Northern Ireland Assembly

Committee for Communities

OFFICIAL REPORT (Hansard)

Licensing and Registration of Clubs (Amendment) Bill: Chief Medical Officer

27 October 2016

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Colum Eastwood (Chairperson)
Ms Michelle Gildernew (Deputy Chairperson)
Mr Steven Agnew
Mr Andy Allen
Ms Nichola Mallon
Mr Fra McCann
Mr Adrian McQuillan
Ms Carál Ní Chuilín
Mr Christopher Stalford

Witnesses:
Dr Michael McBride Department of Health

The Chairperson (Mr Eastwood): Dr McBride, how are you doing? You are very welcome. Sorry for keeping you.

Dr Michael McBride (Department of Health): It is absolutely no problem.

The Chairperson (Mr Eastwood): There is a lot of interest in the Bill. As you probably know, you have 10 minutes or less to present, after which there will be questions from members.

Dr McBride: I picked up on the "or less", so I will do my best.

The Chairperson (Mr Eastwood): Over to you.

Dr McBride: Thank you very much, Chair and members. I thank you for the opportunity to come along and discuss the Licensing and Registration of Clubs (Amendment) Bill. To be clear from the outset, I am here in my capacity of Chief Medical Officer, and I hope that the evidence that I give will be helpful to the Committee in its deliberations.

I want to emphasise from the outset the excellent working relationship between the Department of Health and the Department for Communities — formerly the Department for Social Development — on the issue. That is absolutely vital, because alcohol issues cannot be addressed by one Department alone. It genuinely requires cross-government and cross-sectoral working to have any long-term impact. As I am sure you have heard in evidence, alcohol is not an ordinary commodity. It is not like and cannot and should not be treated like bread or milk. Alcohol is a psychoactive substance, and its sale is highly regulated for a reason. I should also state that I am not promoting prohibition. I think

that alcohol must be sold and consumed in a way that reflects its potential harms and recognises that most people drink alcohol responsibly.

Liquor licensing plays a key role in setting the context. It helps to orientate and set our social norms around alcohol use. Looser regulation and wider availability make alcohol seem more a part of everyday life, and tighter regulation and lower availability signal that alcohol should be treated with care and consideration.

I have often said publicly — it is worth repeating — that alcohol misuse is one of the most important public health challenges that we face. Drug misuse often gets all the headlines, but alcohol remains our drug of choice. Three times as many people in Northern Ireland die from alcohol-related causes than drug misuse-related causes. It costs us as a society up to £900 million a year. As I indicated in the written evidence, £240 million of that is borne by Health and Social Care. That would build the new children's hospital or 15 new primary care centres. Alternatively, the money could be used to employ over 6,000 nurses, pay for 30,000 hip operations or deliver over 17 million hours of domiciliary care. In the week that we are in, and given the discussions that we have had, I think that those are very relevant statistics.

If we look at the prevalence of alcohol use, we know that 74% of us as adults drink alcohol. Twenty-one per cent of men and 8% of women drink more than the new alcohol guideline units, and 30% of us binge-drink. We estimate — it is probably an underestimation — that 170,000 adults here drink at hazardous levels — I have given a definition of that in the written evidence — and around 47,000 drink at harmful levels. However, the real issue is the harm that alcohol causes: increased risk of poor health; cancer; cardiovascular disease; liver disease; increased risk of dependence; poor mental health; suicide and self-harm — an issue that I highlighted in my annual report this year — increased risks of being involved in and causing accidents; and increased risks of being involved in or being a victim of violence or assaults. The statistics themselves reflect those harms.

Provisional reports indicate that 310 people died directly as a result of alcohol misuse in 2015, which is up some 30% from the previous year. Over 6,000 individuals seek treatment for alcohol misuse each year. That is just those seeking help; I suspect that many more suffer in silence and do not or will not seek help. More broadly, there are 12,000 admissions to hospital with an alcohol-related diagnosis each year. Those of you who have been in emergency departments will know the impact that it has there, with one in six attendances being as a result of alcohol, which rises to eight out of every 10 attendances at peak times in the evenings and at weekends in particular.

It is important to note that alcohol does not impact equally on society. It is a key driver for the long-term health inequalities that we experience. As income increases, so does the prevalence of alcohol use. However, how people drink actually changes. A greater percentage of people on low incomes exceed the daily guidelines and binge-drink. The outcome of that and other risk factors is that the death rate due to alcohol-related causes in the most deprived areas is more than double the overall rate and is five times the rate in the least deprived areas.

When we think about alcohol misuse, our mind often turns to those who are dependent: binge drinkers on our city centre streets at the weekend. There is no doubt that those individuals are the most visible demonstration of the harm that alcohol can cause. However, the view that alcohol misuse is about those who cannot handle their drink helps us to depersonalise the issue and makes it someone else's responsibility. That is where I sometimes differ from the drinks industry, which tends to perpetuate the view that it is a personal responsibility issue: it is much more than that. While I recognise the need to provide an appropriate response to support those individuals, through either treatment or support or from a community safety/criminal justice perspective, that is just the tip of the iceberg. Many, many people's lives are negatively affected by alcohol misuse.

With other Chief Medical Officers in the United Kingdom, I recently undertook a review of the evidence base and updated our alcohol guidelines. It was clear when we were doing that that the evidence had changed very significantly. We can no longer talk about safe or sensible levels of consumption. Links between alcohol and cancer mean that the risk for some diseases starts with the consumption of any alcohol. Our new guidelines, therefore, focus on providing advice on low-risk consumption. Drinking above those guidelines leads to significant increasing risk of developing health problems, and the risk continues to increase the more you drink. The risks themselves start to increase at levels that are lower than many people expect. The guidelines, therefore, appropriately state, based on the evidence, that, to keep the risks low, it is safest for both men and women to drink no more than 14 units, and, if you are going to drink as much as 14 units a week, to spread those over at least three days. That is roughly equivalent to six pints of 4% beer.

The new advice on alcohol and pregnancy is also much clearer. The advice is simple: if you are pregnant or are planning a pregnancy, the safest approach is not to drink. Given the statistics, as I highlighted, it is vital that we all — politicians, policymakers, health professionals and the public — are aware of the impact that alcohol has on individuals and society. In 2012, we revised the cross-departmental strategy for preventing and addressing the harms related to substance abuse and misuse, known as the 'New Strategic Direction for Alcohol and Drugs'. That was the second strategy document, so it was phase 2. It recognises the need to reduce overall consumption of alcohol. Almost £16 million each year is invested in supporting its implementation.

The former Department for Social Development, now the Department for Communities, played a key role in the development, review and implementation of the strategy not just through social policy and liquor licensing but through neighbourhood renewal, welfare reform and tackling poverty. I chair the steