim to be myself.

The next early detection point concerns the narrowing of a person's drinking repertoire; this is very difficult to describe, but you see it very clearly in somebody for whom drink is just a part of his everyday living. It is something he does or doesn't do because there are recognised social occasions when you do it. He does not go out of his way necessarily, he is not thinking about it; he is not wondering when this boring Lecturer Clare will sit down and he might go and have a drink in the Hospitality Suite. The narrowing of repertoire is often picked up by relatives and friends or workmates, who notice, of course, that for somebody the trip to the bar at lunchtime is not a sort of occasion to which a lot of energy is directed in anticipation and a lot of memory is directed in retrospection.

These are all early signs, as is indeed, this notion of increased tolerance which is variable and one which you should not get too worked up about as it can vary greatly from person to person. Yet there is no doubt that somebody who is finding that the effects of alcohol are beginning to wear off, or that it takes more alcohol to bring about the same affect, rather similar to certain drugs like valium or the barbituates, that increasing tolerance to alcohol is both a sign of maybe larger consumption than the person realises and also a sign that the person is moviong into an at risk group.

The fourth stage relates to the question of quantity. We were never encouraged to ask questions about quantity because there were two reasons: one was that you never got a right answer and two that there was the assumption that quantity had nothing to do with being an alcoholic. You could be an alcoholic, it has been said, and never drink at all.This was said with great drama to quivering medical students who went off and scratched their heads and pondered on this extraordinary insight into the human condition: An alcoholic and never drink. In fact, the amount that people drink is directly related to the extent to which they have problems and indeed the extent to which they develop a dependence. Recently thresholds of drinking have been tentatively put forward. It has been suggested that if you stay within a daily intake of 15 centilitres of alcohol, absolute alcohol, which is about 3 — 4 pints of reasonable Irish beer or a bottle of wine or 4 singles of spirits, you are quite safe by Irish standards. The dangers with those quantities is that if you tell English people or English business men those levels, they clutch their hearts and wallets and immediately contest them on the grounds that a decent business lunch, a few drinks (around six), a few drinks in the evening plus a bottle of wine, if they do that on a daily basis, quickly puts them over the threshold.

On the other hand if you tell a meeting of the Pioneer Total Abstinence Society, then obviously they would feel that those levels were a gross extreme. Whether that is true or false, the fact is that steady drinking around those levels would start to move you into a group of people that actually are at risk. From this group, many of the people who have problems associated with alcohol are recruited. In addition, in terms of our early signs of detection are the psychological symptoms of alcohol, lets call it misuse for the moment, or excess use. These are symptoms such as depression, lethargy and lack of concentration. These pour over into an impairment of working performance, lack of interest, lack of ability, slight impairments of judgement and depending on the job they will be picked up quickly or they won't be picked up for quite sometime. There are also physical symptoms such as ulcer trouble — how often is gastritis written on Monday morning sick certificates? Also nausea and wretching in the morning? The relief of some of those symptoms by alcohol is well known but is not necessarily an early stage.

If we now start to consider people who do indeed have established problems with alcohol, then of course there is the recognition of the person or certainly by those around him that perhaps he is not in as much control of his drinking as he would like to be.The fact is that now there is an element of compulsiveness about it.This is often related to attempts that the man himself or the woman herself makes to conceal the extent to which indeed the

drinking has now become the focus of a great deal of his/her activity. The so called, quick gulping drinking, the secret drinking, the denied drinking. Also, of course, in picking out people who may have problems with alcohol one thinks of particular groups. This got me into trouble the last time I was here when I made a merely mild joke, self-derogatory reference to the fact that doctors are not the best people to advise other people about drinking since they abuse drink themselves in rather larger numbers than the average. That earned me a headline on the *Irish Independent,* that paper well known for the accuracy of its views — in case there is a journalist present.

As foreign experts lambasted Irish G.P.s for their boozing, I don't think they used the word boozing, some similar, rather discredible word, which earned me as you can imagine warm hearted applause from my medical colleagues in Ireland. It is one of the merits of coming here, giving your speech and then going back. But, in fact, doctors are at risk and it is one of the reasons doctors have been somewhat shamefaced and rather evasive about the extent to which they can explore other peoples' drinking patterns. There used to be a joke that "an alcoholic is a man who drinks more than his doctor." Of course, in some instances, this can be a lot.

The other groups like journalists, printers and people who have got particular access to alcohol, people in the trade, people in the bar trade, retail, selling trade, chefs, people working unusual hours, actors, people under particular stresses, businessmen and managers carrying heavy responsibilities for whom alcohol is often seen as part of the ways in which you take the fuse out, you unload, you take the steam out of your work with occasional drinking or indeed drinking is built into the social life that goes with contract making, that goes with the organisation.

Other groups, like the National Union of Students in Britain is campaigning very hard to get the price of beer sold on campus cut, reduced below the actual price and they look as if they are going to win through. We know from the Armed Forces that people who have particular benefits in relation to their drinking, either tax free or special cut rates or special hours put aside, tend if anything to abuse that particular benefit rather than use is sensibly.

The other problems which I have not come to are the more complicated interpersonal and social ones. Some people will run into difficulties, for instance at work, which is the area you are particularly interested in because at work their work performance falls off or there are difficulties at work which until you know that alcohol is lurking around in the framework would be somewhat difficult to understand. A man whose performance has been impeccable up to quite recently begins to fall off. A man about whom strange, rather consistent comments are made in terms of his performance. Somebody whose breath smells of alcohol rather frequently. Somebody who shows a particular pattern of absenteeism. Or it maybe a more entrenched social difficulty — protracted marital problems either causing, aggrevating, contributing to or the result of a growing dependence problem on alcohol. Family difficulties, stress over roles. Indeed almost any social and interpersonal stress can be related to alcohol. If people are tempted to ask: but why? The obvious answer is because alcohol is a drug that promises transient relief from all kinds of stress. It is readily on sale, it is our anaesthetic and it also is a mild euphoriant initially; it releases inhibitions; it makes us just that little bit more aggressive; that little bit less anxious; that little bit less depressed; that little bit more competitive. It has, in other words many appeals which readily makes it a potent source of difficulty for people who are undergoing stress.

The question of identification, of course is one thing. Picking out people that are at risk is a little more difficult. As I have explained, almost any live stress of a persistent kind, combined to somebody for whom alcohol is readily available or is socially strongly valued and in circumstances where that stress may not be easily relieved or maybe quite persistent and extreme — there you have the seeds of a serious problem. It is difficult to eliminate all social and inter-personal stress, though indeed there are some stresses that we might pay particular attention to. I think that is something I will leave until tomorrow, where in fact discussions will not merely be related to issues of picking out people who are at risk but also identifying some of the stresses that can be remedied that lead people to abuse alcohol in the first place.

Now with regard to early identification, I will say perhaps a little more about treatment in a moment. But one last word, the detection of the serious dependent alcoholic, that is the so called 'alcoholic', the person whose stereo type looms over all of us and causes such problems, as we will see when one is engaged in a one-to-one relationship with an alcohol abuser and/or his spouse. The detection of such a person should not take an elaborate medical training or sophisticated social training. You know, eight year olds in a Scottish study could pick our a chronically depedent alcoholic without any trouble at all. Its the sort of secondary stages of cancer in the alcohol business. It is really something of a disgrace to the medical profession, that until recently it was the secondary stages of a cancer that it only recognised and anything earler than that is completely missed. Now the business is to pick up, (taking the cancer analogy) people before they become full-scale dependent alcoholics. The fact of the matter is that however elaborate the treatment programme or however modest it is, however elaborate the resource you put in, however much the effort and the money and the skill the plain fact is that the recovery of significantly dependent alcoholics is a very difficult business.

Alcoholics Anonymous has perhaps the best record with its straight and simple and unambiguous message and the rest of the evidence suggests that the programme with minimal intervention, has as much effectiveness as highly elaborate and very expensive programming. That is a highly distilled view of a large world literature. It is depressing in one way in that it says that no matter how much one pumps in in terms of immense resources, the recovery of heavily dependent alcoholics is a difficult business. It is reassuring on the other because it says that even the most minimal intervention is as good as the most sophisticated and it has certainly helped British General Practitioners to begin to recover some of their shattered confidence in handling alcoholics. They originally thought that somewhere there was these marvellous clinics that were curing alcoholics. Their problem was that they could not find these clinics or what methods were used. However they discovered that in fact these marvellous clinics were producing results not much better than decent G.P.s with knowledge, information and

patience. In fact many of these G.P.s have begun to feel just that little bit more confident in handling people who bring alcohol and alcohol related problems to their surgeries.

Until quite recently it was thought in Britain and I think I can speak for Ireland, very strongly in terms of intervention in a highly medical way. I'll come back to that in a second. That was the notion of special treatment for alcoholics. The psychiatric establishment, the psychiatric section of medicine was for one reason or another the speciality that was particularly identifed as the resource for the treatment of identified alcoholics. You can see in the Irish Republic the number of people being admitted for the treatment of alcohol and alcohol related problems has mirrored the increase in spending and the increase in consumption that we mentioned earlier. You will also notice if you do a quick calculation on the numbers of people in the country and then marry that to the estimate of something in the region of 75,000 dependent individuals in the Republic of Ireland plus many thousands of people who are not necessarily physically dependent, but who are certainly in trouble with alcohol, you can see that even if we expanded our psychiatric services many times they would but treat a small proportion of people in trouble. In fact, the resources that we are going to have to mount to cope with alcohol within the community are going to have to match the epdiemic quality — to use Noel Daly's phrase of the problem itself. That means, extending it out, not away from, because we will still include them, but into the community and if that is to mean anything more than the vacuous phrase it sometimes does — we mean involving people in frontline jobs that brings them into contact with people in stress. I think again of G.P.s, nurses and physicians in general hospitals, people who are handling particular groups under stress, students, people in management, people in the workforce, people who are physically ill, people who have been recently bereaved and so on.

Of course, when you stop to think that way and the army of possible detectors and educators and even treaters it is a vast one, it includes almost everyone who is involved in some way or another with personal care, health education. The question of intervention as I have dealth with so far, has been concerned with the personal intervention. When I talk about the detection of somebody who is misusing alcohol, detection itself is of little use unless we are also talking in terms of what one does. This as I understand it is part of the notion of a Stretegy of Prevention and Intervention — what to do when youh have made contact with somebody who is in trouble with alcohol?

The first thing you do before that happens is to inform yourself about alcohol. There are now in this country, several publications which are in many ways excellent. I take Noel Daly's point that information on its own is not enough, but if anything does discredit the people who are trying to help others with problems of alcohol, its their ignorance. I should add tht it was said to me coming over on the plane by one of the British speakers and I heartily concur, that many alcoholics know a great deal about alcohol and they have, by and large, not much respect for people who set themselves up into positions of helping those who don't knows much about alcohol. Now, alcohol is a substance available to all and it is a substance of some power and some significance, some importance and some value and it merits our knowledge about safety, its effects with or without food, relation to blood levels, its effect on our kidneys and our heart. We should not just be aware of these physical symptoms but the reasons why we drink, the way we use alcohol and the sort of values we place on it. These are not highly sophisticated metaphysical notion, they are readily available and have been put together. I can think off hand of one publication in the Midland Health Board which I think is very good with its details of alcohol and its position in Irish society, a moral statement, not puritanical. For those who want a little more detail there is a document from the Royal College of Psychiatrists in Britain which is readily available in this country. Indeed there is an excellent document by Brendan Walsh, a somewhat pessimistic one, about drinking in Ireland that has come out of the Economic and Social Research Institute in Dublin. So information is useful, at least first of all in restoring our confidence because if you know what you are talking about, you are confident about what you are talking about. It can do much to help you over the often anxiety reducing situation of discussing an alcohol problem with somebody who is in trouble.

The second point I would make about the management is that very quickly you must establish the extent to which you are talking the same language. I would be interested in what other people have to say. I never use the word alcoholic anymore except when the patient, the person or the client does and then I ask him what he means by it. If he says what I think he will say: someone who is dependent, who is a vagrant who lost everything, is down at luck, the AA stereotype rock bottom, all sorts of physical complaints, his wife has left him or would in another society, his children hate him; he is disgusting; he is clinging onto his job or has lost it. . . . then I very quickly put that out of the way. I say that that is not what we are talking about, something quite different. Then we talk about what we are talking about.

We talk about the extent to which, for any of us, alcohol can be great stuff and it can be a real problem. Indeed the whole emphasis in (I hate the word) psychotherapeutic relationship (because it immediately conjours up something quite strange) is that the two individuals concerned are engaged in a dialogue that is not a moral one, that is in fact a discussion between two people engaged in trying to achieve some kind of common objective. In this case, the first stage is the common objective of clarification of what is the problem. Sometimes that cannot be done too quickly. Sometimes it is genuinely unclear the extent to which the drinking is a response to a stress or stresses are responsible for drinking. It is unclear the extent to which you can say categorically this man is in trouble at work because he is drinking, or this man is drinking because he is having difficulties at work. These are difficulties and it is wise to accept them and not to engage too soon at any rate in arguments with people who ostensibly you are trying to get, tease out, and indeed discuss with themselves problems they are having. If there is a single fault in all people engaged in counselling and advice and intervention of treatment, it is that they talk too much. They intervene too quickly and they are too ready to either reassure or warn. Whereas in fact, basically what you must try and do is learn how to listen or ask non-judgemental questions. Seeking just a little bit more, indeed suggesting as if you yourself can well understand the situation in which somebody drinks too much. Goodness me, that should not be beyond the bounds of any Irishman or woman to imagine the

circumstances in which one might drink too much. In fact it is difficult to imagine circumstances in which one might not!

The other simple ground rule in this business is that question of dual loyalties especially for people in industry or in industrial health, occupational health, nursing or early screening of any kind. I don't know the answer in industry. The fact that some person doing the helping and the selecting may also be part of the organisation has its own difficult views about what is going on. It is slightly easier for a doctor, but not always. However, the question is that it is a very important dilemma and ambiguity should be quickly removed. Because as a general rule, generalisation — people who are abusing alcohol often tolerate uncertainty and ambiguity poorly. You must be fairly clear and fairly straight and very honest with people about where you stand, how much you can and cannot do and what you can and cannot permit, how much can and cannot be tolerated. The extent to which you then call in other resources legally depends on the extent and severity of the problem. I have indicated that, in my view, the specialised services may well be for the more severely dependent, which is reasonable. The more expensive, more sophisticated and the more scarce treatment, the more it should be reserved for people who are in real trouble. The notion of prevention is that if one can get in early enough, one may minimise at a much earlier stage the unfortunate consequences and indeed restore somebody to health much quicker to normal drinking in this instance or to abstinence, if the indications are such as to suggest that must be so.

There are also broader issues which I think is important to refer to because these are the benefits of the recent developments in the way we think about alcohol. I have no doubt that you are involved in programmes and so on or at sometime become involved in programmes and in individual instances which will be involved in the life of your own circumstances, institute or organisation or business.

In the 50s and 60s, we thought of the alcoholic as the source of the problem and we thought of the solution being to approach and attach him and the rest of society could happily go about its business. Therefore, treatment was very individually orientated, as the theory of cause was. Now, of course, our theories of cause are broader and so indeed should our notions of intervention.

That again is a summary about some of the points which I have been making about early signs of possible alcohol misuse. It is very important to say that they may be the signs of other things as well. I wouldn't like it to be thought, even in Ireland, that everytime somebody gets a little low or falls off the job or doesn't come in on a Monday that therefore he has become hooked on whiskey. There are other reasons for not coming in on Monday — the wife's drinking is one, but there are others again. There is also the question of what you are coming into.

I know there are industrialists present, I mean the presence of industrialists — there are certain jobs where it is difficult to conceive how you do them without being tanked up. Of course, none of them are here today.

This question of social control often arises. People say, and you will be tempted to when the going is tough and you are not getting very far with the people you have identified and you are not identifying many of the people you suspect, the going gets tough and you feel this is hopeless — its almost where medicine was 20 years ago. Some realisation that you cannot deliver the goods. The factors that are affecting the poor client in front of you are so great that really you feel like becoming either a politician or a preacher, or maybe both. You fall back on the notions of somehow controlling the social dissemination of alcohol. That is very reasonable and it is a subject of much discussion at the moment. These are four or five of the strategies that people, or rather points, that people attend to. There is the simple question of price, which of course, in real terms has fallen since the War. People say that if you increase the price of alcohol, and you have recently in the last Budget here, then you decrease consumption. If what I am saying and other experts e.g. Lederman; people are saying if you decrease consumption, you decrease problems. That at least is one way around it.

That is true, but the problem in Ireland is that as it is, the people spend much more on alcohol than one would anticipate from their incomes. It is the problem of what is called elasticity. I think I have it right, beer and spirits, particularly beer, relatively inelastic — which means that actually you have got to keep stepping up the price before eventually there will be a fall in real consumption that will last. Indeed, it has been suggested by Walsh that you may have to double the price of alcohol before you bring about a significant persistent reduction in the amount consumed. Now the problem with doing that is that all you might do is just increase the proportion of relative disposable income that the Irish might spend on alcohol and that they might spend less on something else. So the wife who is miserable at the amount of money her husband spends on alcohol may be even more miserable as a result of this brilliant new strategy to improve the situation.

The question of taxation: I mentioned to you that something like 47%—48% of the price of alcohol is already going on taxation. Again, of course if we think in terms of putting that up, then there is a slight problem in that it would mean a great increase, briefly at any rate, of the revenue that the Government was deriving from alcohol and in some senses a rather uneasy dependence on the state of the industry, might if anything, be perpetuated. You might have again to do a significant increase to taxation for effect. But nonetheless, again those two are worth considering.

The third strategy concerns advertising. I often feel, it is terribly unfashionable to say it, that there are times when we get so despairing with out own attempt to change our views and those of our friends that we turn on anything and blame it. Advertising is nice, it is to hand, nobody really likes it, everybody watches it, nobody believes they are influenced by it, it is an extraordinary kind of phenomenon. But why don't we just stop all advertising, we think of vodka and all those dreadful things that suggest and the naked sexism of the advertisements, the macho image that it portrays, the link with sporting excellence, except I never saw an Irish Rugby Team intoxicated winning the Triple Crown! Mind you it is the only thing they haven't tried. The question of advertising is one that rouses great hopes. Sadly these hopes are not necessarily sustained by the evidence. That is not to say that it has neglible effect, but it is interesting that there is much argument about the effect which banning of advertising of cigarette smoking on television actually affected consumption in Britain.

The Royal College Reports, in 1963 had an effect, whereas the TV ban in '65 appeared to have a negligible effect. Of course, it maybe that the culmitive effect of it in line with other things does bring about changes. There is one analysis that suggests the per capita consumption of cigarette smoking would have been one third larger than it actually is had the years of anti-smoking publicity never materialised.

There is some merit in the argument that a ban on television advertising, for example, alcohol is not so much a stimulus to control but it reflects a community's intention. There is no harm in that, a community that signals that it is taking alcohol seriously and it has very few ways of doing that. One is through ensuring that advertising is controlled, maybe even eliminated. Another cause for concern is drinking and driving, that itself has a feedback effect. Society begins to take it seriously. Media begins to take it more seriously; there is more public discussion. A lot of the myths about alcohol drinking are washed away. The long term hope, talking in terms now of even a generation, is that very slowly the haphazard ways into which we have got in using alcohol might be more organised and improved.

It may well be of course, another way in which advertising can be useful is in a positive sense. That is to say positive advertising about the sensible use of alcohol. I don't mean showing heartrendering pictures of diseased brains and awful livers and stomachs falling out, paunch oppulent alcoholics teetering down to their local etc. Information about alcohol, facts about alcohol is needed. It is the disparity between the amount of positive and unreal informaiton about alcohol and the little driblets of sensible advice about alcohol that worries one in relation to advertising.

There is the question about availability. People will point to this as a reason why people are drinking more because there are more ways in which we can buy alcohol: off-licences, retail supermarkets and so on have mushroomed and the hours have liberalised. The exemptions have increased. The number of exemptions indeed allowing after hours drinking has risen from 6,000 in 1967 to 14,000 in 1872 to 33,000 in 1977 in this country. The mean age of 18 years is not enforced. I gather there is a loophole in the Law here that you can actually sell alcohol to over 15 year olds for consumption off the premises in quantities of one pint or less. All of these things, I have no doubt, are important. But in some ways those developments reflect as much as contribute to the ways in which we have changed our views on alcohol and we have changed our buying habits. It has to be remembered that this country is considerably more affluent than it was when some of these first statistics were produced. You are spending more on alcohol to begin with and you start to earn more and spend proportionately, then consumption will go up. Now there are those, Walsh is one, who gazes at those four or five, there has been much medical enthusiasm for these. Doctors despairing of medical intervention, turn to social intervention and for a while the social peers say, you do this, you do that, you do the other. But now I sense a feeling that these kind of interventions may not be as productive as we had thought. That we are dealing with alcohol misuse with something much more complex. These can indeed help, but we will need a far greater awareness on the part of public of the issues involved if these are to be anything other than cosmetic.

I would like to give an example of that, it concerns driving and drinking. You see the problem is that you can berate the industry; you can berate the advertisers; you can berate the medical profession for its failures, but the public itself has got very entrenched and very ambivalent views about alcohol and alcohol misuse. It tolerates a certain kind of misuse. As medical students, considerable amount of alcohol abuse was tolerated by ones peers and ones seniors. As many of the major life events in our life: births, marriages and deaths, alcohol misuse is not only tolerated, indeed it is almost seen as the mark of your relative significance and importance you attribute to these. Indeed many an evening is praised on account of the extent of insobriety that it produced. When it came, in this country, to setting a breathalyser limit, all those ambivalences emerged. Which of us has not driven a car in a state which we would now prefer to forget if we could only but remember it. When we see some poor man, respectable or otherwise, held up in Court with blood levels of some extraordinary amount, as one casts the legal stone with one hand, one hauls it back with the other, it is the very ambivalence, the very endemic nature of what we are talking about. It is not like cigarette smoking and certainly like some of the other vices that society can get very worked up about. This is something in a sense that we are all responsible for and guilty of.

When we did set alcohol limits we set a limit initially I think it was 150 or 125, it is now down to 100. In Belgium, Denmark, France, West Germany, Luxembourg and the U.K. it is 80 and in the Netherlands it is 50 — reflecting the fact that it is at 50 measurable, recognisable mild affects and mood heightening and impairment of judgement can all be detected. We have been generous, we have made it 100. At a 100 you can detect serious impairment of physical and mental functions: loss of judgement and clumsiness in coordination. It doesn't really matter because when people are hauled up they have got levels of usually well in excess of that figure. Nonetheless, the fixing of that limit reflected the ambivalence. Because on the one hand, road accidents due to drinking provoke enormous emotion, enormous feeling. But on the other hand society does not want to restrict too greatly its ordinary everyday access to alcohol. Its ordinary everyday access to alcohol often goes hand in hand with its access to ready transport and automobiles and so on. These are some of the elements that make any strategy for prevention, identification and treatment, which make the need for producing such a strategy, of course, even more pressing, but they also make it necessary for us to approach the subject with an air of realism.

My experience, not in Ireland of Health Education is that it oscillates. That it gets very enthusiastic about things and then it tends to weaken in the fact of a rather intransient and intractable position and then it sometimes turns to other things. Now the medical profession in its favour having bashed it a little, in its favour in the fact that it has struggled for quite sometime with an intractable problem and now one teaches, as I do, young doctors not to throw up their hands at somebody in whom they have detected significant alcohol abuse, but to see such a person as they see so much other disturbance that they are asked to treat, as often intractable and chronic. But that is the nature of much of medicine — we cure little, the notion is that somehow one relieves just a little. Of course, it also makes it mandatory that we intervene far earlier, because if what I am saying about the recuperation of established alcohol dependence is a difficult task then that makes it all the more important that you and your

colleagues are poised to pick up the problems of early abuse. Indeed also to pick up those situations and cues that suggest that individuals, others or yourselves may be prone to become dependent. That realism is difficult to maintain as I suggest. Man progresses, particularly in these areas, with enthusiasm, it is useful to feel enthusiastic, it is useful to feel that one is doing a good job. In the early stages indeed it is hard to see how one gets started without those particular feelings.

Just to end in a sense by reviewing what we are at. Any attempt to arrive at an economic cost, which you will hear something of when industries are involved, is always of course, prone to doubts about the accuracy of the figures. This is Walsh's estimate of the cost and the benefits in purely financial terms, and it is a sobering one, if I may say so. He does not have any way of making an economic assessment of the pain and the misery and the unhappiness and he readily accepts that. This is an Economists attempt to balance the books. You can see that the costs of drinking, borne by the tax payer and the individuals, approaches by those estimates something in the region of £100m. But the revenue is a substantial one as well from VAT and Excise Licenses and taxation. Now the slide cannot be used and should not be used as an argument for saying that since really the benefits out-number the deficits, particularly in these difficult Thatcher/Haughey days, then would Dr. Crawley please turn his attention to other more important things, like the hours of dancing and some of the very real social and inter-personal problems in the family life of Ireland. But, of course, the issues that you will see, it is important to be reminded of this in the setting of industry, the aspects of alcohol abuse that you are well poised to see are the very personal ones, are the sufferings, not always of the drinker, sometimes indeed of those immediately around him, of the difficulties that work colleagues have helping or just integrating and socialising with somebody who is in the grip of an alcohol problem and finally, and that is most important the pain and misery that much alcohol abuse causes to the person who is doing it. It is important to remember that much of the denial, much of the miserable reputation that people get who are beginning to secretely and in a hidden and rather deceptive way play around with alcohol, that much of that activity is precisely because the person who misuses alcohol in a society that tolerates misuse is a major threat to others and is ashamed of it himself.

He is surrounded by others who, he thinks and is led to believe, are handling the pool of alcohol sensibly. You and I know that many are not. Many of the people he will point to as examples of people who drink no more than him and who, therefore, must not have problems, they themselves have problems if he but knew it. But the misery, nonetheless, the temptations to deny the frightful stereo-type and stigma that hangs over everyone that is misusing alcohol. The stigma of the drunk, the vagrant, the important man, the wife beater, the social outcast, the incompetent, the dementing, the comic fool — all of that together make a major and significant contribution to the tendency of a man or woman who is beginning to misuse alcohol to deny it. If you have that understanding, if you see the reasons why people do often engage in extraordinary psychological maneouvers to avoid the obvious. Then you are better poised as individuals to help them get past that mechanism of defence and to readily acknoweldge, not what is weakness but indeed what is almost inevitable in many instances, particularly in a society such as this.

Indeed, people in Ireland will be, perhaps asking or maybe they should ask now, why do so many abuse alcohol? Why do so many misuse alcohol? Why do so many have difficulties in their family, personal, occupational lives because of alcohol? — these are interesting questions. But an even more interesting question is given the pressures and given the stresses why do many people apparently not — the old answer was that those who misuse were defective or were in some medical/biological sense weak; the new answers that there are many factors and they are as I have enumerated them. How much do you drink? what you drink?; how you drink?; where you drink?; what you drink? Many or all of those variables can be changed in any of us if the circumstances of our life, our immediate environment and those we share it with, if those circumstances are changed dramatically and in a way that exaggerates the stress under which we live.

In those circumstances of course, it is not a mystery as to why so many people in Ireland have trouble with alcohol. It is very understandable and the sooner that that fact is conveyed to those who are in trouble, the sooner I think we will get past what is a very real obstacle in Irish drinking. The obstacle, whether it be in industry, the medical profession or elsewhere, the tremendous need people have to deny the extent to which this readily available substance is making trouble for them, because for some reason they see this as the exception to the norm. Many people from time to time have problems with alcohol — fortunately most of them recover themselves or with the support of others. We are talking about those for whom additional intervention of an informed, educated and compassionate kind — that additional intervention is required.

I hope that after the next day and a half, those of you who are very well placed to take a look at another segment of this very complicated picture in industry, in the work situation, that you will feel more confident about your understanding of what is going on, more realistic about what you can do and more determined to do your bit to contribute to the much greater strategy, the greater need that is slowly to turn the Irish attitude to alcohol and alcohol abuse from its chaotic, contradictory, ambiguous and often hypocritical position to a more informed, a more understanding and a more compassionate one. That is a much broader, more long-term goal, but it is one not to be lost sight of, particularly in the small hours of tomorrow morning or tomorrow night when you feel: "Oh let's take up bridge!"

NB. It was not possible to show the tables mentioned above.

"Prevention and Intervention Programmes in Industry"

DR. WARD GARDNER, Senior Medical Officer, ESSO

I would like to begin by showing you just where Ireland is in the league table of alcohol consumption. You will see that on wine you are fairly low down on the scale. These statistics have been supplied to me very kindly by the Irish National Council on Alcoholism to whom I am greatly indebted for the information.

1979

EEC LEAGUE TABLE – WINE

Position	Country	Litres of wine per capita age 15 years and over
1	France	121.36
2	Italy	118.26
3	Luxembourg	49.30
4	West Germany	30.83
5	Belgium	26.15
6	Denmark	17.90
7	Netherlands	16.00
8	U.K.	9.23
9	Ireland	6.85

(1981 statistics from the Irish National Council on Alcoholism)

In spirits, Ireland are fifth equal in the per capita consumption and in beer they are pretty well up the league headed off only by Germany.

1979

EEC LEAGUE TABLE – SPIRITS

Position	Country	Litres of alcohol per capita age 15 years and over
1	Luxembourg	7.25
2	Netherlands	4.54
3	West Germany	4.27
4	Belgium	3.84
5	**Ireland**	**3.27**
5	France	3.27
7	Italy	2.62
8	U.K.	2.45
9	Denmark	1.89

(1981 statistics from the Irish National Council on Alcoholism)

1979

EEC LEAGUE TABLE – BEER

Position	Country	Litres of beer per capita age 15 years and over
1	West Germany	184.1
2	**Ireland**	**178.8**
3	Belgium	161.5
4	U.K.	158.8
5	Denmark	156.0
6	Luxembourg	140.2
7	Netherlands	113.3
8	France	59.7
9	Italy	22.2

(1981 statistics from the Irish National Council on Alcoholism)

Now we all know that it really doesn't matter whether alcohol is taken diluted or undiluted — it is the amount of absolute that matters and that is where Ireland is is in the E.E.C. league.

1979

EEC LEAGUE TABLE – ALL ALCOHOL

Position	Country	Litres of alcohol per age 15 years and over
1	France	20.2
2	Luxembourg	17.4
3	Italy	16.7
4	West Germany	16.2
5	Belgium	14.5
6	Netherlands	12.2
7	Denmark	11.7
8	Ireland	11.2
9	U.K.	9.6

(1981 statistics from the Irish National Council on Alcoholism)

EXPENDITURE ON ALCOHOL IN THE REPUBLIC OF IRELAND

"The figure for *expenditure on alcohol is one eight of the total expenditure on all goods and services.* At this level, *it is the highest of any country which keeps statistics".*

(1981 statistics from the Irish National Council on Alcoholism).

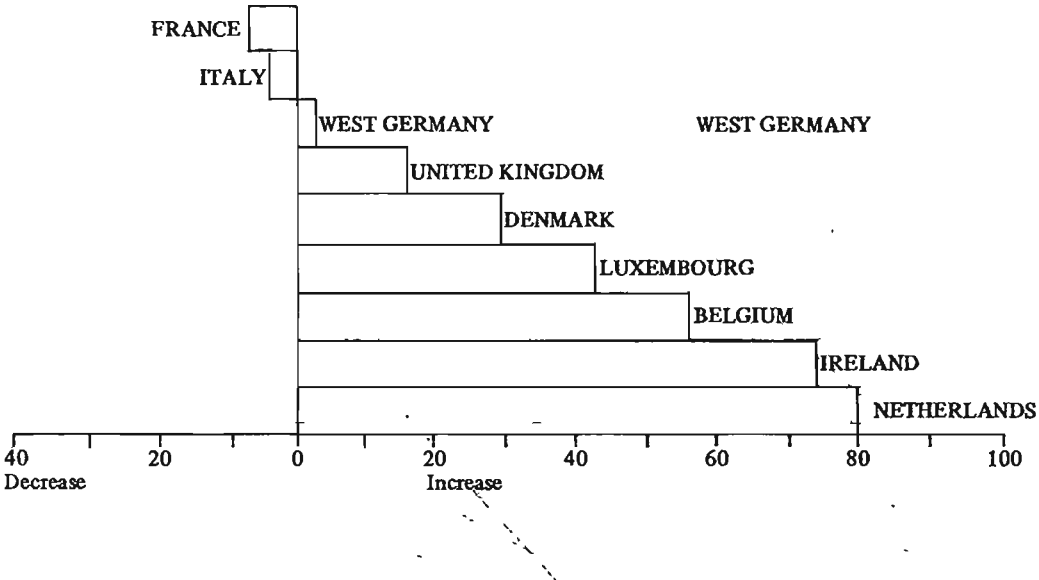
This statistic is higher than the statistic which was quoted to you last night, but this is a 1981 statistic, so I thought it was worth putting it in. At this level:

"In *real* terms (not inflationary terms) the expenditure on alcohol in the Republic of Ireland has *INCREASED* by 51.5 per cent from 1970 to 1978" (latest figure available).

(1981 statistics from the Irish National Council on Alcoholism")".

What does this mean? It means that however bad your problem is now, it is going to get a good deal worse because the consumption of alcohol now is producing the people who will have problem drinking tomorrow. Those of you who are familiar with the Lederman curve etc. will be inclined to believe it. Those who reject that approach might not, but I think there is a lot of truth in it. Certainly, if more is drunk, it would be a fair prediction that the problem will not go away, it will get worse. That, at any rate would be my prediction. So against that kind of background, Ireland has the second largest increase in per capital consumption and so it is heading for more of a problem than the other places, eventhough they drink more. They have their problems in its existing state and in France and Italy, are even knocking it back a little. They are of course very high on the league, but that is how it is going.

PER CAPITA CONSUMPTION OF ALCOHOL
1969 - 1979



Now to get down to the occupational prospects of the problem: I believe in an occupation context it is necessary to try and get Management/Board interested in this problem because I don't think there is anything one can do without management help, without management being on the same side as we are. A policy is probably necessary, or some kind of document which, for example:

ALCOHOL POLICY

1. * Recognises alcohol abuse as a problem
   * Seeks to identify problem drinkers
   * Aims to give help
   * Applicable to all employees
   * Confidential.

2. * Time off for treatment (recovery paid under sickness scheme terms).

3. * Aim is to get people back to work. Job changes may or may not be necessary.

4. * If help is refused or if drinking continues, disciplinary procedures will be invoked.

With regard to job changes, I think it is unrealistic to put people back to their own job. Sometimes if people are in responsible jobs where they have to act alone a lot of the time, if they can't be trusted, they can't do that kind of a job. I will quote to you cases where I have had to people out of for example, where they are acting alone and where they are relatively unsupervised. You can't put people in there unless you can trust them. So job changes maybe necessary where they can do a similar kind of work, but under close supervision for a few years, until they establish a new persona of somebody who is dry or somebody who is drinking in a controlled way.

I think you have to have some sort of clause that says that if help is refused or if drinking continues, disciplinary procedures will be evoked because some of them will go on drinking and you have to have a mechanism for dealing with these people. Our policy allows people one good chance to sort themselves out, then if they put their drinking before their work or before their job or before their life, then they have to go down another route. Discipline may involve mild discipline or firing — it depends on the degree of transgression of the existing codes of the organisation. The difficulty of saying that you will allow people two or three chances is where you draw the line. Do you allow them one or two or three or do you just allow them to go down the steps a number of times until they finally have to go the disciplinary routes.

We made the decision, right or wrongly that they get one very good chance, the best chance that we can give them. We pay them for whatever time is necessary to sort themselves out. If they don't want to sort themselves out or refuse help — they go straight down the disciplinary route — if that is appropriate.

The following statement is the policy as given to anybody who has a problem. If I or a manager or anybody else and it is very much usually a joint effort, identified people as having a problem this is the document they are given:

POLICY ON PROBLEM DRINKERS AND ALCOHOLICS:

* The use of any drug interfering with safe and efficient job function is a matter of company concern and will be dealt with in an appropriate manner.
* The company recognises that people who have a drinking problem should be offered medical help.
* When a person is noticed as having a drinking problem, that individual should be referred at once to a company doctor for help and treatment on the clear understanding that:
  — the company will offer help towards the treatment of a drinking problem if the individual wants this help for its own sake.
  — review of the individual's future with the company will be undertaken at an appropriate time, depending for example, on the severity of the condition, on the understanding that successful treatment does automatically lead to continued employment. The whole circumstances will need to be taken into consideration, including the individual's particular duties.

The above is not in our Company Policy, but it is in "lay language" rather than "officialese".

If you ever have to write policies, beware of saying that you will give the individual's own job back if you reform yourself or stop drinking, it can lead to trouble.

We also try to look at the individual's family, we don't get involved with families, but we try and see that the families are supported by whatever agencies are in the community etc.

What do you do in an organisation?

* Inform the workforce of the problem
* Alter the social climate with regard to alcohol and drinking
* Identify problem people
* Remove cover up
* System for help.

I will continue now to examine these headings in detail.

Inform the workforce of the problem

— Policy
— Discussion with management/unions/joint consultative bodies
— Seminars about alcohol
— Health information/Education
— Booklets, leaflets, drip mats and so on
— System for help spelled out.

The workforce should be told that there is a problem and that there is a policy, if you have one. I am now beginning to speak parochially but I was asked to say what we did as an organisation. I am not trying to tell you how you should do it in your organisation, that is a matter for you to decide. I am trying to say what we have done, and what John Aldridge is going to do and I understand Joy Evans is going to do something similar so you will get a flavour of what other people in the field are doing or are not doing or where we are different and so on. I am speaking about ESSO Petroleum and ESSO Chemical Companies.

We have a policy, then we discuss the policy with management, unions and joint consultative bodies — they all know about it and they all had their finger in the pie or stirred the pot when it was being developed. We run seminars about alcohol to try and inform people as far as the most junior management levels and as far as any joint-consultative committees. We have tried to do health education and information. We have produced a booklet called "This is About Problem Drinking and Alcohol". It is a rundown of the sort of things that are common knowledge within a working community. This is our own effort and it can be given as a handout or to anybody who has a problem or to supervisors. We also produced a set of drip mats "You and Your Health" which is the general title. This we use for a much wider front of health education. On the back for instance, it says: it takes guts to say no and pictures of glasses and on the other one "You and Your Health" there is a sort of fat little chap and on the back it says: "We all like a drink in moderation".

The system for health that you have, must be spelt out so that people understand to whom they can go for help or where in the community help is available. My feeling, having worked with this problem for some years, is that people are not very forthcoming. The usual route for people coming to see me at any rate, is that they are asked to come and see me or I ask them to come and see me for some other reason. The one that comes out of the blue to me and says that he thinks he's got an alcohol problem is, in my view, unusual. I sometimes see people who have medical or other problems of various kinds and I may think they have a drinking problem — not what they think they have — that is fairly common. But the guy who comes to me, or the lady and says that they are drinking too much and they've got a problem and need help, is very low in my order of things. Other people may have different experiences.

Alter the social climate with regard to alcohol and drinking

- Remove alcohol from company dining rooms/canteens
- On ships, limit the amount taken on board
- Do not tolerate lunch time lateness
- Review absences, especially short-term, by day of the week.

Removing alcohol from company dining rooms/canteens is mainly to make a statement that everybody can understand that we believe that drinking on the job is not a good idea. Indeed we don't even have drinking on these premises off the job, in the evening if we are entertaining the local Mayor or whatever it is, they get their orange juice then. Sometimes they don't like it, but that is what they get

On ships we limit the amount of alcohol taken on board. This, of course, does not stop the guy who really want to soak it back from getting somebody else's ration or from smuggling his own bottles aboard. He is told he is not allowed to bring alcohol on board. The amount that is put on board the ship is related to the number of people and the length of the voyage and the number of days. The Master of the ship is held accountable for amount per head drunk on his ship. These numbers are actually recorded and looked at by our Transportation Management. We have brought these numbers down twice in the last eight years.

I fear a difference in the opinion at sea about Jolly Jack Tar and where drinking is a social pastime.

Identifying Problem People

- Often 'Good chaps, but ....'
- Late back from lunch
- High M and F absences
- Performance falls without obvious explanation
- Short term absences increase (usually attributed to 'illness').
- Often smell of drink
- Excuses, excuses
- Nipping out for drink
- Appearance may deteriorate
- Hangovers, pale, sweaty and trembling, 'the shakes'
- Injuries especially R.T.A.

We try not to tolerate lunchtime lateness and all these other kinds of things. We would view absences by the day of the week, especially the short term; the Monday and Friday and the absence related to holidays. "He is a good chap but ..." — the but says he drinks too much. If that statement is ever made, that is an indication that help is needed. Late back from lunch, high Monday and Friday absences, performance falls with obvious explanation — we heard about that last night. Repetition may be valuable because common factors can be seen. Short term absences increase. I don't know how your organisation keeps records of absence, but if you have any medical group — nurses, doctors — absence should be recorded by diagnosis and by duration. If these things are done, the thing begins to shine out at once when you look at the idividual's record of their short-term absences increasing.

The smell of drink, often disregarded, but a very useful clue especially at times like 11.00 a.m. in the morning, you should really wonder about that; nipping out for a drink. Appearance may deteriorate, where before they looked as if they washed their clothes, pressed their suits and brushed their hair — or the female equivalent.

They begin to look slovingly and untidy. Then at the more extreme — people with hangovers look pale and sweaty and trembling. People often have an image of alcohol abusers as people who are red faced and rather florid, that is not always so. Some of them look like that when they have the drink inside them, but the next morning they often look a bit pale.

Injuries, especially road traffic accidents at the danger time on Friday and Saturday (perhaps even Thursday and Sunday) — if you don't have to drive your car, don't go anywhere because the other chap may come at you even if you are very good.

Remove cover-up

Talk to people about their *effectiveness* and *performance*

- — Keep a log of lateness
- — Keep records of absences
- — Seek help for problem people and *insist* that they, as well as you, follow up.

FAILURE TO REMOVE COVER UP ONLY MAKES EVERYTHING TAKE LONGER AND GET WORSE.

Removing cover-up is a very difficult problem. We have the schoolboy/schoolgirl feelings about this that it is telling on others. This has to be countered because if it is not done then the hidden alcoholic is not detected for a longer time and the problem just gets worse. Superivsion and management can talk to people about their effectiveness and their performance. If these diminish with apparently good reason, they can use these as levers to seek help.

You can also keep a log of lateness and record lateness and absences if you are a manager. You can insist that problem-people seek help. Failure to remove cover-up only makes things worse and everything takes longer. That is an important message to get over within the organisation.

System for help

- — Clear system of referral for problems (personnel, medical, special counsellors)
- — A policy
  - * full help given, including necessary time off
  - * if help rejected — disciplinary route
  - * if full help given and person then puts drinking before work etc. — disciplinary route.

The system for help should be known in the organisation if they have this or that kind of problem and where help can be obtained — this should be signposted in their minds. There should be a policy and some kind of statement that they can use as a background to any necessary discussion.There is a little repetition in this, but it falls into these categories. I would like to move to some of the more medical aspects of it. This is a subject in itself. If we look at present industry, there are a lot of diseases that are associated with alcohol.

Alcoholic symptoms, many of them are associated with the diseases that are associated with alcohol and people don't see them as alcohol problems if they are not aware of this kind of list.

History

* PRESENT	diseases, injuries especially R.T.A. Alcoholic symptoms Detailed drinking history
* PAST HISTORY	Diseases
* FAMILY	Other relatives with alcohol problem very strict about alcohol or T.T. Neglect of children, Nocturnal enuresis, soiling, Mental disturbance, wife-beating
* OCCUPATION	Some occupations carry high risk,
* CRIMINAL OFFENCES	Drunk and disorderly Drunken driving Other offences under influence of alcohol
* WORK	Becomes less effective.

A detailed drinking history is necessary. Past history, certain diseases shine out in the history of people who have drinking problems and if you don't know them I will show them to you in a further view point.

Family history: If there are relatives with alcohol problems, or if there is this problem of their father and mother being very strict about alcohol or teatotal, or if their father and mother, or sister or uncle or aunt have been heavy drinkers, then the light should flash a bit. You know about the generation skip? If my parents had been very very teetotal and very anti-drinking, I might well be a very heavy drinker and my children, seeing my performance might revert to grandmother's strict teetotalism. This one generation on, one generation off, does occur, it is worth looking for. Then the signs of neglect of children. Nocturnal soiling, mental disturbance and wife beating — well we all know about that. Some occupations carry a high risk, we shall see the statistics later on. Criminal offences: doctors don't always or don't sometimes ask about people's record with the law or health professionals of all kinds. They feel it is not a subject that should be talked about or they feel embarrassed to

raise it. I think it should be talked about. If you think someone has a drinking problem, you should ask them "Have you ever been in trouble with the law?" That is quite a general question and people will usually respond to it honestly if the rest of the atmosphere of the consultation is right. If they reply 'yes' you can then ask what has the trouble been and ask them to tell you all about it. Wait for the next thing and you just go on like that and you get to the end of whatever they have to tell you. That gets a lot of information.

Detailed drinking history

What did you have to drink yesterday?
Begin on waking and continue till bed time.

Bout drinking. What is taken? — Beer
Spirits
Wine

How much of each?
Answers here often evasive and low!

Duration of drinking and build up to prevent levels.

Smoking History

Heavy smoking often goes with heavy drinking.

Drinking histories are often, in my view, taken badly. What did you have to drink yesterday? is often quite a good opening question. You begin on 'waking' and continue till 'bedtime'. This my seem rather strange but the guy who has got more experience of alcohol will recognise that this is a serious attempt — I mean do you wake up and have a drink? If you don't ask that question it may not be volunteered. The one who reacts with amazement to this and says 'oh no, I never do anything like that' well, that is another kind of clue. If they say they have had absolutely nothing at all, on the wagon yesterday — then that does not exclude bout drinking — the kind of guy who has three weeks completely off and then a blinder for two or three days. Then you have to ask what is taken: beer, spirits, wine and how much of each. Beware, of course about the answers being evasive. Then work through the duration of drinking and the build up to present levels. Any sort of rapid steps on the subject. Smoking history is also worth taking because heavy smoking very often goes with heavy drinking. If you can observe the people who are heavy smokers or get their smoking history first, it may be a clue. This table is taken from the Decennial Supplement on Occupational Mortality in UK and its occupations with the highest mortality from cirhosis of the liver, which is a good marker of excess alcohol intake.

OCCUPATION UNITS WITH THE HIGHEST MORTALITY FROM CIRRHOSIS OF THE LIVER

Occupation Unit	Title	Rank in top 20	All deaths SMR	Number
154	Publicans, innkeepers	1	1,576	106
115	Dock, engineering officers and pilots, ship	2	781	11
155	Barmen, barmaids	3	633	16
116	Dock and engine room ratings, barge and boatment	4	628	16
001	Fishermen	5	595	5
156	Proprietors and managers boarding houses and hotels	6	506	16
149	Finance, insurance brokers, financial agents	7	392	8
159	Restaurants	8	385	17
134	Lorry drivers' mates, van guards	9	377	2
162	Cooks	10	354	14
124	Shunters, pointsmen	11	323	3
066	Winders, reelers	12	319	1
030	Electrical engineers	13	319	5
206	Authors, journalists and related workers	14	314	10
181	Medical practitioners, (qualified)	15	311	14
147	Garage proprietors	16	294	5
125	Signalmen and crossing keepers, railways	17	290	5
164	Maids, valets and related service workers	18	281	5
082	Tobacco preparers and products makers	19	269	1
202	Metallurgists	20	266	1

That's the situation in England, I was unable to get the Irish one, but I have no doubt it is fairly similar as these occupations occur in a variety of countries and there seems to be a great deal of common thread. Work History is also worth getting.

Work History — best from a third party.
Performance suffers, less effective
Lateness, especially after lunch and Mondays.
Absence rate rises, especially short term absences and usually worse Monday and Friday and around holidays
Unexplained lapses of all kinds.

Speak to his boss because the person concerned is often not very accurate about how they are doing at work. Their boss is usually a great deal more accurate.

The following is a set of information on cover diseases — the alcohol masquerate. These are diseases that are commonly picked up and written down on medical certificates and recorded on sick notes and find their way into a variety of bits of paper. Unless you are aware that these things are or can be connected with alcohol, you miss them. If you get two or three of them on a list, it should shine out and flash the light at you. There is a useful book on this subject, it is called: "The Hidden Alcoholic in General Practice" by R. H. Wilkens and it has some of the diseases that are on this list and also a very good discussion about looking for the hidden alcoholic.

Cover Diseases — the Alcoholic Masquerate

1. *Digestive*
   Haematemesis
   Oesophagitis
   Mallory-Weiss Syndrome
   Gastritis
   Peptic Ulcer
   Pancreatitis
   Cirrhosis of liver
   Melaena

   Cancer of Pharynx and oesophagus and stomach occur with greater frequency in heavy drinkers.

Cover Diseases — The alcoholic masquerade (cont.)

2. *Circulatory*
   Congestive failure of unknown origin
   Alcoholic cardiomyopathy

3. *Nutritional, social infective*
   Malnutrition
   obesity, especially 'flabby jelly' fatness
   vitamin deficiencies (peripheral neuritis)
   Tuberculosis

4. *Nervous*
   Epilepsy — for the first time aged 25 or over with no apparent cause
   Peripheral neuritis
   Anxiety state
   Depression
   Attempted suicide
   Unexplained ceregral degeneration (Korsakoff psychosis)
   Unexplained blackouts.

5. *Injuries*
   Road traffic accidents/injuries
   Work injuries.

I believe that anyone who does not have a family history or a head injury or some obvious reason for having a blackout or fit and who is over the age limit of 25, you should suspect alcohol. You should investigate for alcohol before you put them through the 3½ — 4 month ritual that involves full neurological investigation, brain scans and all the rest of it. If you find other clues that it may be alcohol — you have saved everybody a great deal of time.

Some of my colleagues find it necessary to exclude everything else before they face the obvious that the person is an alcoholic. People who drink a lot tend to fall down more often and bash themselves around.

Alcoholic symptoms
Blackouts
'The D.T.'s (Delirium tremens)
Alcoholic epilepsy
Peripheral neuritis
Any symptoms of the diseases in the cover diseases list.

Examination

Appearance	—	High colour, red eyes, pale sweaty, trembling
Smell of drink	—	
Demeanour		Restless, irascible, aggressive
Spider naevi		5+ below root of neck
Liver edge palpable/ liver enlarged		—
Cover diseases list.		

I believe that a comination of a raised gamma GYP and a raised MCB, with no obvious explanaton is almost a bull's eye alcohol. If there are liver enzymes raised or their gallstones, or if they have a history of liver disease, you are off to the races in the usual way.

Use of tests

GGTP
MCV
Triglycerides
Serum urates

I believe that these clues are not used enough. It is a simple matter to take some blood and to request liver enzymes and a full blood count.

That is what I have to say on the subject and I would like to leave you with the following, just to think about the effaffects of alcohol:

"Prevention and Intervention Programmes in Industry"

DR. JOHN ALDRIDGE, Senior Medical Officer, IBM

Mr. Chairman, I was going to start off by saying that the views which I am going to express are virtually my own, but I think that my company would probably own most of them, I hope anyway — particularly as I am going to talk about the company and what it does — but if I do make any mistakes those are the things that are my own and not the company. I think I better try and put it all into perspective if I can. I would like to talk to you a little bit about IBM because you need to see it in the context of that company.

IBM is, as you know, a US multinational company. It is very successful, I am glad to say, and I am also glad to say it is profitable. It is a single status company; by that it means that everybody is treated in the same way. There are no great privileges for some people rather than others. Although there may be some dissent about that and in some areas — although I think that it is always explainable. It is mainly a data processing company — we make computers and all the various devices which are attached to them. Of course, we will compute things for people without them actually having to buy the computer in the first place.

We also have various other activities, I won't go into all of them. The other big division is in office products where we have typewriters, copiers and word processing equipment and so on and so forth. Just out of interest, because this is a largely medical audience, we do have a small amount of medical kits which we now make and market. I am not sure whether they are marketed in Ireland but certainly they are marketed in most of Europe. This is a blood cell separator, which as it suggests, separates blood into all the various different fractions. A blood cell washer — if you happen to want to store your blood and then wash it to wash the cells before you can use it. Also an ECG machine — which will be a great pleasure to some because it actually tells you what is wrong with the patient when you have done it. It has a programme which actually prints out the differential diagnosis and gives you all the perimeters that it has measured.

Worldwide, we employ something in the region of 337,000 people and we operate in 122 countries. It is a dry company. By that I mean we do not have alcohol on the premises. So in no IBM location throughout the world, I am going to alter this very slightly, but let me say it to start off with — will you find alcohol. If you walk into anybody's office they won't open a drawer and offer you a drink. If you go into a canteen in most countries you will not be able to get a drink. I have to tell you that there is a slight difference, because in France, for instance, where it would be considered curious not to have a drink in some cases at lunch, there is wine and beer available in small cartons. But that is because it is a tradition of the country and it had to be fought through originally by the French with a great deal of difficulty, as you can imagine, against the very strict views of the people who are running the company in the States. That has relaxed a little bit and whereas in days gone by if you went to any IBM function in the States you were never ever offered alcohol, even if it was in a hotel — you were always offered a fruit cup. It was never laced either, I mean nobody ever got at it. If anybody did serve or try to serve alcohol in the States, they really were in very considerable trouble. I think it is a very good system, I am all for it. I was delighted to hear Ward saying that ESSO have taken alcohol out of their own locations.

IBM, U.K. of which I am the Medical Officer was established in 1951 in London. It has a rapid growth and it now has two manufacturing plants — one is in Greenock in Scotland and one in Hampshire. It has a development laboratory in Hampshire. It has 30 or more sales offices across the whole of the country. It has 15,000 employees.

Just to give you a little bit of demography: 16% only are female, that surprised me actually; 84% male, male stronghold bastion. It's overall turnover of people in 1980 was only 4.2%. Very small. The average age is 36, though I am considerably older than that. There are 30% of graduates or people of equivalent status. So now perhaps you can understand why I think it is necessary to give you this background. It is also a non-union company. We do not have unions in the UK, there are no unions in the States in IBM, there are, of course unions in countries where unions are required by law.

We have, I believe extremely advanced personnel policies. We have a very strong personnel function of which I am not part. Our sickness and accident scheme includes, of course, people who have alcohol related illnesses. My role in the UK is: I report to the Director of Personnel. I am responsible for health and safety within the UK and I have an involvement from mental health on the one hand, which happened to be of particular interest, through to toxicology on the other. As your Chairman mentioned, I also currently have this role, which is very interesting, which brings me into contact with a lot of Europeans on this Occupational Health Board which we have developed. I only have one slide and I will just show you that although IBM is a dry company, there are other companies obviously, and now you know what goes on behind those computers. It struck me as being particularly apt and I hope that Mr. Corke won't mind me blowing his excellent cartoon up.

Well, now I want to talk first of all, just briefly perhaps about the size of the problem, because it is always under estimated. It is usually seen as very small, although as we have heard already its incidence across the world is very variable — the US, Scandanavia, France have a very high incidence, Scotland is certainly very much bigger than England and Wales — it is said to be 20 times more prevalent (that's alcoholism) than any other addiction and it is said to be the third major health problem by the World Health Organisation after heart disease and cancer. I am not going to give you a large number of figures, but the drinking driving convictions went up by 50% between 71 and 76 and we are all very aware of the effects of alcohol in accidents especially after 10 p.m. and during the week-ends, particularly Friday and Saturday evenings. The offences involving drunkeness in the past two years have increased by a factor of two for males, aged 18 to 21 has increased by four — very considerable indeed.

Of course, the cost of drinking is huge if you consider all of the various effects of illness and absence and lost production and spoiled work and road accidents and home accidents and fires, very common, and damage to property and crime and so on and so forth.

I said that the incidences are frequently under-estimated and that is obviously true. In the States a typical estimate of the number of problem drinkers or alcoholics in the nation's workforce is between 5% and 7%. But it is very rare for there to be 1% to 1½ to be identified, that is only by the very best schemes that industry have developed in the States. In the UK the figures will be less. I don't know how much less, I can't say that. But if you go and talk to industry and ask them how much that they believe there is in their workforce — everybody will tell you considerably less than 1%. That cannot really be so — it must be considerably more than 1%. I don't know if these are confidential figures or not but IBM in the US identifies about 2% of its workforce. Yet the total workforce under normal circumstances has somewhere between 5% and 7%. Now there may be some differences in the type of people we have working for us — but nonetheless I would not expect there to be that huge difference.

The probelm, of course is identification. It is undoubtedly in many respects proportion to company attitude and to the zero and the law of the investigator. Now I would like to go onto the way in which cases present starting with a working definition which we will term as someone who has a drinking problem. Dr. Davies, the Medical Director of Alcohol Education Centre in London describes it as the intermittent or continual ingestion of alcohol leading to dependence or harm — which is fine. There are many others as you will know that have been produced. The one that we use in the company is a consumption of alcohol which adversely affects satisfactory job performance or normal social adjustment at work. That is in other words, something that adversely affects work performance or behaviour at work. We see from time to time changes in performance with errors and omissions or the reduced volume of work that somebody does or the fact that they are away frequently from the work place (to sup a few drinks perhaps?), their memory or concentration may be reduced, they may have accidents at work or on their way to and from work, they may fall or have blackouts.

At this stage, I must apologise for some duplication of what I am saying. Also, you may notice that in some cases there are some minor differences in what for instance, Ward believes and what I beleive.

As far as behaviour is concerned, we notice difference in absence—Mondays after week-end bouts of drinking. That really does happen. I mean it is told—if you teach people that it is a classical thing—it really does happen. Lateness, sleepiness, unexplained illnesses, their appearance including people who are overtly drunk — which in IBM leads to immediate suspension. Anybody who arrives in drunk would be immediately be sent home and told to report the following morning. Also smelling of alcohol at unusual times, as Ward said. This decreased tolerance to alcohol may eventually lead to an increased tolerance. At this stage I would like to stress more than anything else is the secrecy of alcohol dependence. It is a very secret condition. Everyone tries to hide the problem. The drinker does. His family does. His friends do. His workmates do, his management do and sometimes, my goodness, his doctor does. They somehow all get into a collusive state of denying the fact that here is somebody who is ill through alcohol.

Because of the way IBM is constructed and managed, the person who is best able normally to see alterations in performance or behaviour is the immediate manager. The manager in charge of that person — it may be a manager in charge of another manager — but the manager who is in charge of the individual.

The immediate initial concern may not necessarily be from a manager and in other organisations and other institutions it could be from the Trade Union Shop Steward and I would hope that it could be that way frequently. It could be from the Nurse in the company. It could be from a friend or a relative and it could indeed sometimes be from him/herself. But all this points to the need for a policy which Ward has told you about in his policy.

I will give you some examples of cases just to give you an indication of the way in which cases are presented to me. I thought when I was listening to Tony Clare's presentation last evening, that it might be helpful to tell you about 9 cases that I have seen in the fairly recent past. I don't believe that IBM has a very large problem, it is undoubtedly bigger than I know about, but it certainly has become very much visible in recent years. I am very well aware that in the last 3 to 4 years I have seen very many more problems than I have perhaps seen in the previous 10 years. I don't entirely know what has caused it. I do not believe it is just a sudden jump in the number of cases or change in the social values or something of that sort. I am sure there are all sorts of reasons. Multifactorial reasons which would bring that result.

The first case — a man: I was telephoned by a non-drinking alcoholic female whom I had seen some years previously who said: I am worried about Bill Bloggs, he seems to be doing a lot of the things that I used to do and he has fallen down a few times and has hurt himself. I just wonder if it isn't something to do with alcohol.

I knew Bill Bloggs, I knew him well enough to be able to ring him up and ask him to come down and see me on some pretext or other. In fact the pretext I used was that he had knocked his teeth out! His front teeth were out and he came down and he was looking dreadful with half a broken tooth and one completely broken out on a stump and so on. I said "Good Heavens, what on earth happened? I'm sorry to hear about these accidents you have had" — what a curious concidence. He said it was stupid of him and that he had tripped up the steps of the tube at the tube station. He then told me about two other falls he had had (as I asked him) and I tactfully said: "Well you know the thing that worries me is that when I see people who have had a lot of falls like this, it does sometimes point to the fact that they may be drinking rather a lot." "O Good Lord", he says, "nothing like that all, good God I hardly touch a drop." But in fact, he did as we then went into each one — "Well er that one as it happened after a party, yes and the other one was after my daughter got engaged" and so on. There was always some reason for it. So that was one.

The second case: the first time anybody else in the company knew that this man was drinking too much was

when he had a horrendous motor accident in which somebody else was killed. The amount of alcohol in his blood was staggering so it became clear then that he had a drink problem. He is now a recovered alcoholic.

The third case was a woman: The manager rang me up and said: "she's got bad work performance, she is frequently absent and she shuffles about, walks badly and she has to be helped to the loo". I was fascinated by this and it worried me when I first saw her as she undoubtedly had a drinking problem. She has improved very considerably and she now can get to the loo without help and can walk about perfectly adequately and in fact is very proud of the fact that she can walk around and look at herself.

The fourth one was a female who was actually drunk and cause a disturbance in one of our office location receptions. She in fact was referred to me but didn't come and resigned. I heard afterwards that she knew that the screws were going to be put on to her to deal with her drinking and she was not clearly prepared to do that.

The fifth person was a male who happened to be on very good terms with his manager, I would hasten to add. They had a particularly friendly relationship because they had known each other for a long time. His manager had noticed that his work performance was altering and the man was also concerned about it. They talked together and it came out that he had a drink problem, so he came to see me. I talked to him, I referred him to a Consultant. He rang me up and said: "Look, all the talk that you gave me and the way you made me understand — I now see the error of my ways. I can stop drinking entirely, in fact I have not drunk a drop since I last saw you, so I don't think I need to go to the Specialist." I told him that I could not force him to see the Specialist but I told him to understand clearly what the position would be if he failed. He said yes and of course, 6 months later we had a similar problem.

The next was another male whose job performance had reduced. His wife rang me up. This is always quite difficult because we employ employees and not their spouses and one has to be very careful about what one says, but nonetheless it was a very helpful telephone call and he has done very well since. Although he is now divorced. Well, that was not meant to be funny, but obviously it is. It is just another complication of alcoholism — divorce, separation and marital problems.

Then there was someone who had repeated absences for a large number of apparent reasons — every certificate that came in was a different one.

The final one is a man who was teaching customers various programming in hotels. It all came to light after some customers said that it was a bit curious because at times we have to put him to bed, I mean the customers putting the chap who was actually teaching them to bed at night. On one occasion he was found in the early morning with one of the Receptionists in his bed and who, of course, immediately lost her job. If that wasn't bad enough — the ceiling below his bathroom had come down because he had just turned the bath tap on and left it running for the whole night and he seemed to be fairly unconcerned about the whole thing. He believed fervently that the company would just pay for it, which they did, and that would be the end of that. He never ever accepted that he had a problem. Eventually he left.

That just illustrates the sort of way in which cases have come to me within the recent past.

Policies should be developed by Management but they should be developed as a result of joint discussion where there are third party involvement of unions. Discussions should take place and should eventually be some sort of written document as Ward has said. The objectives should be to offer opportunities for treatment and rehabilitation to those who do have a drinking problem with the very sincere wish for success. I think it is always very important that when you are dealing with somebody who has an alcohol problem that you go back and remember what that objective was.

In our company, although I think Ward would not agree, we see alcohol dependence as being an illness. We accept it as being an illness from which recovery is possible in the majority of cases. We stress that there should be identical treatment from the top to the very bottom. Again that would be absolutely correct in terms of our single status within the company. We stress that confidentiality should always be observed. We would stress that we are concerned with the problem at work and we are not concerned with the private lives of our employees or their dependents or with social drinking. I think that it is important otherwise there may be faintly paranoic feelings that the company is muscleing in on something which is no business of theirs. That really brings us back to our definition that it is to do with work performance and behaviour at work.

It should have the obvious backing of management and has to be seen to be to have the total commitment of management from the very top throughout. An introductory paragraph should be signed by the top man in the company. It should underline that the normal disciplinary procedures remain valid if the form or conduct is not corrected. It should identify someone or several people who can counsel those who have problems. It should encourage those with problems to seek advice on their own accord. We don't necessarily want people to come because they have problems at work. It should be supportive not punitive. Should solicit not as a patient and not alienate all of the employees.

A friend and colleague who is Irish, which will give him even more credibility, who works in England told me of a company which their policy has been adopted for alcohol in that organisation which is seen as a confidence trick by the employees, which clearly does not have the commitment of management and which actually excludes the medical department from any involvement in it. Now that really is staggering. A company that should know better. I just mentioned that because all of the things that I have said should appear obvious — but they are not always put into practice.

As far as implementation is concerned, there should be counsellors who may be either the Doctors or the Nurses in the Medical Department. We have both, as well as a lay counsellor who is very successful in our Scottish plant. His name is John Walker. He is a great speaker about alcohol and of course he makes a great play of that. He was recently awarded the OBE for his services to the community in general, not least for services to alcohol

problems. All of the people who are involved in the company process should be committed to the success of the implementation of the programme.

The following is the way in which referrals reach me. The management or the manager or whoever it is, first discusses their suspicion with me or one of the other counsellors. We encourage them to come to us first before they take any steps themselves because they are not sufficiently trained to be able to deal with the problem. They give us the evidence and if we agree that there is a problem sufficient for them to talk to the person, they go back to the person and explain, with the evidence they have that they may have a problem and what they believe that problem to be. If the employee concerned agrees that there may be a problem and agrees to come to see us, we would then see them and would evaluate the case ourselves. If the person says 'absolute rubbish' there is no problem. The manager is left no choice, and we explain to the employee that he will be treated like anybody else who has a performance or a behavioural problem. Counsellors assess the person and refer them for treatment. We do not treat at work other than very simple first line treatment. We normally refer them to other Agencies in the community for treatment and I would say that it is sometimes difficult to find an appropriate Agency. It is not always easy, we are lucky in some areas, we are not so lucky in others.

The disciplinary standards are the same as for any other breaches of performance or behaviour. If their performance or behaviour is sufficiently bad, then they would be put onto an unsatisfactory report with the idea of improving them. The idea is not to get rid of them, but to try and improve them. However, they may have to go eventually if they fail to improve. They are warned verbally and then they are interviewed. They will have a written warning at the second stage and so on to make sure it is all legal in the long run. With the Employment Protection Act, we have to make sure that all the right steps have been gone through.

Now on the question of lapses: we in fact do allow lapses. We don't fire after one failure. We accept that it is probable that people will have lapses — we would prefer that they didn't. We would probably allow them at least one or two lapses after the initial one. These would be documented so that they would then be on the path to dismissal if there was a third one. This has to be very clearly understood.

There are some factors which, I think, inhibit the use of a company programme because these are based on attitudes obtained in the U.S. from employees and principally those who have had or have got at the moment a drink problem. The first and the most obvious is the fact that there is bad publicity particularly if spouses don't know of a company programme. You lose a lot of useful leverage. The affect on the family is frequently seen earlier than the effect that is seen at work.

The second thing is that people are concerned about confidentiality. They don't really think that the whole thing is going to be kept in confidence — that will inhibit them.

They may be concerned over the persisting authority judgement that is in the company and the feeling that if they are identified as an alcoholic they will be seen as an alcoholic for the rest of their lives. This could cause damage to their careers.

There is a stigma in the company in the states which stress in articles that IBM apparently have very few alcoholics. The recovered alcoholics and the alcoholics resent this very much. They say that you have alcoholics but you don't identify them. They see it as a denial of the problem and the tendancy, therefore, to bypass the company scheme. They see it as a low priority being given to the problem. They say that not only spouses, but also some employees seem not to know about the programme and the active ex-alcoholics anonymous members have reacted, of course with missionary zeal and they are vehement in their criticism, as you can understand. Sometimes there is the feeling that it is wrong to combine a programme for alcohol with a programme for drug abuse. Certainly, IBM in the states at one stage, had a combined problem — a combined programme for alcohol and drug. They say drugs are different. It is one thing to be a junkie, it is quite another thing to be a bit of a problem drinker. I can understand that view. They say there is much more criminality associated with drug taking and so on, as compared with the social aspects of drinking.

The final thing was that they felt a lot of the couonsellors who they went to see had relatively poor expertise and did not believe they knew very much about the probelm or how to treat it. There is a scheme that is going to be put in as a pilot scheme in the U.S. which is going to call on the resources of alcoholics anonymous members within the company who will provide a confidential support network for anybody who believes they may have a problem. So either an employee or a friend of an employee or a spouse of an employee or the children of an employee will all know about this or should know about this. A telephone number will be available for them to ring where a sort of programme manager will give them a telephone number of someone in their area from Alcoholics Anonymous who will be able to give them advice and also to their local resources of Alcoholics Anonymous, Alanon, Alateen and all the various other community resources that are available. In this way they are hoping to be able to get over the creditibility gap between the company and its programme and the actual problem that exists.

Finally, I don't think we are good enough in the U.K. at passing out information either to employees or families. Everyone must know, otherwise if you don't know about it you are not going to take advantage of it.

We would hope to publicise all of the helping agencies which are available. We would also like to make sure that management understand we are committed and would hope to introduce some management development modules. As you will know, those of you who are involved in management training, the difficulty is that there is always something more to be put in and it is often difficult.

I want to make sure that all our medical, nurse and lay counsellors are appropriately trained and finally we are going to monitor the results and continue to monitor results carefully. We are introducing a new monitoring scheme at the moment to see whether we can chase people and make sure they don't drop out. To confirm what we believe is our success rate which is about 65%.

Finally, I would like to tell you a brief story about another sort of person who was talking to missionary zeal about this problem who used as an illustration two worms. He had two glasses in front of him — in one glass he put water, in the other glass he put whiskey and he dropped the worms in half way through his talk and said I'm going to refer back to these later in my talk. At the end of the talk he took the worms out of the glasses and the worm in the whiskey was dead and the worm in the water was still wriggling vigourously and he said: What does that mean to you? A voice from the back said: If you have got worms, whiskey is a good treatment.

"Prevention and Intervention Programmes in Industry"

MRS. JOY EVANS, Personnel Officer, Bradbury and Wilkinson Ltd.

I will start by giving some background information about my company. We are printers and certainly in England this raises all sorts of horns on people because of us having union commitments. Unlike John Aldridge, although we have single status in the company, we also have a multiunion set up which can be very difficult, particularly in this sort of area.

It is a male dominated company with approximately 2,000 people, 1,500 of which are situated on the site that I deal with and about 400 of those are women, with about 50 people under 18.

My role and my relevance today is because I am responsible for the production of policies and procedures manual and also for welfare, so you can see perhaps how they dovetail into looking at this particular problem. Within the occupational health department we have two occupational health nurses. However, in my own company very little creedance in fact is given to occupational health. It is seen really as the plasters and pill brigade. If they get involved in some of the larger issues that is very emotive and causes quite often a lot of problems. We don't have a company doctor. We have a local G.P. who comes in for half a day a week. So in terms of looking at something like a problem of alcohol in our particular industry — we don't feel we can rely on them in any particular way — not at this time.

My company finds itself poised on the threshold of involvement in this problem of alcohol in our industry. It is fairly well recognised that it is quite a problem within the printing world. However, I guess just like many other countries, it is very reluctant to recognise that it actually has a problem and also because the printing industry generally tends not to be concerned with the individual. It is not very keen to become involved and it will continue to try and avoid becoming involved if that is at all possible. In spite of that, there is a lot of pressure in my company coming from the shop floor through the Health and Safety Committee, which from talking to people last night, you don't have many in this country. They can be a very strong body. I'll come to them later.

As far as our company is concerned, I feel we are actually progressing along paths which the company itself may not really want to be going along with. As an industry we pay very well — perhaps better than most. It is also an industry which in recent years has become more and more sophisticated in its machinery and its methods. This came about against a background of poor industrial relations, high manning and therefore less job satisfaction. The combination of these factors lends itself very well to boredom, easy availability to drink, particularly in places like Fleet Street where bars are open virtually the clock round. Companies such as ours, unlike the two other companies are certainly not a dry company. We have a bar on the premises and everybody has plenty of money, which unfortunately facilitates matters further. In my company this is likely to get worse as we have a Sports and Social Club currently who run the bar. They are to open a new Club House later this year and I have just been told this week that they will have their bar open for 9 hours a day, 7 days a week. As we work a shift system I think you can perhaps guess what that means. At the moment we have it open between 12 noon and 2.00 p.m. and from 5.00 p.m. to 7.00 p.m. and we have enough problems with that.

The money aspect of printing in England is very relevant. It is a very highly paid industry and because my company is within the London area many of our people have, what they call, casual cars to work in Fleet Street, which means they can moonlight — have a full-time job and then work on the papers in the evening and get large amounts of money.

During the last 18 months it was becoming apparent to me that there was a problem within the company. There was a small number of people who had some sort of drink problem. This was first highlighted by a lady being brought to my office at 9.00 a.m. one morning absolutely roaring drunk. She was a very large lady and I had a very small office. As I am very small, you can see just what could happen. In fact she proved to be a very good test case because I had no idea quite what to do with her. I set a programme which in fact turned out to be much along the lines that one would hope to see eventually. These problems were really being brought to my attention under the heading of welfare and that was either directly by one of the managers or supervisors or occasionally through the surgery through our occupational health nurses.

Each of the people I have seen in this period were dealt with on a very individual basis. I tried to match the needs of the individual. As I gained confidence with people I learned more and more about other people with problems within the company. All of these people had been in the company for many years. The problems, it seemed, were known to others and were covered for by their colleagues even to the point that we had people who when working an afternoon shift didn't in fact ever complete a shift. They were alright if they came in in the morning — but when they were on afternoons they were sent home for some reason — never drink — but for some reason they did not complete the shift. This had never been taken up so I felt that we were beginning to see perhaps just the tip of an iceberg.

The implicatins of the Health and Safety at Work Act which came out in 1964 were very relevant and they can be used very much as a lever in trying to finish an acceptable policy. It is worth elaborating here because I don't think you have this Act.

We, about six years ago established a Committee within the company for Health and Safety under this Act. It is comprised of representatives from various areas of the site and are nominated by the Trade Unions and they sit together with representatives of management such as the Works Director, Occupational Health Nurse, Chief Engineer and a full-time Health and Safety Officer. It is quite a powerful body — it meets regularly and it has

the ability to co-opt any outside Specialists into the company for advice, should that be necessary. The Health and Safety Act makes it very clear that everybody has a duty to ensure health, safety and welfare at work of others. Once alerted to a problem, the Committee can be an extremely powerful lobby. Indeed this is really how they started to move in the creation of a policy in my company. What might happen, for example would be someone incapable of operating a machine as a result of drinking might be brought to the attention of the Safety Representatives for that particular area who would then be responsible for bringing it to the attention of the Health and Safety Committee. This is what happened in my company and it has resulted in my being approached to endeavour to find a way of dealing with problems satisfactorily. I think what wasn't realised is just how complex and difficult this was and indeed how long some of the problems had been covered up.

Our first step was to do a lot of running around to try and find information and then eventually we alighted on the Alcohol Education Centre. Together with a colleague of mine, who is responsible for Health and Safety, we decided that we must try and obtain the direct support and backing of our main Board. I would agree with what John Aldridge was saying: that without that there really is very little you can do. We anticipated that this would be very difficult anyway. It was known that our Board hold the view that we don't have any problems in our company and if we did that production was much more important. The fact that one of these factors may affect the other doesn't really seem to have connected. However, with the Health and Safety Committee as a lever, we were able to arrange a presentation to our Works Director in his role as Chairman of the Health and Safety Committee. As a result he agreed to make a planned approach to the Chairman. I think this is where one can see how easy it is for things to go wrong. Well, perhaps not go wrong but not go according to plan.

Our Chairman then took off abroad for some time and so things in that area have been left in abeyance. In the meantime, I am sure all your companies have got the same superb grapevine as we have, a fifth of communications are not that good but the grapevine is absolutely superb — and that resulted in word getting around that we were doing something. This in fact, was the very thing that we didn't want to happen.

The Personnel role is a delicate one in that we are seen as an unproductive department and therefore what we see as priorities are very often not seen as the priorities of others. Unfortunately, the managers and supervisors had been alerted to the fact that someone may be willing to relieve them of the responsibility of covering for some of their staff. I use that phrase particularly because I think in some cases the company are now beginning to realise just how onerous Health and Safety Education is.

Printing is a very difficult industry in which to operate with very entrenched ideas on both the management side and the union side. It is particularly resistant to dealing with individuals.

Three years ago as a company, we approached the Health and Safety Committee of the T.U.C. Printing Group to consider the introduction of pre-employment medicals, totally without success. The union attitude is that this will be used as a tool of selection and whilst in fact that is obviously so — the fact that it might also benefit their chapel members doesn't seem to be their concern. Nor is it their view that the company has any responsibility not to employ people who are basically unfit to do a particular job. However, we are still pursuing this and we hope eventually we may have a breakthrough. We have one or two chapels who are now beginning to come to us and say: we think what you have said is sense.

The best way of talking to managers about this particular problem is to gain their attention by being supportive in order to gain support and to emphasise the effects of his department's work as a whole. For example, lateness, absenteeism equates with loss of production which equates with loss of bank notes at the end of the day — and bank notes out of the door is the prime objective of the company. It also may equate with such things as accidents — not necessarily major accidents, although in heavy industry this may happen. But the sort of accident that may put machinery out of action for a period or have a man sitting unnecessarily in the surgery for a period, during which time his machine is not running. Because we have agreed manning levels in the printing industry, this can very easily happen. If the machine is scheduled to run with 4 people — it will only run with 4 people. So if a man is injured, the machine will stop until that is sorted out. If he is in the surgery it will stop until he is back at work, or, if he is unable to work the others will have to wait until someone else is brought in, so you can see there can be a great deal of lost time. This situation does not just affect shop floor workers, it may affect decision making and judgement.

Poor decision making by a manager may not necessarily be noticed initially by his boss, but it may well be noticed by his workers whose movitation can be very adversely affected by their manager making wrong decisions. Their confidence in him will be impaired, therefore their motivation to work under him will also be impaired.

I feel that we are being carried along on a tide of pressure now from the supervisors and safety representatives as a result of recent talks by health and safety officers. One of these included a short film in which it illustrated how much the managers and supervisors can be held responsible for any accidents on the shop floor if they can be seen to be a party to what is happening. This has alarmed a great many people in my company and is probably now responsible for some of the pressure which is coming along. It is not a very comfortable situation, it is not a new one, but in the last few weeks I have been approached by managers and supervisors for advice and support and hopefully some sort of action. As I said earlier, it would have been preferable to have had our policy all sorted out nicely beforehand and our main Board to have agreed to that policy; then we would all be quite clear the line we wish to take, rather than have the possibility, quite dangerous possibility, of managers taking unilateral action particularly in highly unionized environment which we have with a number of very strong Unions involved. What this can mean is that a manager of one print shop taking some sort of action against one of his union members and a member of the same union in another print shop being treated differently by another manager, because there is a lack of policy. I am sure you can see just how emotive that can be.

In industry where the unions dislike each other as much as they dislike the management on occasions, they are

always ready to have some reason for having a sort of metaphoric punch up. It is particularly important to gain the co-operation of the unions. This can only be achieved by involving them in the plans and discussions very early on. I feel a little disappointed at this end that we may have jeopardised our situation a little by the course of events which seems to have taken place.

However, it has been quite interesting that in spite of these very entrenched ideas, 3 cases in this week have been brought to me. I will outline them for you briefly because I feel it illustrates what has been happening and what is now happening and given the right opportunity I think this is an excellent opening for us to now do something about the policy.

The first instance: I was approached by the manager because one of his men had dropped a piece of machinery on his foot. He was taken to the surgery where he was extremely abusive to the nurse. It became very apparent that he was severely under the influence of drink. He had to be assisted to hospital. His manager became very alarmed about this — bearing in mind he had recently seen a film which said: He could be liable legally. There is a possibility of imprisonment under the Health and Safety Act for being a party to certain things happening at work. The Manager was very alarmed as he normally worked on a large machine with other people. Conversation with the manager revealed that this man had recently returned from sick leave. After some further prodding, I discovered that in fact he had been drying out for two weeks. This wasn't the first time. We thought the best thing was to discuss the case, unofficially, with the F.O.C. of the Chapel (shop steward) to try and reach some sort of rational agreement about how we were going to deal with this man. At this stage we did not have an official policy. This is still off sick as a result of his injury.

The next case that was brought to my attention was the result of an anonymous phone call from a member of the department, where, on the previous day there had been a retirement party. In my Company, it is traditional that people retiring, people getting married, people leaving to have babies, and what we also call in the industry "Bang outs", which are when an apprenticeship finishes, when the apprentices come to the end of their apprenticeship we have a big celebration called a "bang out". This is quite something to see. The noise is horrific and they have been issued with ear protectors because they do "bang out". They bang on anything metal with hammers and all sorts of things. There is also a great deal of drink around on these occasions. At this particular retirement, apparently there was a great deal of drink around, resulting eventually in one person being totally unable to work on his machine. Again his friends covered for him, even to the point that he was extremely abusive to his union representative. Somehow that was managed to be covered up and eventually they managed to get him allotted to another machine with just one other person. By this time, half the shift had been lost and the break had arrived so he went off together with his friends to the bar where he had some more drink. When he came back he was in no way fit to work and the result in fact was a fight. The manager was not present at the time. The whole thing was covered up and had it not been for this phone call this particular incident may well have gone unnoticed. The person said to me that he was just so fed up with having to work and cover for somebody who for the most part was unable to do his job. I drew it to the attention of the manager who then went off to investigate. We are still processing that particular one.

The third instance was reported by the Manager, who had made a correct diagnosis. He noticed that the person in question had developed the usual symptoms: Lateness, poor work performance, had the shakes, all sorts of things. He felt he would tackle this one on his own. He spoke to the individual and suggested to him that he seemed to have a drink problem. This man is an engraver and as you can realise, anybody with the shakes who is trying to do any sort of engraving is not going to produce very good work. I think the manager could see the writing on the wall and realised that it wasn't going to be very long before someone picked this up if he didn't. However, to his credit he certainly had a go at trying to talk to this man. Rubbish, was the reaction of this man, no it wasn't a drink problem, he said he was suffering from nerves. He didn't elaborate as to what the nerves were. The manager was quite flumoxed by this and didn't quite know what to do, so he came to see me. We discussed the matter and I suggested one or two other things to him, I felt that we musn't let this man go. However, as I said previously, we were in a very difficult situation of not having a formal polciy and this is an area which I am very concerned with. When you go back to your companies whoever is responsible for policy making needs to be talked to in order that you can try and get the official backing of your company to do something.

I quoted you these three cases in an effort to show you how easily it is to be caught unawares. I feel it is extremely important that we don't discourage our managers from highlighting these probelms in spite of the fact that we have not settled the policy. What I have tried to do is tread a middle path because I know where I want it to go and I am hopeful that I will eventually be able to steer it in that direction. In this way, I hope that I will be able to keep things on an even keel. Meanwhile, the pressures that come up via our Health and Safety Committees will serve to obtain a modicum of positive agreement to agreed policies and procedures that we are going to deal with as a company.

It is our aim to make it very clear to everyone, unions included, that offers of acceptance of help won't be an easy option against disciplinary action. There are, in my company, a considerable number of people who would like to see the bar closed, there is also a great deal of opposition to seeing the bar closed. I don't know if this in itself will solve matters because at the end of the site where I work, there is a pub. Someone with great foresight before I joined the company did away with all our clocking procedures. It is quite difficult to keep track of 1,500 people who don't work in a sort of conveyor belt system particularly when there is a history of people covering up for them. I don't know that the bar is necessary, I think it would be a contributory factor, but it is clearly not the sole factor, anymore than posting notices. It is helpful, the fact that my works director has posted a notice in the bar saying: "that anybody taking alcohol onto the shop floor will be dismissed". However, this does not help the problem of people who are taking some to the shop floor already inside them. These people who have learned to top up, these people are already heavy drinkers and are very adept at topping up, they bring it in their flasks and all sort of places, even in bleach bottles.

It must not be underestimated that it can take a great deal of time to deduce such a policy. It will create resource problems, particularly in a company of our size. I feel it is very advisable that at least one senior person within a personnel function must be made responsible for handling the problem connected with alcohol. Obviously, if there are occupational health nurses within the company, then they should be working very closely with the personnel department.

It is very important to establish credibility. Confidentiality is an extremely important factor if one is going to progress and have people either come to you voluntarily or even if they are directed to you. These people will not feel confident that their problem will not be over the firm in two minutes flat.

A greater degree of seniority is needed in the sort of person that is going to have this job. I think in all too many companies some poor unsuspecting soul gets dumped with a problem particularly if it is a problem that other people are reluctant to pick up and those people are quite often totally unsuited to dealing with, particularly an emotive probelm such as this. Having adequate knowledge of the outside resources that might be at ones disposal are all essential, particularly where the personnel officer's role would be one of making an assessment about what to do with the individual.

Whilst I do an amount of counselling in my company, judging by what I have seen already, I think I will be taking on the role of full-time counsellor, certainly at the outset and that clearly would not be very feasible. It would be essential to one or two other people around who are trained and who can help, but we can all feed into the one senior person. The counselling aspect is extremely important, perhaps the most important, because from the people I have seen it has been my experience that whilst alcohol is the presenting problem — its the problems behind why people drink that in industry we need to try and find an answer too and that means somebody who is able to listen and understand. Quite often people come up with their own answers. They know what their problems are and that will help them to cease to use alcohol as a crutch and use it, as most of us are able to do, as a pleasant social experience.

"Prevention and Intervention Programmes in Industry"

JOHN DEACOCK, Head of Welfare Services, British Airways

***John Deacock was unable to be present in Killarney but his paper is included in its entirity.*

PART 1

Introduction

1. Despite the heavy weight of scholarship and statistical surveys in the field of alcoholism and problem drinking, the number of British Companies with published and well thought out policies on prevention and intervention is comparatively small.

2. Marcus Grant argues quite rightly, that Health and Safety legislation in the UK places a charge on employers at least by implication, to adopt a preventative approach. Where alcohol is specifically used in processes or is part of the final product, there is a direct charge in the statute to take steps as are necessary to secure that there will be adequate information available.

3. We may read from surveys that the Scottish Council on Alcoholism in its 1976 Annual Report stated that, "Alcoholism costs industry thirty-five million pounds a year, or six hundred pounds per alcoholic employee." Yet the British Institute of Directors in 1977 took the view that, "The air in Britains board rooms is so rarified that no alcoholic could ever survive." It is not surprising that given this attitude, few organisations have set up education and intervention programmes. Consequently, we have limited experience arising from the operation of company programmes.

4. Despite incontravertible evidence from within individual Companies, their Boards of Directors steadfastly refuse to allow programmes to proceed. In fairness however, companies, for example, in the transport sector of industry, would feel uncomfortable with their customers trying to explain away drinking problems, especially amongst drivers, pilots and other technical operatives into whose hands they are placed. The recent London Underground disaster at Wood Green when the driver simply drove a full train into a dead-end tunnel, is a vivid example where an intervention programme might have prevented the accident. The driver was alleged to have had a drinking problem.

MOVING TOWARDS A PROGRAMME

5. However, let us not be discouraged. Let us assume that the rarified air of the Board Room has been enriched by weight of evidence and we have our directive to proceed with a prevention and intervention programme. It is nevertheless a difficult task to draft a document with which the supervisor or manager can cope comfortably with the company's disciplinary procedure.

6. The USA has had programmes running for many years and experience has shown that the only viable and acceptable method is to centre the programme strictly upon the job performance and to involve line management as much as possible. This way is objective and to a great extent reasonable. It is comfortable for the trade unions and fits neatly into a typical company disciplinary procedure. Most important it is fair to everyone, especially the drinker.

LEGAL ASPECTS

7. It should be borne in mind that the dismissed employee has a legal recourse in UK through the Industrial Court. Any alcohol intervention programme likely to result in the termination of employment must stand the searching examination of a public hearing. Consequently, the programme must be based on a sound equitable process and not develop the kangaroo court tendency of, "One strike you're out." Trade union and labour relations law in UK have resulted in a number of safeguard to workers and not even the problem drinker will face a knockout in the first round, that is unless he has committed a serious offence which of itself constitutes gross misbehaviour.

PART 2

THE MODEL

8. The following policy and procedure document is primarily concerned with intervention, certainly in the short term. However, it contains elements of prevention and long term application of the document would provide an adequate strategy of prevention. So, grasping the nettle, let us look at a model to meet the needs of a modern, large sophisticated corporation. One with considerable trade union involvement and high risk of dispute which can bring production to a stop.

9. (First and foremost, the document should have a punchy unequivocal start):

INTRODUCTION: (Please Note. Parts of the text have been cut out for brevity only)

1. Alcohol is an intoxicant .....
   Excess may lead to dependence .....
   Alcoholism is recognised as an illness .....
   May be controlled by the individual .....

2. The use of alcohol .....
   Affects mental and physical functions .....
   Co-ordination, re-action .....
   Judgement and emotional behaviour .....

3. British Electronics Limited is concerned with the misuse of alcohol which might affect:
   Staff performance ..... Attendance
   The Company's image to customers .....
   Health and safety of staff .....

10. (Next, there should be a straight statement of policy. This is an essential ingredient):

POLICY

1. It is British Electronics Limited policy:
   To assist managers ..... identify problem drinkers and alcoholics .....
   To assist those who wish to be helped .....
   To require restoration of acceptable performance ..... reasonable timescale
   To increase the awareness ..... misuse of alcohol.

This policy does not diminish any individual's liability to disciplinary action for behaviour, or incidents which themselves constitute misconduct.

2. Diagnosis of alcoholism lies with the Company Medical Department but responsibility for initial identification lies with LINE MANAGEMENT .....

3. Misconduct brought about by alcohol should be dealt with ..... normal disciplinary procedures. Where dismissal does not apply, follow up action to overcome drinking problems should begin.

4. The Company will ..... for problem drinkers:
   Interview ..... help individuals to accept he has a problem.
   Offer skilled help through ..... Company Medical Department.
   Confirm Company sickness benefits under agreements ..... will apply during treatment.

5. Ultimately, failure to reach acceptable **PERFORMANCE** ..... termination by dismissal or ill-health pension.

6. The Company will ..... create a climate of employee awareness ..... alcohol related problems ..... staff communication ..... management action.

11. (Now we go into action).

APPLICATION OF THE POLICY

1. The line manager's role is concern for staff welfare, safety and effective performance. Line managers' accountability for others' performance places them in a position to identify emerging and established problems.

   The line manager must:
   Deal with specific incidents involving alcohol

   Introduce measures to minimise risk ..... those exposed to alcohol risk in job .....

   Adopt procedures to measure performance shortfalls.

   Remedy shortfalls by telling individuals, specifying required standards ..... offering assistance.

   Terminate service of staff ..... persistently failing to reach standards in reasonable time.

12. (Enter the Physicians left).

ADVICE FROM COMPANY MEDICAL SERVICE

1. Whilst line managers should identify problem drinkers, confirmation of diagnosis must rest with the Medical Officer who will state whether individual is fit to perform job. Appropriate advice on treatment and arrangements may be planned.

2. The Medical Service will also give advice to private independent enquiries from staff who think they have a drinking problem.

13. (Enter the Personnel Men right).

ADVICE FROM PERSONNEL

1. Line managers should discuss non-acute cases with Personnel officials to explore possible action. Cases may be referred to Personnel for counselling.

14. (The first mention of disciplinary action).

ACTION RELATING TO DISCIPLINARY PROCEDURE

1. Consistent failure ..... reach performance ..... dismissal.
   Essential to document incidents .....
   Statement of evidence produced
   Statement of standards expected
   Report of individual's response to allegations.
   Confirmation of action (including dismissal)
   Review date (unless discussed).

15. (And getting to the nub of the problem).

IDENTIFICATION OR PROBLEM DRINKERS AND ALCOHOLICS

1. The distinction between normal social drinking and problem drinking is not well defined ..... Anyone on 3 doubles or 3 pints of beer a day is at risk.
2. Action must be taken (by line manager) from one-off incapacity due to alcohol to well-established dependence.
3. Be alert to the signs of possible drinking problems which may have causes unrelated to alcohol.
4. Adapt systematic approach to all forms of ineffectiveness. Review performance against targets over long period. Look at quality, attendance, punctuality .....
5. Before approaching individual ..... managers should explore remedial possibilities ..... check with Personnel and/or Medical Service.
6. Consider implications of individual remaining in current job if alcohol problem is confirmed. Can continuance be tolerated?

16. (Who faces up to the individual?).

INITIAL APPROACH TO INDIVIDUAL

1. By level of manager closest to employee.
2. Discuss details of unsatisfactory performance.
3. Restate standards required and get understanding.
4. Try to establish cause of problem. Remember concealment techniques.
5. Advise of Company treatment facilities and referral to Medical Service. State Company policy to require restoration of performance ..... otherwise essential termination.
6. Get acceptance from individual on follow-up action. Arrange consultation with Company Medical Officer for diagnosis and fitness to perform job.

17. (enter Medical Service again).

ACTION BY COMPANY MEDICAL SERVICE

1. To report results of consultation with employee.
2. Treatment arranged, where appropriate.
3. Liaison with external medical services (detoxification, analysis, counselling etc.) and monitor progress.
4. If absence authorised, examination before return to duty.
5. Declaration of fitness.

18. (Benefits during absence).

PAY WHILST UNDER TREATMENT

1. Normal sickness absence benefits under Union Agreements.

19. (Feeling better? Back to the Job).

RETURN TO WORK FOLLOWING TREATMENT

1. Should return to normal job.
2. Monitored by manager and Medical Services.
3. Reports on progress.

20. (Nothing goes smoothly).

REFUSAL TO UNDERGO TREATMENT

1. Interview and warn. If work satisfactory no further action ..... monitor. Give time limit.
2. If work **NOT** satisfactory, interview again, warn consequences of not reaching standard ..... could involve dismissal. Give time limit.
3. If situation does not improve refer to disciplinary board. Dismissal or final warning. Give time limit.
4. If improvement occurs at any stage, the employee must be informed. Continue to monitor.

21. (The back-sliders).

RELAPSE FOLLOWING TREATMENT

1. Refer immediately back to disciplinary board after full review of circumstances with Medical Services.

22. **RECOGNITION OF THE PROBLEM DRINKER OR ALCOHOLIC**
See attachment 'A' to paper.

23. **ACTION PROGRAMME FOR DEALING WITH PROBLEM DRINKING AND ALCOHOLISM**
The various steps outlined in the foregoing programme can be set down in a flow diagram. See attachment 'B' to paper.

24. In summary, this programme is a fully comprehensive and very detailed set of procedures but to succeed, they must be taken up by line managers and personnel officers. Industrial Physicians in the main are co-operative.

25. Two case histories are attached which give life to the programme. They could have been influenced by its application.

See attachments 'C' and 'D'.

26. By kind permission of the Welfare Manager and Personnel Director of Watneys Breweries Limited, a complete copy of their Alcohol Education and Intervention Programme is shown at Attachment 'E'. Watneys faced up to increasing problems in their plants by total commitment to a polcy which has already arrested the problem.

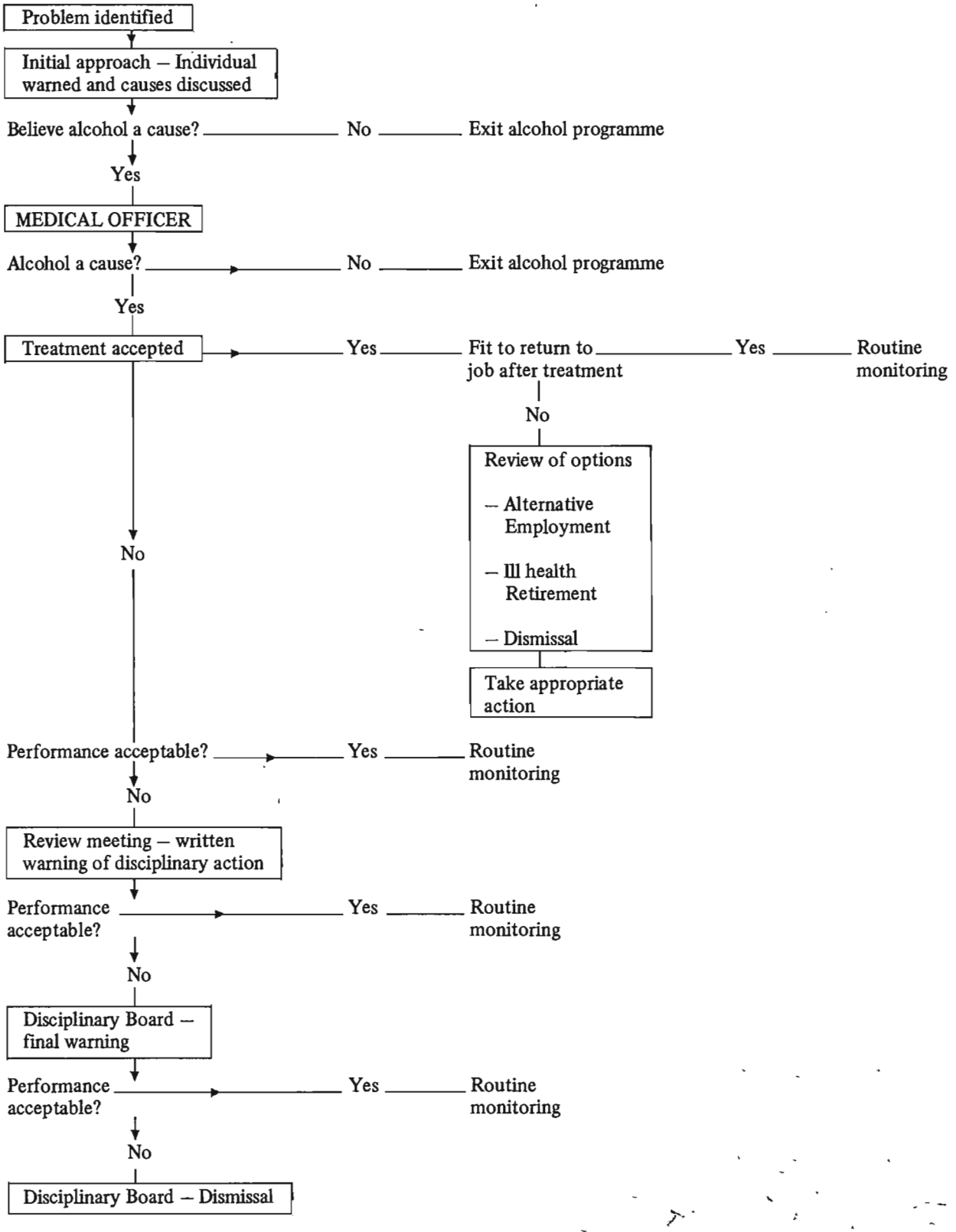
Recognition of the problem drinker or alcoholic

Observation of the following signs in an individual may indicate an alcohol problem:

Known Drinking Habits	— Smelling of alcohol at work; — Known drinking in the morning; — The habitual drinking of doubles or putting down a drink in one gulp.
Physical Appearance	— Hand tremors; — Signs of a hangover e.g. bleary-eyed; — Obvious signs of intoxication e.g. flushed face, slurred speech; — Less neat in dress or appearance or alternatively greater care about dress and appearance.
Attitude and Habits	— Rapid changes of mood; — Increasing irritability/nervousness/argumentativeness; — Tendency to blame others; — Poor relationships with management and fellow workers; — Evasion of supervisor; — Going to sleep on the job.
Absence	— Frequent absenteeism, particularly around weekends or rest days; — Frequent lateness in the mornings; — Long lunch breaks/leaving work early; — Unexplained disappearances; — Frequent minor disorders on medical certificates e.g. flu symptoms, gastroenteritis, backache, nervous disability, fatigue.
Job Performance	— Deterioration in standards of work performance; — Lowering in quantity and quality of work; — Increasing numbers of mistakes and errors of judgement; — Loss of interest in work; — Procrastination and/or failure to meet deadlines; — Spasmodic work pace; — Lack of concentration/inability to sustain effort.

Accidents	—	Specific alcohol-related accidents e.g. drunken driving;
	—	Accident proneness — on or off work;
	—	History of road accidents.
Domestic Circumstances	—	Evidence of family problems;
	—	Evidence of money problems.

ACTION PROGRAMME FOR DEALING WITH PROBLEM DRINKING AND ALCOHOLISM



PREVENTION AND INTERVENTION — CASE STUDY 1.

Company: Large International Combine (45,000 plus)

Base: London Headquarters

Patient: Female, spinster. *Age:* Over 50.

Job: Executive Management Secretary

Service: Over 25 years.

Case History: The subject was unmarried, living alone with limited or no friends or social intercourse. She was supported and protected by her working peer group for over 2 years as her condition deteriorated. She invariably came to work smelling of alcohol and in poor physical state. Whilst her behaviour patterns were restrained, she was often unable to cope with her work for more than a few hours and tended to leave her office in the mid-afternoon. Whilst work performance deteriorated, her experience and inate sense of duty kept her going, probably at the expense of her nervous stability.

As dependence on drink increased, a group of her secretarial colleagues confidentially petitioned the Company Medical Officer to intercede. The Medical Officer referred to subject's boss who was in top 12 of Company. Boss was acutely embarrassed as he had known about his Secretary's condition for over a year but had protected her and taken no action.

Treatment: Subject persuaded to go into care. Liver function and other tests revealed acute alcoholism.

Counselling revealed subject's food intake minimal.

Alcohol intake not specified but clearly at dangerous level.

Referred to Clinic for intensive treatment.

Follow up action: Counselling and discussions with Medical Officer.

Prognosis: Good, condition vastly improved. Trend towards full recovery.

Boss: Delighted and co-operating.

PREVENTION AND INTERVENTION — CASE STUDY 2

Company: Senior Captain of medium sized Airline.

Base: U.K.

Patient: Male, married. *Age:* 40 plus.

Job: Pilot of Jet Transport Aircraft.

Service: 18 years.

Case History: The Company Medical Officer got a 'phone call from a doctor living near subject's home. Asked if he knew Captain 'X', which he did. The doctor who was not the subject's general practitioner, found subject in his car at 11.00 a.m. intoxicated and incapable. Drove subject home which was shuttered and barred. Took subject inside to find house littered with vodka bottles and in a filthy condition. Wife had walked out 18 months before because of his drinking habits.

The Company Medical Officer looked at Captain'X''s medical file but found no previous history of drinking problems. He contacted the Captain's Flight Manager suggesting that he be taken off the Flight Roster. This was refused. "Too difficult", was the response. The Manager did not want to know. In effect, he had ducked the issue.

Captain 'X' operated a service to the Far East. He became drunk whilst at the crew hotel and was involved in a brawl. He was suspended and returned to UK.

Treatment: Subject was found to be in advanced state of alcoholism with badly affected liver. Could be described as a 'raging alcoholic'. Underwent intensive detoxification and made sufficient recovery to resume flying after 3 months.

Additional information: Medical Officer in subsequent conversation with Captain 'X''s colleagues was told: that they thanked goodness something had been done about Captain 'X' as he was becoming a danger to himself.

Comment: The professional Peer Group (pilots) had protected Captain'X' against allcomers. He had probably been dangerous in a technical sense for many months despite the legal constraints on flying crews drinking before operating a service.

The Flight Manager was more culpable. He had prima facie evidence of a chronic drinking problem and yet was unwilling to prejudice a colleagues professional career.

Conclusion: Despite logic and a clear path of duty, there is considerable resistance to reveal individual's drinking problems amongst professional classes despite public risk.

The number of problem drinkers cannot be estimated in any precise way, but evidence suggests that heavy drinking causes accidents, losses in production, man-hours and efficiency. Further, what is not generally recognised is that the effects of alcoholism are irreversible: excessive drinking inflicts permanent injury, often to the brain, even if the individual eventually dries out.

Excessive drinking is a serious risk to health and alcoholism can undermine the welfare of an individual both in the industrial and domestic situations. As the very nature of our operations exposes persons to a potentially enhanced risk of drink dependence, we clearly have an obligation under the H.A.S.W.A. to take all reasonably practicable steps to deal with the problem. We must, therefore, be clearly seen to have an effective policy through which help is provided to the problem drinker.

POLICY ON ALCOHOLISM

1. The Company recognises that alcoholism is primarily a health problem and, as such, sufferers require treatment and assistance. Accordingly, the Company will do all that it can to ensure that any employee suffering from the illness is identified, counselled with sympathy and understanding, and encouraged in every way possible to follow such treatment as is prescribed.

2. When an employee comes to notice as possibly suffering from alcoholism, encouragement to seek help and treatment will be given immediately on the clear understanding that:

a) the employee, whilst undergoing treatment, is considered to be on sick leave, and entitled to whatever sickness benefits are provided under the Company's terms of employment.

b) every effort will be made to ensure that the employee, after treatment, is able to return to the same job, if it is still available, UNLESS:

i) the effect of the illness, before treatment, affected the individual's ability to such an extent that resumption of the same job would be impossible

or

ii) resumption of the same job would lead to a serious risk of undermining satisfactory recovery.

c) in the event of the employee, after treatment, not being able to return to the same job, every effort will be made to:

i) offer the individual an alternative job commensurate with the status of the previous job or, if this is not possible, to

ii) allow the individual to consider any other alternative job which is available.

3. Should an employee who has come to notice as suffering, or possibly sufferng, from alcoholism either decline the opportunity to undergo treatment or, having embarked upon a course of treatment, discontinue it before satisfactory completion, appropriate measures within recognised normal disciplinary procedures will be taken to remedy the situation. Such measures may result in written warning to the idividual that unless work performance and behaviour improve within a specific and monitored period to the required standards, employment will be terminated.

4. Followiong return to employment after treatment, should the individual relapse, due consideration will be given to the circumstances, although such relapse would normally indicate that termination of employment in a brewery would be in the individual's best long term interest.

5. This policy applies in the case of an employee confirmed or suspected as suffering from alcoholism. It does NOT apply to an employee who, because of excessive alcoholic indulgence on random occasions, behaves in a manner contrary to the standards of conduct required by the Company. Such behaviour will be dealt with in accordance with recognised normal disciplinary rules and procedures.

6. Such a Company policy is applicable to all employees from Directors to Shop Floor workers and there is no discrimination at any level. The policy must be seen to be scrupulously fair in all cases.

THE ROLE OF MANAGEMENT

Managers at all levels, from Director to Supervisor, share a common element in their activity. Bosses are judged on how they get work done by other people. If a subordinate does poor work, the boss is responsible for improving the situation. There are many possible reasons for poor work (including excessive drinking or incipient alcoholism) and improvement is most likely if the correct reason can be identified.

Thus, the boss must try to:

i) recognise poor work
ii) identify the cause
iii) remove the cause

so that the work in his area of responsibility is efficiently performed.

This guideline looks at the misuse of alcohol as a possible cause of inadequate work performance, but alcohol must be seen as only one of many possible damaging influences (domestic trouble, boredom, etc). In practice,

alcohol related problems are comparatively rare, although serious and potentially dangerous when they do occur.

1. Role of line management:
   The boss (Director, Office Manager, Head of Department, Supervisor or whoever) is, as part of his job, required to manage individuals, not just a work force.

   1.1 Where possible, small working units are preferable so that bosses can know the individuals. Managers should consider any necessary organisational changes, including those which will make jobs more interesting and less repetitive.

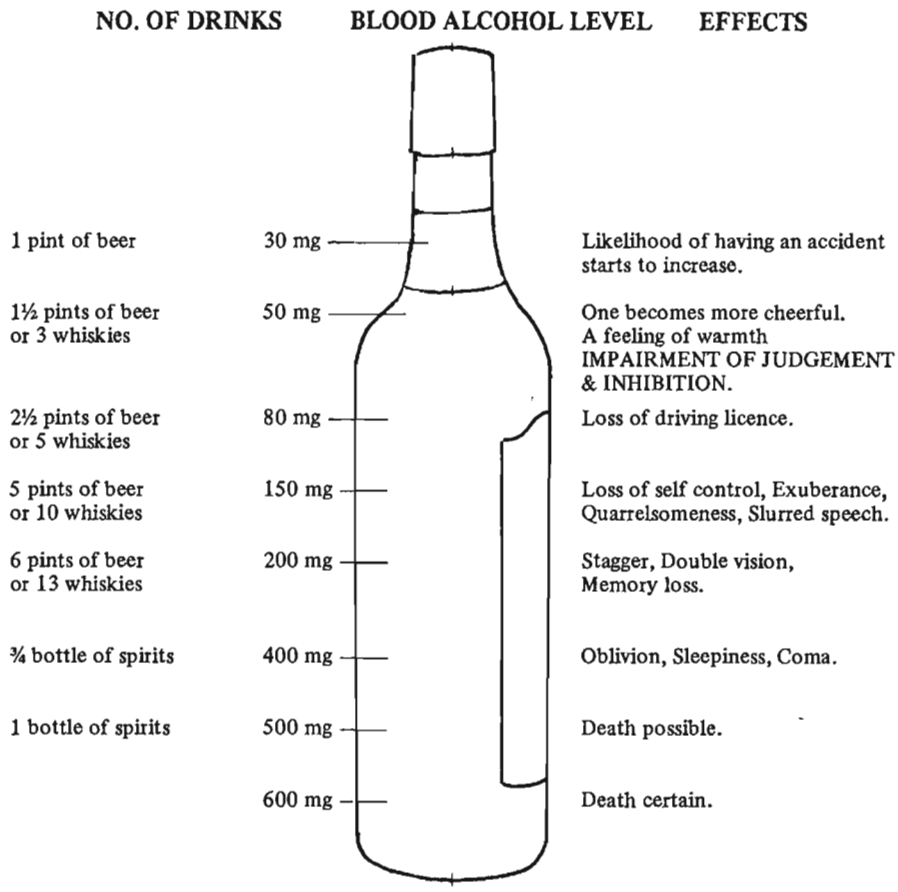
   1.2 Bosses should make it clear to their subordinates that failure to reach agreed standards of performance will lead, as a matter of course, to investigation of the reasons for poor performance. Consider joint target setting.

   1.3 People have to work together as a team to get jobs done, so the following are legitimate areas for investigation:
   a) Absenteeism from work or the job; frequent, and often short, trivial or unexplained periods of absence; sickness — certified or uncertified.
   b) Deterioration in relationships with colleagues.
   c) Moodiness, irritability, lethargy, depression.
   d) Poor productivity.
   e) Poor timekeeping.
   f) Reluctance to accept responsibility.

If rational explanations for the above occurrences cannot be established, there may be an alcohol related problem which should be dealt with in accordance with the Company policy.

Note that it is each Manager's responsibility to see that during working hours, all their employees should be fully capable of performing their duties to the best of their ability. It is not his responsibility to diagnose or treat alcoholism, or to manage alone the problem until it becomes intolerable; so early use of the Company policy is in the interests of both boss and subordinate. Remember that alcoholics are past masters of deception, and it is only when the problem is brought out into the open that 'constructive confrontation' can begin. Once the Company policy procedure has been activated, the boss must not relent, except by agreement with the Medical Department.

Successful treatment is dependent upon the individual **admitting** he has a problem; the manager's work here is crucial. No one is suggesting this is easy. It can be very frustrating, particularly as the success rate can be low. However, **the problem cannot be ignored and must not be skirted.** Problem drinking is not a matter for levity.

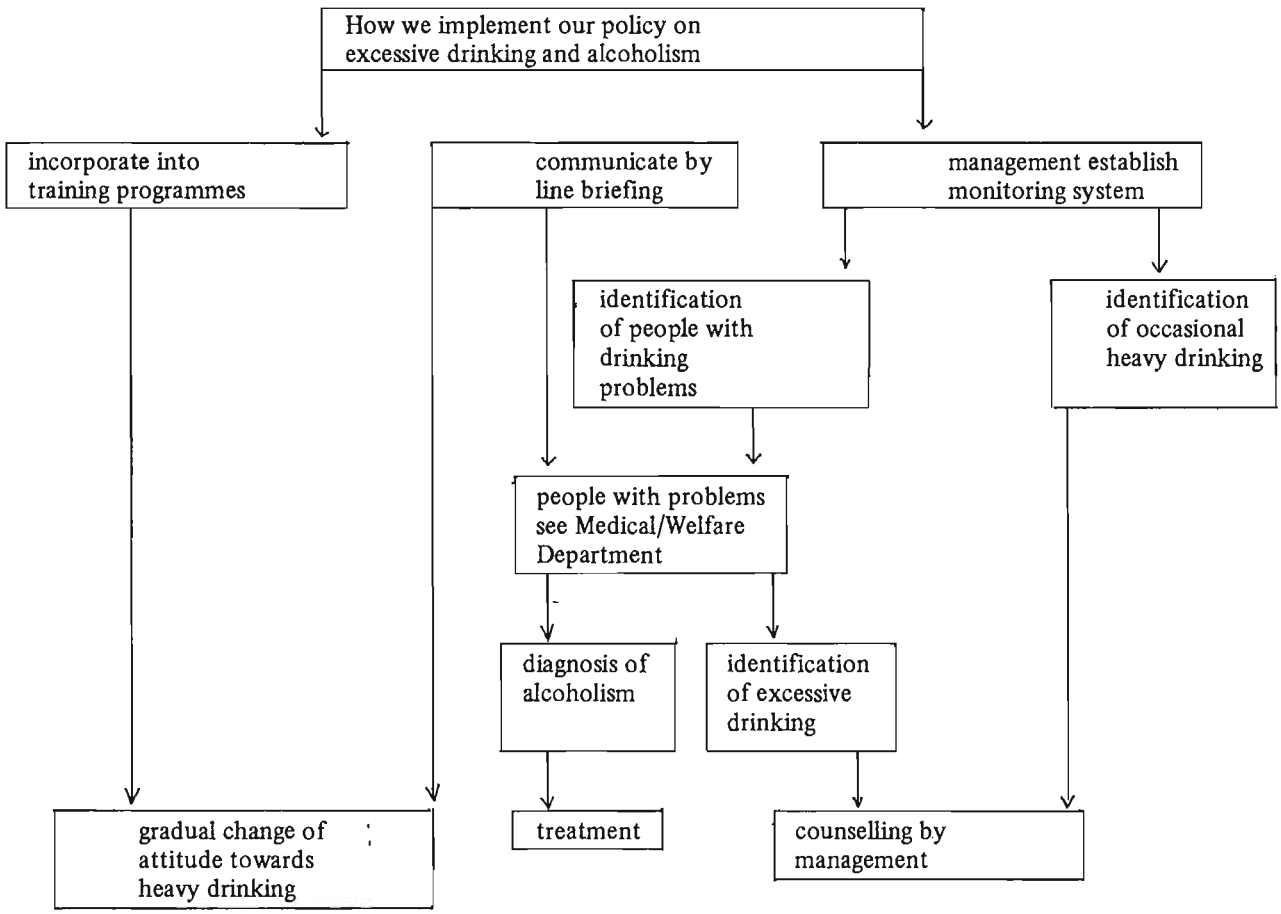


RESOURCES AVAILABLE

1. **Personnel Managers**
   Necessary support line for management.

2. **Medical/Welfare Departments**
   The Medical/Welfare Departments can be a valuable and trusted link which ensures effective liaison between the individual, his family, management, the medical profession, and the unions, so that the ultimate course of action is in the best interest of those concerned. Close co-operation between the management and the Medical/Welfare Departments is essential, but the latter must be seen to retain its professional independence.

3. **Regional Co-ordinator — Welfare Manager**
   To maintain up-to-date information of services/facilities available.



"An Irish Response"

DR. CORMAC McNAMARA, Honorary Secretary, Irish Society of Occupational Medicine

At the outset, Chairman, I would like to place on record the gratitude of the Irish Society of Occupational Medicine to the Health Education Bureau for arranging this Conference and inviting so many of our members to be present here in Killarney.

The workplace offers unrivalled opportunities, not only for alcohol education, but also for the early identification and referral of those with alcohol problems and it is to be regretted that to date in this country, with one or two notable exceptions, these opportunities have been largely ignored. I am optimistic, however, that this important Conference may mark a new beginning. On a personal note, as someone who has been interested in alcohol related problems at work for almost a decade, I am particularly grateful to the Bureau for this opportunity of hearing and learning from so many distinguished experts in the field.

"AN RUD A DEIR GACH EINNE IS FIOR E". We Irish tend to be regarded as having a problem with alcohol and by any yardstick indeed this would appear to be the case. Occasionally, reports in the media exaggerate the extent of our difficulties; for the most part, however, they tend to underestimate them. Per capita, alcohol consumption, absenteeism, hospital admissions and convictions for drunkeness all point to a serious and growing problem. To date the Irish response has been entirely inadequate. Despite the fact that availability and public attitudes are key factors widely recognised as influencing alcohol dependency rates and despite repeated expressions of concern and goodwill on the part of the Government and the community, the net effect of the policy of successive Governments has actually been to increase the availability of alcohol across the community — nor is there any real evidence that public attitudes have significantly changed. The ease with which exemptions are granted in our Courts, the readiness with which many voluntary organisations seek and obtain licences for clubs, the failure to exclude alcohol from the consumer price index, these are but a few examples of our ambivalent approach. Surely a serious attempt by the community would involve action in some or all of these areas.

On the treatment front we have had only limited success in identifying and encouraging those with established problems to accept treatment. Affected persons can for a variety of reasons conceal the extent of their disability for many years. General practitioners for example, who often pride themselves on their intimate knowledge of their patients and their patient's behaviour patterns, consistently and seriously underestimate the numbers of alcoholics in their Practices. In addition only a minority of those actually identified, seek or are willing to accept treatment.

The special potential of the workplace stems from three basic facts:

1. The vast majority (95%) of persons with alcohol related problems are in employment.
2. They are readily identifiable at the workplace.
3. They can be motivated through work based programme to seek treatment.

Even today, the general public all too often think of the person with an alcohol related problem as being a down and out, a hobo, or penniless vagrant. The reality is that while alcoholism rates are particularly high in certain categories outside those employed e.g. the retired, disabled and retired and the unemployed, the vast majority of persons with alcohol related problems continue in employment. Identification of such persons at the workplace is relatively easy. In the first instance, being referred by their immediate superior e.g. supervisor — because of poor job performance, multiple short spell absenteeism, lateness, inefficiency, frequent brushes with the disciplinary machinery etc.

While such referrals will include persons with other problems, it is estimated that as many as 80% of job performance problems are alcohol related. Perhaps the most important point, however, is that persons so identified can be readily motivated to seek treatment. The suggestion that more men commit suicide over the loss of a job than over the loss of a wife or child may contain a clue as to why men can be more readily motivated to seek treatment through work based alcohol programmes than when they are confronted by a general practitioner, a nagging wife or a neglected child.

Interestingly, psychiatrists generally tend to regard those who do not seek treatment on an entirely voluntary basis as having a rather poor prognosis. Experience with work-based programmes however, suggests that this is not necessarily so and that cure rates amongst those seeking treatment, largely at the insistence of their employers, are of the same order as those who seek treatment off their own bat. On reflection, however, probably few alcoholics seek treatment entirely voluntarily, the majority seeking it as the insistence, if not of the employer, of their family and friends.

To date in this country, despite being faced with a significant and growing problem and despite official trade union support, there has, with a few exceptions, been little enthusiasm for the concept of work based programmes. Indeed, even in North America where the cost effectiveness of such programmes has been consistently demonstrated, only 1 in every 600 corporations has such a formal programme.

Quite apart from alcohol programmes, the workplace offers other equally exciting opportunities to promote alcohol education and change attitudes, again, as yet, these opportunities are largely unavailed of.

In interviewing AnCO trainees and others commencing employment, I have been struck by the prevailing attitude amongst today's youth to alcohol, particularly their perception of 'moderate' drinking. This intense public relations and media promotion is clearly aimed at increasing overall alcohol consumption while at the same time representing the industries concerned as responsible and anxious to play their part in combating abuse.

Coming then to the practical situation on the ground — Irish Industry varies from those employing single figures to those employing several thousand, so both the nature and extent of their problems and their capacity to respond to them vary considerably. Only a handful for example, are in a position to employ full-time counsellors. A greater number have access to a complete or partially complete occupational health team, but by far and away the largest number do not to date have a formal realtionship with either health professionals or counsellors.

Such alcohol education as has taken place has been organised by the medical and nursing professions, by management and/or by the trade union representatives and almost always on an ad hoc basis. To me it appears that a more co-ordinated aggressive approach is essential if real progress is to be made. We need to identify specific targets and pursue them by all the means at our disposal both inside and outside the workplace.

As a first step, we must ensure that key personnel are fully briefed both as to the nature and extent of the problem and as to how best they might cope with it. Personnel should include the members of the occupational health team, senior members of the management staff and personnel officials, trade union officials and shop stewards, supervisors, safety officers etc. We must convince them of the opportunity presented at the workplace for tackling the problem and enlist their help and support. In larger companies, alcohol education should be an important part of induction courses for all new employees. Such courses should include the elementary pharmacology of alcohol, its short and long-term effects and the consequences and likelihood of abuse at any given level of intake. More importance should be attached to the selection, education and monitoring of recruits for high risk industries and particularly where individuals are being recruited from the ranks of the long-term unemployed. Similar intensive alcohol education should be continued right through the employees working life, with particular emphasis on the high risk groups including those about to leave the company whether due to retirement on grounds of age, disability or redundancy. By introducing such an intensive educational campaign before and during employment and prior to retirement, it should be possible to modify individual and group attitudes towards alcohol and alcohol related problems and to facilitate an increased willingness on the part of those who experience difficulties to accept and benefit from appropriate treatment.

Plant enumerates eight factors which emerge from the literature as those most commonly suggested to explain why some occupations have a high risk of alcohol related problems.

1. Availability of alcohol
2. Social pressure to drink
3. Separation from normal social or sexual relationships
4. Freedom from supervision
5. Very high or low income
6. Collusion by colleagues
7. Strains, stresses and hazards
8. Pre-selection of 'high risk' people.

The list is not exhaustive; clearly other factors operate in many instances but people from the same or similar backgrounds are far more likely to experience alcohol-related problems in certain occupations than others e.g. publicans, sailors, barmen, those associated with the catering trade, journalists, members of the medical profession etc.

For a variety of reaons then, the extent of alcohol-related problems may vary considerably from one industrial concern to another. Before any remedial action is planned, an accurate assessment should be made using as a guideline such indicators as absenteeism, the accident rate, hospital admissions, the factory grapevine and personal observations. Where any concern finds that it has a problem or a potential problem, it should, in consultation with its professional advisors, devise a company policy to include both an alcohol education campaign and an alcohol programme. In addition, the company should take all practical steps to reduce risk factors at the work place bearing in mind the list already referred to. Such steps should include outlawing alcohol from the canteen, the vending machine and the board room cabinet and the substitution of cash payments in lieu of a free take-home entitlement where this is traditional. The trade unions for their part must use their power to convince their members that it is in their own interest to forego such privileges. Similarly, it would seem prudent to exclude from employment in high risk occupations individuals having one or more personal risk factor e.g. particular attention should be paid when recruiting sailors, bar staff and staff for the hotel and catering industry.

Some industries have a tradition of heavy drinking. Where companies are faced with this problem, every effort should be made in consultation with professional advisors to identify and encourage those who have already developed problems to seek and accept treatment and to change the profile of the company by being particularly careful when recruiting new employees to exclude high risk individuals. Every effort should be made to minimise the separation from normal social or sexual relationships occasioned by travelling, working overseas etc. Indeed, some companies with extensive overseas experience accept the necessity of flying employees temporarily based overseas home at intervals as frequent as once a fortnight. On the factory floor every effort should be made to improve inter-personal relationships by promoting social, sports and recreational activities etc. particularly those that exclude alcohol. Recognising the extent to which a high disposable income can contribute towards the development of alcohol related problems, particularly in the younger age group, management and unions should jointly offer constructive financial advice and proposals e.g. inplant credit unions, saving schemes for house purchase and holidays etc.

Traditionally in this country both industry and indeed the wider community have shown a high degree of tolerance towards persons with alcohol related problems. This can be attributged partly to the widespread acceptance of the disease concept of alcoholism so successfully promoted by Alcoholics Anonymous, and partly

to our national sympathy as Irishmen for the underdog. In recent times, however, there is, I believe, evidence of a growing concern across the community that this approach has been misguided in that it allowed or possibly even encouraged large numbers of individuals to avoid facing up to their responsibilities to themselves and to society. At the professional level, the disease concept has been largely surplanted by the addiction concept and more and more doctors are coming to realise that by issuing 'cover up' certificates to persons with alcohol related problems, they may well be contributing to rather than alleviating the condition of their patient. In the future, persons with alcohol related problems may find they cannot rely on the medical profession to certify them unless they are actively participating in a recovery programme. On the factory floor, management can be expected to adopt a much tougher approach, job security, financial compensation and freedom from disciplinary action being guaranteed only to those who agree to participate in such programmes. Trade Unions who have already shown their willingness to play their part in combating alcoholism and alcohol related problems among the workforce may increasingly refuse to offer their protection to those who unreasonably seek it. Even amongst their own colleagues workers may find themselves being denied the cover to which they have become accustomed.

Such a hardening of attitude in the community need not relfect any lessening of sympathy for the affected individuals but rather a clearer understanding of the nature of the problem and likely solutions. Our task then is to ensure through alcohol education and other means that every possible step is taken to reduce the incidence of alcoholism and alcohol related problems, to identify as early as possible, those who are developing or who have developed such problems and to ensure that they are referred for and agree to participate in effective recovery programmes.

"An Irish Response"

MARY MULKERRIN, Health and Safety Manager, Warner-Lambert [Irl.] Ltd.

INTRODUCTION

The purpose of health education is to alter life styles, so that people with unhealthy habits will adapt better ways and attitudes to daily living. This is usually done by trying to influence the community as a whole. Little attempt is made to discriminate between one section of the public and another, and this is probably a mistake. Such a blanket delivery makes health education more diffuse than it should be, as there is a lack of impact. In a sense this broad method of disseminating information can be compared to the blunderbuss therapy of older times, rather than the specific curative treatment which is expected today.

Luckily, the disadvantages of a generalised approach are now being realised. A more critical attitude is being taken towards that part of the population which is the object of the exercise. This is necessary because the community can no longer be regarded as an amorphous whole. Within our present day society there are many diverse groups, each having its own cultural and social patterns and differing from the others in many important respects. These differences may not always be large, but in health terms, they may be quite significant.

One of the major categories is the working population. This group can be regarded as captive in that the workers are gfenerally restricted to one environment for prolonged periods. I suggest that this particular group would often welcome a change in the daily routine and will listen to health education advice but, what is most important is that special communication techniques be developed so that the group will respond to the stimulus of health education.

In the context of this Conference, much greater thought and planning must be given to alcohol education in industry and an overall strategy considered.

RESPONSE TO PREVIOUS PAPERS

My immediate response is that most programmes are limited to treatment and rehabilitation. To me, the traditional "five r's" have been the hoped-for scope of these programmes:

1. Recognition
2. Respect
3. Referral
4. Restoration
5. Re-adjustment.

This emphasis on treatment and rehabilitation is borne out by the study carried out jointly by the Bureau of National Affairs and the American Society for Personnel Administration in 1978. In that survey, only 38% of the respondents had developed company programmes to alter employees to problems with alcohol. Allied to this emphasis, is the development of company policy. In my own company the title of the policy is "Alcohol and other drugs of abuse guidelines" while Watney's policy outlined in the paper by John Deacock is "Policy on Alcoholism". To me both are designed in the negative vein and are problem orientated and could lead to confrontation on many fronts.

I suggest that companies retitle their policies and become positive in their approach by calling them "Alcohol Education Policies". They could design their policies using Michael Goodstadt's Grid as outlined at the Health Education Bureau Conference in 1979 — this grid is:

EXAMPLES OF PREVENTION OBJECTIVES, TARGETS ETC., AS A FUNCTION OF LEVELS OF PREVENTION

Level of Prevention	Presenting Problems	Workforce	Programme Objectives
PRIMARY	No alcohol problem	– No Risk – At Risk	Maintain status quo Prevent initiation of alcohol. Introduce the need for caution and preventive measures re alcohol, behaviours etc.
SECONDARY	Alcohol use at risk of developing into problem – level of use – nature of use – non-alcohol behaviours likely to lead to substance abuse related problems	– At Risk	Modify Alcohol use – level of use – nature of use

TERTIARY	Alcohol use is causing problems – Personal – Social – Economic – Health	– Problem Drinker – Alcoholic	– Return to pre-problem behaviours – Achieve a satisfactory level of functioning etc

The main reason I suggest for retitling is:

There is one undisputed technique in preventing alcohol related problems and that is: Education.

In relation to policy, another important decision to settle is: Who is going to design the policy?

The personnel, industrial relations, training, safety and medical departments are obvious, but what about the workers themselves?

Involvement of the workforce in policy design is important for two reasons. Firstly, it will help them to build on their own experience. Secondly, it will give those who are responsible for design the opportunity of learning more about the problem in reality and the effects of the policy.

Dr. Aldridge dealt with factors which inhibit the use of company treatment programmes. I would like to add to that and say that the same problems would inhibit an alcohol education programme:

1. Union neglect
2. Apathy in top management
3. Inadequate or sporadic efforts at implementation
4. Inability of line managers to analyse and confront poor peformance
5. The perceived role of the medical department or the occupational health unit.

In addition, three other external factors act as barriers:

1. **Person to person information**

Workers tell each other about their experience with alcohol — positive and negative. Which of them predominates depends on the cultural patterns and the level of consumption.

2. **Advertising for alcohol**

People selling alcohol try to give the public as positive a picture of alcohol and its effects as possible. It is no exaggeration to say that the alcohol industry lives from what we have called the 'placebo' effects of alcohol. Advertising builds on widespread attitudes and is only good if it corresponds to the informal communication which goes on among possible customers.

3. **Mass Media**

Mass media can be used for education, but it is not the main function of mass media in our open societies. Facts about alcohol very seldom count as news. The normal situation is that alcohol related questions play a very small role in the news picture.

On the entertainment side we meet alcohol very often. To some extent it mirrors what alcohol means to society — where happy successful people meet, they drink alcohol . . . . Alcohol also serves as a symbol of masculinity. He-men, like James Bond drink incessantly. It is only a pity that in real life nobody can drink like James Bond without damaging consequences.

There are two ways of overcoming these barriers:

1. If we stick with alcohol education programmes, the whole concept of training will have to be looked at. Training programmes will have to be organised for all sections within industry to understand how programmes can be developed and implemented and to stress that the entire organisation has a role to play.

2. A larger prevention theme should be developed for health education in industry. Here I would like to recommend to you the project that has been undertaken by 'American Re-Insurance', 'Blue Cross', 'National Science Foundation' among others. The project emphasises that many health risks "can either be prevented or modified through your own awareness and your own actions".

The ten programmes which are part of the preventive health education project include:

(a) Stress and its effect on body systems, stress factors and how to deal with them.
(b) The benefits of exercise and participation in exercise programmes.
(c) Weight analysis by skinfold assessment
(d) The drug scene
(e) Effects of alcohol on the various body systems, stages of alcoholism — key work, moderation
(f) Understanding blood pressure
(g) Quit smoking programme
(h) Heart disease and the risk factors that contribute to its onset and how to modify them
(i) Cancer prevention and screening
(j) Nutrition programme.

Sessions (a), (d), (e) relate directly to alcohol abuse while other programmes deal with other total health factors.

Participants in the programme receive a physical examination and answer a detailed personal medical history. A ten-year health risk profile is then prepared for each individual — using a computer to forecast risks in a variety of health categories. Three ages are given in the profile:

1. Present chronological age
2. Current risk age computed from one's lifestyle
3. Achievable age possible with lifestyle changes.

Group sessions are conducted to explain the results and risk factors that can be changed or identified. The programme emphasises wellness or feeling good and self-responsibility for this.

COULD WE TRY SOMETHING LIKE THIS IN INDUSTRY HERE?

A major boost for the concept of prevention should come from the Commission on Health, Safety and Welfare at Work.

HEALTH EDUCATION BUREAU — What can it do?

At it's 1980 Conference, the Health Education Bureau posed the question — "Whither Health Education in Industry?"

Among the answers it got were:

1. That those programmes most likely to be effective are alcohol and substance abuse prevention programmes.
2. There is an urgent need to train and educate more personnel to disseminate information and to motivate unofficial group leaders in specific industries in order that in an informal way these key people can perpetuate the concept of health at shop/factory floor level.

If the Health Education Bureau is serious about its commitment to health in industry, it can take the following lines of action to signify its intent:

1. Provide an advice service on request to occupational health teams in industry to assist them to draw up, develop and implement programmes of health education.
2. Make available to industry: posters, films, leaflets, pamphlets etc. which would be invaluable to prevention efforts.
3. Participate in research into health problems in the workplace and the recommendation of solutions.
4. Initiate health education programmes for various personnel in industry. Emphasis should be given to programme development, communications, alleviation of behavioural problems.
5. Incorporate industry into community health education programmes.
6. Devise an in-service training programme on health education in co-operation with the occupational health nurses section of the Irish Nurses Organisation and the society of occupational medicine.
7. Foster concern for health in industry among the numerous voluntary health organisations.

"An Irish Response"

DR. DAN MURPHY, Medical Officer, E.S.B.

THE IDEAL PROGRAMME

The cornerstone of a successful company programme is an attitude change towards problem drinking employees at a very high level in the organisation. It should set very clear objectives identifying levels of responsibility. It should be frequently reviewed and improved. It should be coordinated at a high level. A recipe for disaster is to allow it to be left to someone in a relatively junior position, who has no particular influence with top line managers. The programme should be comprehensible. An obvious sign of failure here is "we saw the new programme. What does the fourth paragraph mean?" These misunderstandings could lead to patchy, and perhaps unfair, administration of the programme. There should be agreement on the programme at all managerial levels. Supervisors are at the sharp end. Most of the identification of drinking problems should be by Chargehands and Foremen. It is important that they are properly educated and prepared and that they are content to take on this responsibility.

TRADE UNIONS

The agreement of the Trade Unions is fundamental to the success of a programme. The consultation process, apart from knocking the edges off an over-idealistic programme, is an opportunity for the dissemination of information.

PUBLICITY

The agreed programme should be widely publicised among the employees. Notice boards and staff newspapers should be used but word of mouth and group discussion are more important. The biggest challenge to be faced is to get the message to families and friends of problem drinking employees who are not themselves employed in the firm. The possible answer is to use social gatheirngs where spouses are present and introduce the programme in conversation or in speeches.

PREVENTION

It is very tempting for company programmes to make a passing nod at primary prevention and then pass straight on to the identification, intervention and treatment areas. It is important that a large portion of available resource should go into education to prevent alcoholism. Mistakenly, education is often seen as the only preventive strategy. Some companies have shown the way by modifying their entertainment practices with regard to alcohol and by becoming less tolerant to the workday drinking patterns of employees.

INTERVENTION & TREATMENT

Supervisors, shop-stewards and line managers should have training in intervention techniques. In our own company at the moment, we train in group intervention techniques often involving a Welfare Officer, but always having the line manager present. Where the best conceived programme can fall down is where suitable treatment centres are not easily available. The programme must take this into account. An agreed programme and successful intervention can come to nothing when the alcoholic is admitted to a local hospital without a special interest, dryed out, and discharged with no special aftercare. It is important that the names, addresses and admission procedures of the appropriate treatment centres are included in the programme documentation.

JOB SECURITY

The programme will of course promise that jobs will be kept open during treatment. It should not however give a bland "everything will be alright" assurance. Crane drivers, lorry drivers and others in critical occupations will have to be grounded for a year or so before achieving the stage of "sobriety". It might be questioned whether guarantees of equal promotion opportunities shoud be written in.

EVENESS OF APPROACH

A programme coordinator should be identified in the programme documentation. His duty is to ensure that all parts of the company are applying the programme and all levels of staff are being equally treated. Saying that failure to apply the programme to managers discriminates against shop floor workers fails to identify the injustice being done to these managers by allowing them to continue to develop this creeping disease.

DISCIPLINARY PROCEDURES

Obviously it must be clear that a return to disciplinary procedures for non co-operation is an essential element in the programme. In other words, if someone refuses to accept treatment or continues in their denial that they are back to the normal disciplinary scheme. Now it is important not to confuse this with saying that if an alcoholic fails to treat themselves, they are going to risk removal from the company in some way or other. There should be no element of being "sacked" for failing to get treatment. Dismissal may come eventually because an alcoholic, back under normal disciplinary procedures, behaves in an intolerable way.

THE ROLE OF THE OCCUPATIONAL HEALTH PROFESSIONAL

The most important first question here is whether the nurse or doctor should be the programme coordinator. There are, undoubtedly, disciplinary elements involved in the coordinator's role and this may be antipathetic to the traditional caring role. This also raises the question as to whether the Occupational Health Physician should actually make a diagnosis of alcoholism rather than referring the idividual to hospital as a suspected drinking problem and allowing the diagnosis to emanate from the Psychiatrist. This diagnostic question is important. Some Trade Union members might feel that this particular diagnosis should come from a Specialist not employed by the organisation. The Occupational Health Services role may, in some circumstances, have to be purely advisory. An Occupational Health Service serving a large widely distributed industry may only be in a position to give managers advice by telephone as to how to approach particular situations where drinking problems are involved. A lot has been said about the role of occupational health servies in the area of counselling. Counselling can take up a great deal of time and any nurse or doctor in Industry who has this sort of time can consider themselves lucky. If counselling time is available, it would be well worth while giving drinking problems a high priority. In this way, people who are at an early stage in the development of their drinking problem, can be advised to modify their drinking habits.

Has the Occupational Health Unit any role in intervention? Interveners must be meaningful to the individual. An Occupational Health Service that gives an on the spot clinical service in a factory or other compact working site, will be staffed by nurses and doctors who know the workforce well on a day-to-day basis. They in turn will be well known to the workforce. They would thus be seen to be meaningful people when they took part in an intervention involving one of the workforce whom they had known fairly well for some time previously. In a utility such as the Post Office or an Electricity Service on the other hand, the rather distant Medical Officer is hardly going to be seen as somebody meaningful.

After intervention and treatment the most vital element of the Company Occupational Health Programme is aftercare. This means setting down definite days and clinics which those who have had treatment, will attend. The programme should stipulate that certificates should be produced after each visit, to a nominated supervisor, and that these certificates should also contain the date of the next appointment. Any failure to attend or other errant behaviour, should be quickly notified to appropriate senior management, programme coordinator, or the Medical Unit as appropriate. Again it is probably more appropriate on a small compact worksite that the Occupational Health Unit should be the centre where these certificates are monitored.

MEDICAL CONFIDENTIALITY & ALCOHOLISM

Alcoholism is a secret disease. It is also slowly and inexorably progressive, "creeping alcoholism" as one young manager once put it to me. An "Enabler" is someone who wittingly or unwittingly, allows an alcoholic to persist with his denial of his problem and anti-social behaviour, thereby enabling him to carry on with his progressive alcoholism. Medical confidentiality if it is applied in its strictest sense to this distressing disease, is going to be an enabling factor in itself. There is nothing an alcoholic would like better than to trot into his Occupational Health Unit and pour out his hangover symptoms and other alcohol-related problems in the secure knowledge that at least "this place isn't going to blow on me". Se we really have to look at confidentiality and see what it means. There are obviously aspects of an alcoholics medical condition or an alcoholic's personal behaviour that can and will remain confidential. If the organisation is going to intervene successfully however, the existence of the problem has to be known to a certain number of individuals.

BIOLOGICAL TESTING

Blood tests are now available, the most important being the liver enzyme Gamma-Glutamyl-Transferase (G.G.T.), which will assist in coming to a diagnosis of alcoholism. In no way, should the G.G.T. be taken as a total diagnosis in itself. Many people have a raised G.G.T. without having a serious drinking problem. It is however of enormous help in overcoming resistence and denial. How should the individual be approached when seeking to take a sample for this kind of test? One approach is to say "Look, I must do these tests because if I do them, it will probably outrule the problem we suspect you have." I would be a bit doubtful about the approach which says "Look, having examined you, I am not too happy about your liver, I think I ought to do a few tests". Blood alcohol measurement will say someting about an individual's fitness to drive a crane or heavy goods vehicle, but maybe no indication as to whether he has an ongoing alcohol problem.

TRAINING IN ALCOHOLISM FOR OCCUPATIONAL HEALTH PROFESSIONALS

Doctors and nurses in Industry must have training, firstly in how alcoholism programmes are set up and how they should work with them. They should also get training on the counselling of individuals with mild problems, so that they can help those who are at an early stage of dangerous drinking. Another area where skills need to be developed is assessing the different types of alcoholic, so that they can be referred to the sort of treatment unit which will suit them best. In Ireland we have the added problem that, depending on their income level, patients may or may not be able to afford treatment in certain centres. When people are beginning to take an interest in the area of alcoholism for the first time, they need training in what to avoid. We have seen disastrous effects following from intervention in the wrong way, at the wrong time, and by the wrong person. Another area where doctors and nurses need to educate themselves is in the whole area of stress in the organisation and how it can be modified or prevented. Occupational Health professionals are in a unique position to identify and measure the interelationship between alcoholim, accidents and absenteeism. Training in the accurate measurement of accidents and absenteeism will in the long run, lead to the more accurate identification of those with drinking problems.

"Alcohol Education in Industry — the future"

MARCUS GRANT, Director, Alcohol Education Centre, London

INTRODUCTION — WHY EDUCATION?

It is common for people who are not themselves practitioners in a particular field to have unrealistically high expectations of what can be achieved in that field. Nowhere is that more true than in the field of education. And within the whole field of education nowhere is it more than in that muddy ditch called health education. Without wishing to spread gloom and despondency, but extending that metaphor still further, it could certainly be argued that, within the ditch of health education, alcohol education may be a particularly malodorous little backwater. It is malodorous not because it is impossible to achieve positive results. It is difficult certainly, but competent reviewers (Blane 1976; Gatherer, et al 1979; Goodstadt et al 1978; Parentea 1974; Unterberger 1968) have demonstrated that careful design leads to modest gain. The unpleasant smell that emanates from alcohol education has to do with the fact that powerful and vociferous sections of the community expect it to achieve results that would have been far beyond the capacities of the Lone Ranger himself. And, in alcohol education, let it be said, there are no magic bullets.

In this paper, therefore, an attempt will be made to examine in some detail what can reasonably be expected of alcohol education within the context of the working environment. Educational effort will be seen in relation to other relevant initiatives, such as the development of alcoholism policies and the instigation of various employee assistance programmes. The questions which will be raised will be concerned with how best to maximise the impact of a limited educational thrust when the target is as vast as the whole workforce and their families. Particularly at a time of general economic recession, there is undoubtedly a tendency for industry's traditional lukewarm interest in alcohol problems to turn into frank indifference. Alternatively, the availability of a few therapeutic dustbins into which hopelessly alcoholic employees can conveniently be tipped, is seen as a humane and holistic solution to the problems caused by alcohol at work. It is, of course, no solution worthy of the name, since it makes no attempt to deal in any way with the causes of problems. In the long term, alcohol problems at work will not be solved by providing bigger, better and more attractive dustbins. They will be solved by a co-ordinated approach, embracing both education and treatment, which seeks to have its impact before the problems are so far advanced that people start thinking in terms of any kinds of dustbins at all.

ALCOHOL PROBLEMS AT WORK

For practical purposes, it is important that those involved in occupational health should distinguish between the short and long-term effects of alcohol consumption. Acute alcohol intoxication is certainly likely to cause problems. Most organisations, however, have clearly defined procedures for dealing with drunkenness among employees and it is likely that, where only a single incident is being considered the pattern of the employee's previous work record will be taken into account. Legislation relating to employment protection should be taken into consideration as well (Osborne and Gordon 1978) since the decision is likely to be of a disciplinary rather than a medical nature.

Clearly an employee who is drunk is likely to show reduced efficiency and loss of fine motor skills. The evidence has been reviewed by Hore (1977a). It is seldom, however, that the occupational health specialist will be involved in such isolated cases, except where called in to determine whether an employee is indeed drunk. On such occasions, considerable caution must be exercised since no really satisfactory criteria for establishing objective standards of acute intoxication exist. It will usually prove better to suggest that the decision as to whether an employee is drunk and therefore unable to perform his task relates most directly to the nature of the work in which he is engaged, and that is therefore more properly a managerial decision to be made by his immediate supervisor.

Where, however, there is evidence of repeated drunkenness, the nature of the problem is very different. Any of the effects listed below might, of course, occur in relation to a single episode of drunkenness and depending upon the seriousness of the consequences, might require action by the organisation. It is when they form part of a demonstrable pattern of behaviour that the occupational health specialist has a special role to play because it is then that the problem moves from questions of discipline to questions of health and continuing safety.

Hore (1977b) has also reviewed evidence relating to rates of absenteeism and industrial accidents amongst employees who drink heavily. The number of days loss of work is shown to be as high as 70 — 85 per annum with a corresponding tendency towards frequent late arrival for work. It should be noted that episodes of absence will often be explained most convincingly by the employee and that vague complaints such as gastritis and back trouble will be blamed for the time away from work.

The evidence on accident rates is just as convincing, even if the figures are rather less dramatic. Studies in the United States and in France (Dunkin, 1981; Godard 1981) have indicated work accident rates of twice or three times the normal. The differential rates are particularly apparant amongst young and middle-aged employees. The majority of alcohol-related work accidents occur in the afternoon.

In summary, therefore, although the effects of excessive alcohol consumption make themselves felt in all aspects of physical, mental and social functioning, those items which are most directly relevant to the employment situation relate to loss of efficiency, absenteeism and increased liklihood of accidents.

Thus, the issue which emerges here is the extent to which education *per se* can be expected to limit, alleviate or eradicate either short or long-term effects of alcohol consumption.

If these two sets of problems are conceptualised as, on the other hand, drunkenness, and on the other hand, addiction, then the importance of distinguishing between them for educational purposes becomes all the clearer. Ensuring, for example, that all employees understand the company rules about being drunk at work (and remember that ensuring they understand the rules is an educational talk whilst merely giving them a copy of the rules is bareboned tokenism) may very well reduce the number of drink-related incidents, but is unlikely to alleviate long-term health problems amongst employees. Equally, a well trained counsellor in the personnel or occupational health department may well be able to help an alcoholic unravel the causative knot of their addiction, but is unlikely to make much impact upon how much is drunk at the Christmas party. Decisions have to be made, therefore, about which sort of problems the educational efforts are supposed to be addressing. At the very least, it has to be clear whether priority is being given to drunenness or to addiction. This is a theme which will be taken up again in the last section of this paper.

POLICIES AND PROGRAMMES

There is no doubt that preventive and therapeutic efforts are most effective within the context of a written statement of policy which has been produced by a company and has been agreed by both unions and management. The most productive terms for such a statement of policy have been reviewed by Grant et al (1978) but a number of central issues are crucial. These include:

1. That the employee, once identified, is offered appropriate treatment;
2. That refusal to accept treatment returns the handling of the cast to the disciplinary procedures of the company;
3. That the employee's job is kept open while treatment is being undergone;
4. That the policy applies equally to all employees.

The advantages of such a policy hardly require enumeration.

If, instead of being dismissed or covered up for, alcoholics are successfully treated, then this is good for the economic health of the company just as it is good for the personal health of the drinking employee. The pivotal position of the occupational health department in the creation and implementation of an alcoholism policy is reinforced by the growth in most countries of legislation relating to the protection of the health and safety of employees.

The extent to which any occupational health department feels confident in undertaking the task of treating those suffering from alcohol-related disabilities will depend both upon the severity of the disabilities, and vary likely, the availability or lack of availability of outside referral points. The modern view of alcoholism treatment is certainly that it is best undertaken in a multidisciplinary context. It is only fair to add, however, that there is a wide variety of standards of care on offer so that it is of crucial importance, where outside help is being sought, that the occupational health specialist should satisfy himself as to the competence of the agency and should go out of his way to explain to that agency the special circumstances which will make industrial referrals rather different from other patients or clients. Ideally, of course, there should be access to a sufficient range of treatment options so that each case can be assigned to the combination of agencies most likely to prove effective. Care should certainly be exercised in avoiding inappropriate referrals. Alcoholics Anonymous, for example, can provide a total salvation to one individual and a total disaster to another.

Given the probability that those identified at work will be less advanced in their alcohol dependence than if they had emerged in the community, it is wise to accept the necessity for a range of treatment goals. For most alcoholics, the outcome of a successful treatment programme is total abstinence from alcohol. There is now, however growing evidence (Hodgson 1977) to suggest that a proportion of alcoholics can return to what is often called 'normal social drinking.' It may be that this goal will prove particularly relevant to the better motivated and more supported individual, who may well emerge in the employment context. The function of an occupational health programme in the area of alcohol-related disabilities is, after all, to restore the individual to full, effective functioning. This may or may not be the same thing as stopping his drinking.

PREVENTION AND EDUCATION

As in the general community, it is convenient to consider the prevention of alcohol-related problems in the workplace under two separate headings. The first of these — alcohol controls is clearly an essential pre-requisite for the second — alcohol education. One is sufficiently accustomed to the hypocrisy of central governments, whereby massive increases in the availability of beverage alcohol are accompanied by miniscule increases in the provision of alcohol education, not to need to tolerate it in the microcosm of a commercial company or similar organisation.

Possible control strategies for use in the employment context have been discussed elsewhere (Grant 1979) and a detailed consideration of them is outside the scope of this paper. In summary, however, it is worth noting that such controls can relate to

(a) the real availability of beverage alcohol on site, whether provided by the employing organisation or brought on site by employees;

(b) the actual practice of enforcing or ignoriong existing company rules on drunkenness;

(c) routine or spot-check monitoring of staff and

(d) pricing policy with regard to any bar or similar facility operated by the company or its agents.

One educational task of considerable importance is therefore likely to be to ensure that everybody associated with a company is aware of the control mechanisms which exist and recognises that compliance with these controls is an important aspect of their contract of employment. Often, this talk can be summarised as communicating 'the company's attitude' to alcohol and to drinking, but actually it is something rather more specific than an attitude that is in question. Indeed, many of the unrealistic expectations about the effects of alcohol education are based upon the assumption that such education is about behaviour whilst those providing the education are actually only in the business of communicating attidues. It can, of course be argued that alcohol education can and should be concerned with a great deal more than attitudes. Indeed, one of the purposes of this paper is to attempt to be rather more specific than tends to be the case about what exactly can be achieved and how.

A difficulty frequently encountered by those involved in providing education, particularly education directed towards adults, is the lack of easy access to the target audience. The phenomenal success of the Open University in the UK and of similar media-based higher education schemes in other parts of the world is an indication of the extent to which the means of educational access have frequently been blocked in both directions. Those with something to say cannot reach their audience and those anxious to listen cannot locate their sources. And, taking this a stage further, since adult education is at best an interactive process between educator and educated, the moral and intellectual growth which is at the basis of educational change can never occur without the opportunity for trust and respect to develop within an unthreatheing context. Not all these difficulties, of course, vanish in the working environment, but at least there is a massive increase in the duration and intensity of potential access.

Another important issue to remember here has to do with the nature of alcohol problems themselves. There is growing evidence (Clare 1977) to suggest that there is a significant spontaneous remission rate from alcoholism. Thus, whilst it may be that harm, particularly work-related harm is most likely to lead to the identification and subsequent treatment of the alcohol dependent employee, it may be that the condition of dependence is susceptible to a variety of educational approaches (Davies 1980) which could be seen as stimulating or reinforcing natural tendencies towards remission without intervention.

SEGMENTING THE TARGET AUDIENCE

Although, as indicated in the preceeding section, it is essential when considering adult education to remember the interactive nature of the process, it is probably true that in most cases the impetus to engage in an educational experience, certainly within the context currently under discussion, comes from a decision by a relatively small group of individuals that they wish to influence the knowledge, attitudes or behaviour of a larger group. It is therefore possible to conceptualise that impetus and the consequent educational activity in terms of a linear communication proceeding from the smaller to the larger group. Such has been the primitive state of alcohol education in industry that there has frequently been an assumption that all that was required was for the smaller group to aim an educational blunderbuss down that line and to discharge it promiscuously over the entire target audience.

A somewhat more sophisticated approach relies upon a recognition that the educational requirements of the larger group are not uniform. In order to increase the chances of actually hitting the target, it is therefore helpful to define it more clearly. The next two sections of this paper, rather like a gunnery manual, will be concerned with improving the aim. First of all, however, it is helpful to know what it is that one is trying to hit.

Particular job titles used here may not be standard and the assumption that the employment context takes the form of a commercial company will not, of course, always be valid. Where a different organisational structure is more relevant (such as a hospital, a local authority or a trade union) or where job functions attract different lables (such as employee relations instead of personnel) there should be little difficulty in making the necessary translation. Equally, since this version of how to segment a target audience is based upon the assumption that the smaller group represents management, broadly defined, a readjustment of the axis will be required should that smaller group actually represent, for example, a trade union initiative.

Any subdivision of an organisation as complex as a company is bound to be simplistic and, to an extent, arbitrary. An attempt has been made here however, to create segments which are relatively autonomous in terms of their likely role with respect to the prevention, identification and treatment of alcohol-related problems. The list may not be comprehensive and, particularly for very large organisations, should therefore be viewed as illustrative. In the case of companies with comparatively few employees, different job functions may be telescoped into a smaller number of total segments. One way of segmenting the target audience is given in Table 1. The job functions are in no particular order.

TABLE 1

Segmentation of Target Audience

Company Board	Occupational Health Staff
Total Workforce	Safety Officers
Groups at special risk	Welfare Officers
Supervisors	Union Officials
Personnel Department	

It will be immediately apparent that the different target audiences listed here can be distinguished from each other in a variety of ways. Number, percentage of total workforce, seniority, income levels, age and sex distribution, average education level — all these criteria, and others, could be used to provide a profile of each target audience segment. Indeed, such criteria are likely to prove useful when considering the form and content of the educational experience to be offered to them. Long before that, however, comes the question of aim; and here the crucial differentiating criterion is the role those people are expected to play in responding to alcohol problems at work.

PROVISION OF INFORMATION

In order to clarify the diversity of relevant educational aims, it may prove helpful to distinguish between the provision of information and training in specific skills. Even within the first of these areas, it is possible to describe at least five separate and distinct aims.

1. To enable individuals to gain a *basic understanding* of drinking and alcohol problems. Within this basic understanding, a further two objectives can be identified, namely (a) to enable individuals to see the relevance of that information to their own drinking habits and those of their colleagues (see Gwinner and Grant, 1979) and (b) to enable individuals to appreciate the terms of any company alcoholism policy and to be familiar with relevant agreed procedures.
2. To have broadly based and up-to-date knowledge of relevant research data regarding the extent and nature of problems resulting from excessive alcohol consumption, particularly when those data explicitly or implicitly concern *employment contexts.* Further, to be able to relate those data to decision making processes involved in the development and implementation of company policies.
3. To possess accurate, scientific knowledge of the nature, causes and effects of *alcoholism.* Accepting that a dimensional model of alcoholism has now largely replaced the previous categorical model, it is nevertheless important to recognise that, whether or not it is strictly speaking a disease, by whatever definition alcoholism is undoubtedly an occupational health hazard with implications for physical, psychological and social functioning which, particularly when considered in terms of the disease characteristics of addictive behaviour, which requires some specialist understanding.
4. To be aware in realistic rather than idealistic terms of all potential *sources of treatment* and to be familiar with the strengths, weaknesses and operating policies of each, so that relevant referrals may be made. Chances of successful treatment outcome are enhanced by careful routing of patients to those treatemnt centres which best match their needs (Glaser, 1980). This information requires continual updating and is likely to be even more relevant if good working relationships can be maintained with the various treatment agencies involved.
5. To be familiar in detail with research data showing the relationship between *alcohol consumption and work performance* (see Hor 1981). The application of this knowledge to a variety of specific occupational settings is a necessary consequence of the educational task, particularly where the occupation carries high alcohol damage rates (see Table 2) or where a particular job involves responsibility for the safety of others, as, for example, drivers, pilots and mariners (page 12).

TABLE 2

Table 17.1. Occupations with the highest mortality from cirrhosis of the liver. (From Occupational Mortality, 1970-72, England and Wales, Office of Population Censuses and Surveys. HMSO London 1978). Crown Copyright.

Occupation Unit Title	Rank in top 20	All deaths SMR
Publicans, innkeepers	1	1,576
Dock, engineering officers and pilots, ship	2	781
Barmen, barmaids	3	633
Dock and engine room ratings, barge and boatment	4	628
Fishermen	5	595
Proprietors and managers boarding houses and hotels	6	506
Finance, insurance brokers, financial agents	7	392
Restaurants	8	385
Lorry drivers' mates, van guards	9	377
Cooks	10	354
Shunters, pointsmen	11	323
Winders, reelers	12	319
Electrical engineers	13	319
Authors, journalists and related workers	14	314
Medical practitioners, (qualified)	15	311
Garage proprietors	16	294
Signalmen and crossing keepers, railways	17	290
Maids, valets and related service workers	18	281
Tobacco preparers and products makers	19	269
Metallurgists	20	266

*Standardized mortality ratios are calculated taking into account the age composition of an occupational group. The average standardized mortality ratio is expressed as 100.

SKILLS TRAINING

Just as within the general area of the provision of information, so within the area of training, it is possible to describe at least five separate and distinct skills which can then be translated into coherent educational aims:

1. To be aware of potential indicators of alcohol problems and to be able to *identfy* individuals who may manifest them. It should be noted here that the aim is not to develop a battery of sophisticated diagnostic skills, but rather to create an awareness of those behavioural cues (See Hore, 1877b) which should alert the sensitive observer to the possibility that excessive drinking may be implicated.
2. To be able to undertake *assessment* of individual cases where the possibility of alcohol problems has already been identified. Assessment in this sense may involve physical testing of key functions (see Palko, 1978) but will certainly include the ability to make appropriate recommendations for the continuing handling of a case in terms of the relative weighting to be given to various treatment options and to any outstanding disciplinary procedures.
3. To be able to offer appropriate help to identified individuals who have accepted the treatment process suggested by the company or its agents. Such help will, of course, frequently take the form of *counselling,* whether individually or in groups. Although in some, more difficult cases, this will be made available through an efficient and confidential referral system, it is to be hoped that companies will increasingly feel able and confident to offer such counselling from within their own resources. The ability to engage in and to sustaiin a mutually beneficial co-operative treatment system, involving external and in-company resources is likely to prove invalualble.
4. To be able to *monitor* the performance of individuals who have returned to work following treatment or who are working while being treated. This requires the ability to balance objective assessments of efficiency and effectiveness alongside a special sensitivity to the particular problems associated with recovery from alcoholism, especially the possibility of relapse.
5. To be able to formulate action plans designed to minimise the likelihood of alcohol problems. Such plans would require to be translated into particular *preventive strategies,* embracing alcohol controls and alcohol education, as indicated earlier in this paper.

INTEGRATING EDUCATIONAL EFFORT

Having identified relevant segments of a heterogeneous target population and having specified a range of educational aims in terms of defined areas of impact, the final step is, of course, to attempt to fit the two together. Taking as a preliminary typology the five aims in the areas of information and the five aims in the area of skills, it is possible to suggest which of these aims are of greatest relevance to the audience segments listed in Table 1. Thus in Table 3, a pattern emerges of which aspects of alcohol education are most relevant to which groups.

TABLE 3

Target Audience Correlated with Educational Aims

	Info.	Skills
Company Board	1, 2	
Total workforce	1	
Groups at special risk	1	5
Supervisors	1	1, 4
Personnel departments	1, 5	2, 4
Occupational Health staff	1, 3, 4	2, 3
Safety Officers	1, 5	4, 5
Welfare Officers	1	3, 5
Union Officials	1, 2	1, 4

Thus, instead of the blunderbuss approach to alcohol education in industry, a clear picture emerges of how particular targets can, as it were, be picked off with increased precision. This approach minimises the waste of scarce educational resources, in terms of finance and manpower. It also increases the probability that those towards whom the education is directed will perceive its relevance to them and will not therefore be inclined to ignore or repudiate it.

Brief mention should, perhaps, be made here to the experience of the Alcohol Education Centre in providing education and training along the lines discussed in this paper. Some people, looking at Table 3, might be

forgiven for thinking that the task was so huge and so complex that there was little chance of achieving any success at all. In point of fact, since the totality of the alcohol education process is divided into particular tasks with respect to particular groups, the overall process actually becomes all the more manageable because it is comprehensive and because it is possible to maintain a system of continuous assessment of the effectiveness of the educational programme. At the very least, such an assessment can be based upon self-reported evaluations comleted by those undertaking particular training courses. Finally, of course it must relate to the prevalence and severity of alcohol problems in the workplace. The experience of the Alcohol Education Centre has certainly been that it is possible to design compact and comprehensible curricula to meet the various needs outlined above and that these curricula appear to be reasonably effective when translated into actual training courses in a wide variety of different industries.

DECIDING ON PRIORITIES

The final issue which requires to be considered here relates to how, within the correlation of target audience with educational aim, it is possible for any company to decide upon its particular priorities. Clearly two of the underlying principles which should inform such decisions relate to the relative vulnerability of particular segments of the target audience and the specific functions accorded to specific individuals by any alcoholism policy or procedures which have been agreed. There is, for example, little point in establishing a policy which enables identified problem drinkers to be sent for treatment if there is nobody competent to identify them and nobody aware of where they can be sent.

Reference was made in the opening paragraphs of this paper to 'powerful and vociferous sections of the community' who may have unrealistic expectations of the potential impact of alcohol education. At a national level, this description could apply equally well, though for rather different reasons, to the beverage alcohol industry (and their advertising agencies), to the temperance movement and to central government itself. Within the employment context, the chief executive who expects results overnight or the union official who sees an alcoholsim policy as a universal panacea may be equally likely to expect time frame and current climate of opinion. That climate can change and education can play a part in changing it. But what is most important for those with an interest in promoting and encouraging alcohol education at work is a firm commitment to two basic principles. It must be clear from the outset exactly who it is that any particular educational effort is intended to influence. And it must be clear exactly what it is that the education is intended to achieve. Education may not always achieve all that is expected of it. But without education, nothing is likely to be achieved at all.

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Group Reports

Group 1

Leader: Mary Barrett
Adviser: Dr. Ward Gardner
Rapporteur: John Condon.

At the outset Group 1 took as its brief the following points.

1. To identify the elements involved in planning alcohol education programmes;
2. To consider special problems relevant to this area;
3. To look at specific problems that certain industries and businesses might have;
4. To make specific recommendations relating to these problems and to the implementation of alcohol in industry.

The key elements involved in planning alcohol education programmes were identified as follows:

1. The occupational health team;
2. The attitude of management and unions, the various voluntary and statutory bodies involved in alcohol education;
3. The role of the general practitioner and
4. The need for up-to-date research and information on alcoholism.

The special problems relevant to alcohol education were considered to be:

1. The prevalence of alcohol in our culture;
2. The effect of advertising whose message is contradictory to alcohol education;
3. The question of certification for people with alcohol-related problems;
4. The laxity in the enforcement of legislation especially in the areas of extensions, licensing hours and under-age drinking.

Specific problems which certain industries and businesses have were identified as:

1. The lack of alcohol counsellors in certain regions;
2. The inclusion of bars in social and leisure centres;
3. The need to convince management of the cost effectiveness of alcohol education programmes — hard cash speakes louder than guilty consciences or public relations exercises.

The main recommendations of the group can be summarised as follows:

1. The occupational health team has a key role in implementing alcohol education in industry;
2. There is a need for co-ordination between alcohol education in industry and alcohol education in schools;
3. Legislation is needed which is a reinforcement of alcohol education rather than a contradiction;
4. The need for industry to go dry at all levels from management to shop-floor was considered laudable but doubts were raised as to its feasability;
5. Alcohol education in industry cannot take place in a vacuum — there must be a national awakening to the problems of alcohol aimed at all levels of the community;
6. There is a need for information to be readily available to those who want it;
7. The role of the Health Education Bureau was seen to be:
   (a) the provision of a package for the occupational health team containing information on how to deal with the problem in all its aspects specifically recognition, relationship with management, supportive agencies etc. — such a package to be disseminated by means of in-service training;
   (b) the continued provision of pamphlets, posters etc. with an informational content. The effectiveness of media campaigns was questioned;
   (c) to influence local opinion leaders, especially those in management and trade unions by means of inputs at Conferences, Seminars etc.
8. The role of the Health Boards was seen as the provision of alcohol counsellors and as resource centres for those involved in alcohol education. (The work of the Midland Health Board health education staff in providing alcohol free discos was considered a step in the right direction).
9. Bearing in mind the complexity of the problem, the occupational health team should be provided with:
   (a) information and methods of recognition;
   (b) in-service training to be provided by the Health Education Bureau;
   (c) training in counselling;
   (d) training in social skills relevant to the involvement of managements, unions and staffs.

10. The difficulty in implementing the previous nine recommendations all at once was recognised so that the number one priority is for a two-day seminar for occupational health teams with built-in modules in the following areas — information, recognition of alcohol-related problems, supportive agencies and the skills needed to convince management of the validity of the programme.

Group 2

Leader: Dr. Des O'Byrne
Adviser: Dr. John Aldridge
Rapporteur: Kathleen Mooney

Group 2 started off by introducing themselves, the work they did and how they were concerned with the problem of alcoholism. The following are some of the more important items discussed by our group:

5. The need to obtain supportive commitment of both management and trade unions at national level i.e. the Federated Union of Employers and the Irish Congress of Trade Unions;
2. The development of the general policy in the treatment of all members of the national work-force who have alcohol drinking problems.

The feeling of the group was that if you want to get something going at local or factory level, you must have the lines cleared from the top down. When this is done at national level, then it would be more feasible and possible to try and have a polciy on alcohol at company or facory level developed. In trying to develop such a policy, the group felt that it was necessary to involve not only management, health personnel and even foremen and charge help but also shop stewards. The group also wished to stress the importance that any such policy on alcoholism would apply equally to all members of the Company or factory or organisation and not to have one policy for the workers and another for the management. In this respect, the group was endorsing views expressed by some of the Speakers in their papers.

There was considerable discussion on the possible role industry might play in educating the public especially the youth on the dangers of excessive drinking in industry. However, it was felt the main responsibility laid with the teachers to develop in the school children a responsible attitude towards life not least in the proper use of alcohol and the dangers of misuse. Speakers from industry or the occupational health professions might, on request from the teachers, give a talk to the school children on their main concern in industry, not just alcoholism.

CONFIDENTIALITY

The group spent considerable time on the question of confidentiality and the necessity to protect the rights of the individual worker who had an alcoholic problem. Given the nature of alcoholism, some members felt that they might go directly to the relatives or friends of the person with a drink problem, but after discussion it was agreed that no approach whatever should should be made to the relatives or friends of a particular person without his or her permission.

The safe limits of drinking alcohol, which might be recommended to the general public, was discussed. The general feeling was that there was a danger in setting such limits which might be used on the one hand as an excuse to drink up to the given limit, or on the other hand be completely ignored as being too restrictive.

KNOWLEDGE ABOUT ALCOHOL

The general knowledge among the working population on the dangers of alcohol abuse and on the signs that indicate that there is a drinking problem was felt to be low. It was agreed that there was a need to have an education campaign to increase the level of knowledge among the workforce on the proper use of alcohol.

The possibility of introducing legislation to reduce the size of the measure used in serving spirits was raised, but received very little support. It was felt that if the measure was reduced in size, the customer would simply buy extra measures.

Alcohol and its removal from the consumer price index was also raised. This would involve many political issues and it must be seen how the removal of alcohol from the C.P.I. would help to alleviate the problems of excessive drinking.

DRY COMPANIES

When no alcoholic drink is served at the place of work for functions etc. which was mentioned by Dr. John Aldridge in relation to IBM, received little support except in industries where it was already accepted policy. The group felt that it was more important to stress the more positive side that is the proper and responsible use of alcohol rather than the negative.

Arising from all the questions, the group wish to make the following recommendations:

1. That the Federated Union of Employees and the Irish Congress of Trade Unions make a statement recognising problems in industry because of abuse of alcohol and giving their support for the development of company policy on alcoholism.

2. That the individual companies, firms and organisations should develop a policy in consultation with the relevant groups i.e. management, health professionals, charge-hands, shop-stewards etc. on the proper treatment and rehabilitation of all staff both management and employees.
3. The group recommended that there should be an educational campaign to increase the general level of knowledge among the working population and all matters relating to the use and abuse of alcoholism.
4. That a well-planned and structured programme not just once-off on health education with special reference to alcohol, should be organised for all the staff in industry.
5. That a specially designed course or courses should be given to the personnel, medical services and management.

Group 3

Leader: Dr. C. McNamara
Adviser: Joy Evans
Rapporteur: Maurice Cashell

We took it as our terms of reference that we should first develop certain criteria for an education programme directed not at the community at large — we recognised the need for such but decided to set priorities — but at what we considered to be one of the most important, if not the most important sectors viz young people. We make this selection not because they are the soft option captive audience in schools that are to be zapped with the education programmes of all the attitude changers. Rather we focussed on them as a group in society who have not yet started seriously drinking and who are particularly susceptible to certain types of approach. Some of us felt indeed that we are in for a long haul in relation to controlling alcohol dependance and that there is merit in thinking on a long time-scale. Among the key areas in which the education programme would take place were AnCO training establishments and the workplace itself.

Two general points we felt

- an education programme is only one approach, one of an integrated series of means of action, including possibly legislation, all of which focus on the need to change behaviour;
- an education programme needs to be carefully designed, communicated properly and by the right people and relevant to the target audience.

Our more detailed observations in this respect were that

- first, young people had to be given a clear unambiguous perception of what moderate drinking is: the concensus was that the present perceived level was pitched too high and that it was urgent and important to promote quantity and frequently guidelines;
- secondly, whether as the objective of an educational programme or as a means of action independent of education, or both, considerable emphasis must be given to the need for activities of the type best characterised by the so-called "no-name" club. Young people who use these clubs note that they offer concrete alternatives to drinking. These clubs (now co-orindated by a National Centre and receiving some grant aid from Government) enable young people to remain part of their chosen social scene without exposing themselves to drink. We felt therefore that there was both a need for alternatives and an education programme aimed at encouraging and enabling young people to explore alternatives to drinking;
- thirdly, we felt that there was need for more precision as to who best influences young persons; parents, teachers, counsellors or outside people including sports personalities and indeed alcoholics. (Alcoholics and doctors don't seem to have a great track-record in impressing young people). Some raised the question of what was the role of the "occupational health professions" in relation to education and indeed as a group we felt at times short of important information;
- fourthly, an education programme must be straight, factual, uncompromising and amoral; particular stress was laid on the need not to preach — to do so is to run the risk of inspiring a negative reaction;
- finally, as with all educational programmes we felt that the various modules had to have clear verifiable objectives; it is not a matter of having "motherhood and the flag" objectives, vague things to which we all subscribe; vague objectives led to dispersal of resources; we could do well to remember the saga of Marcus Grants' foot-and-mouth shoes.

Let me repeat very briefly why the workplace is emphasised

- the great majority of problem drinkers spend a great deal of their time there;
- they are most likely to be recognised, at work, for what they are and possibly sufficiently early;
- there is considerable evidence that job loss is a powerful motivation factor even in countries with very progressive employment protection systems.

We felt *at this stage* of our deliberations that the size and urgency of the problem now facing us warranted both short-term and long-term responses.

In the long-term we felt that the Commission on Safety Health and Welfare at Work should be asked to identify the place of alcohol education prevention and intervention in its recommended programme and priorities respecting safety health and welfare at work.

Among the points that were stressed concerning an education programme geared towards the workplace:

(1) no workplace-level education programme would achieve very much unless it had the compete support of top management expressed through line management to front-line supervisors;

(2) no programme would survive unless it had the support of the workers and their organisations;

(3) such an education programme should not be soft and indulgent; a tough uncompromising line was now called for;

(4) it should not be presented as something unique or extraneous to the management of the undertaking like the periodical fire drill or the annual inspection of the factory inspector; rather to ensure dynamism it shold be integrated into the normal communication of the undertaking and reviewed and evaluated as are other elements of the system being managed;

(5) we discussed certain elements of an educational programme which would be likely to have an influence on young workers in terms of a trade-off between drinking moderately and problem drinking; apart from loss of job, there was room for stressing waste of money and unstable sex relationships.

RECOMMENDATIONS

Our main suggestion was that in the days after this Conference the HEB could turn its mind to the development of guidelines (criteria rather than a blueprint), for adaptation to local needs, for the content and delivery of education programmes.

Secondly, the HEB might send a direct request to the FUE, ICTU and the Government Departments and public authorities primarily concerned to come together, to recognise the need for such programmes in the national interest, and to hammer out a common policy.

Thirdly, the Group considered that there was a marked lack of expertise and data on the nature of the education need: the HEB in consultation with the health boards was invited to set up a training programme for health care professionals.

Fourthly such data as had already been produced — for example that produced by the Midland Health Board and INCA — might be more widely disseminated.

TREATMENT

In the Group the same cri de coeur was heard which had been echoed earlier from the rostrum: all very well to identify the problem people but where do you refer them? Country voices were raised in a familiar refrain: more units for alcohol treatment should be established down the country . . . at present they're concentrated around Dublin.

This led indeed to a most interesting discussion: is Dublin right?

In relation to treatment, many said, we should look at alternative approaches and institutions: the concensus was that we may well be placing excessive confidence in traditional treatment centres; hospital in-patient treatment was not necessarily the first approach or indeed the correct approach at all; in our quest for alternatives we should be looking at what treatment could be carried out in the workplace; we should also be looking at what contribution could be expected from community-based institutions.

This leads to our last two recommendations: while prevention was the priority strategy there was a need for revitalisation of treatment facilities. The Group considered that a clear responsibility should be placed on the health boards to provide emergency services and detoxification facilities; it was also necessary to think of rehabilitation and to involve the appropriate establishments.

Finally, the discussions over the weekend had no more than one occasion elicited a response "we need to educate ourselves more about this phenomenom." This, too, is a recommendation to the HEB.

Group 4

Leader: Claire Devlin
Adviser: Dr. Dan Murphy
Rapporteur: Stephanie Prior

In group 4 the discussion was stimulating and wide-ranging. Many opinions were expressed and views exchanged on different aspects of the alcohol problem. Emphasis was laid on the confidentiality aspect of alcohol treatment. The group also emphasised the idea of alcohol being a psychological, social and cultural phenomenon and not just a medical problem as it was seen that there had to be many approaches to the problem. However, it was stressed that there was a need to integrate many elements of the workforce into any viable alcohol programme. The role of both management and trade unions was emphasised.

Another point on which great emphasis was laid was the need for there to be a caring element in alcohol problem and it was stressed that the occupational health nurses had a great role to play here both in prevention and after-care. Stress was seen as the contributing factor to alcohol problems and ways of aleviating this was discussed.

The legislation aspect of prevention was dealt with as were the cultural facors.

Throughout the whole discussion, the various element of the alcohol problem were borne in mind.

The following recommendations were made:

1. A national policy for alcohol education and intervention be drawn up. Unions, management, workers to become involved so that people with alcohol problems could be identified, referred and treated with built-in protection for the alcoholic employee and for the employer. Within the national polciy, it is recommended that firms build in a programme to deal with both alcohol education and treatment programmes.
2. The group recommended that there is a need for a realistic legislation control. No alcohol to be served at discos for young people and that the number of extensions to be reduced and that the availability of alcohol to be seen as a factor in the increase in alcohol dependence.
3. Progress for alcohol education be incorporated into the new health and safety act.
4. The employment appeals tribunal will rarely find a dismissal to be unfair unless reasonable warning procedures have been carried out. Initial warning procedures should also be accompanied by a caring approach where there is an alcohol education programme, presently to be carried out by the occupational health nurse, rather than by personnel or line management. This caring approach to be seen so that when people are identified and referred for treatment, contact be maintained when they return to their job.
5. People in occupational health should build up a liaison with shop stewards and peer group leaders to wade identification and treatment of people with alcohol problems.
6. Policies controlled and sensible drinking be recommended by industry e.g. promotion of non-alcoholic drink; money for social events provided by the company be given where alcohol is not served; employers should provide recreational and social activities for their workers as an alternative to going to the pub. Alcohol Education, including films and discussions be included as a part of induction programme for employees.
7. Employers should be encouraged to provide alcohol education for all its workers on an on-going basis. These programmes to be organised during working hours if possible.
8. Stress should be seen as a contributing factor to alcohol problems. Efforts should be made to aleviate this by encouraging good communication within the organisation.
9. The need for local sources of information on alcoholism and its treatment was stressed. Ways of providing this input be posters, pamphlets, readily available and on display in the workplace.
10. Where confidentiality is involved and is an issue, the health and safety of the worker and fellow worker is a determining factor but counsellors should persuade those with the alcohol problem to declare themselves.
11. The position of the occupational health nurse should be a neutral one and her relationship with the patient should be the most important aspect.
12. The main emphasis from the group was the need for all sectors of industry to be involved in the process of alcohol education from management down.

Group 5

Leader: Dr. J. Cunningham
Adviser: Col. J. Adams
Rapporteur: Sam Docherty

Group 5 said from the outset, whereas it was in total accord with this particular conference and its aims, nevertheless they would make an appeal for a specific package of materials and policy documents to result from the deliberatins of this conference. It was felt that the elements of this package were already in existence and the INCA's trial materials with the electrical supply industry was quoted that these required to be collated and collected together to form a cohesive package for all industry and commerce. Again, this package to be loose enough and flexible enough to allow articilation with specific industries to express that specific need.

The basic and large scale lack of information about alcohol and its possible abuse stemming from the figure of 5% of Irish skills involved in alcohol education was quoted and the missing information was recognised, should have been there to form the basis of decision making in terms of any individual alcohol behaviour.

As far as the occupational physician was concerned, there was a great deal of discussion about confidentiality and two possible sources of referral were identified. The self-referral to the industrial physician where the individual makes the approach himself because he has or she has identified that they may be having a problem with their drinking behaviour. It was thought that in that self-referral situation that the total confidentiality between a patient and his/her doctor was the only thing which would be accepted.

The management referral whereby an individual was referred to the occupational health staff because of a disciplinary breach or something else was felt that the confidentiality in this instance should relate to subsequent reports from the occupational health staff back to management on the progress of the individual. It was felt also that terms such as alcoholism and alcoholic were emotive and as far as possible should not be used in the description of any patients progress and all the relevant information to be passed from the physician to management thereafter in the normal way.

The possibility of Alcoholics Anonymous being involved in an educational process in industry was discussed and this was seen generally to be problematic because it was felt that some screening of the individual from A.A. should be involved and this might lead to a better response from other individuals in industry. Not withstanding the problematic nature of the A.A. involvement in this way, it was felt that within a specific industries, A.A. members could provide an appropriate approach point i.e. some level of placement within the industry for other problem drinkers in that industry. It was also expressed that A.A. perhaps would have a much broader base to operate and mount such an approach policy than for example I.N.C.A.

The Health Education Bureau was asked to organise and run a series of courses for industrial nurses to help identify key areas with a greater educational input. Conferences to be run along a workshop style basis to allow working through actual problems which industrial nurses may face in relation to an alcohol policy within their own specific industry. Although the industrial nurse is heavily involved in a referral, a point was made strongly that the pre-service training of industrial health nurses at the present time does not include appropriate training and counselling and the industrial health nurse should not be expected to act as a counsellor until training has been given.

Several models were looked at: maintaining a national awareness of alcohol and its related problems and a member of the group suggested that the format for a national school on ancoholism on an annual basis, where all the probelms could be raised and kept in the public awareness could be mounted.

LIST OF PARTICIPANTS

SPEAKERS

1. Noel Daly, Head of Education and Training, HEB.
2. Dr. A. Clare, Institute of Psychiatry, Maudsley Hospital, London.
3. Dr. Ward Gardner, Senior Medical Officer, Esso, Southampton.
4. Mrs. Joy Evans, Personnel Officer, Bradbury, Wilkinson & Co., Surrey.
5. Dr. John Aldridge, Senior Medical Officer, I.B.M., Portsmouth.
6. Marcus Grant, Director, Alcohol Education Centre, London.
7. Dr. C. McNamara, Honorary Secretary,, Irish Society of Occupational Medicine.
8. Mary Mulkerrin, Health and Safety Manager, Warner-Lambert (Irl.) Ltd.
9. Dr. Dan Murphy, Medical Officer, E.S.B.
10. Col. J. Adams, Director, Irish National Council on Alcoholism.

Chairmen

11. Dr. H.D. Crawley, Director, Health Education Bureau.
12. Mr. A.M. Morris, Head of Administration and Finance.

Leaders

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14. Dr. D. O'Byrne, Head of Research and Information, H.E.B.
15. Claire Devlin, Librarian, H.E.B.
16. Dr. Joseph Cunningham, Medical Officer, C.I.E.

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17. Harriet Duffin, Public Relations Officer.
18. Maggi Masterson.
19. Bernadette O'Hare.
20. Celene Craig.
21. John Condon, Education Officer.
22. Dave O'Connor.
23. Liam Walsh, Institute of Advertising Practitioners in Ireland.

Guests

24. John Bolger, A.T.&G.W.U., Member of Alcoholic Rehabilitation Committee.
25. Det. Insp. D. Mullins, Head, Garda Drug Squad.
26. Sr. Consilio, Cuan Mhuire, Athy.
27. Joe Cregan, Assistant Principal Officer, Department of Health.
28. Arthur Rice, The Federated Union of Employers.
29. Maurice Cashell, Principal Officer, Department of Labour.

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30. Samuel C. Docherty, Scottish Health Education Group, Edinburgh.
31. Adrian Pollitt, Health Education Council, London.
32. Linda Singer, Further Education Lecturer, Nelson & Colne College.

Occupational Health Personnel

33. Maisie Fitzgerald, AnCO Training Centre, Shannon
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35. Brid McCrea, AnCO Training Centre, Ballyfermot.
36. C. Gregory, AnCO Training Centre, Cabra.
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38. Catherine Moore, AnCO Training Centre, Waterford.
39. K. Sugrue, AnCO Training Centre, Tralee.
40. Kathleen Mooney, AnCO Training Centre, Letterkenny.
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81. Mary Murphy, Pfizer Chemical Corporation, Cork.
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83. Joanna Murphy, Batchelors Food Ltd., Dublin.
84. Mary Fahy, Digital, Galway.
85. Mary Quirke, Digital, Clonmel.
86. Marian Rackard, Irish National Council on Alcoholism, Mullingar.
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139. Alice Hunter, Relief Occupational Health Nurse.
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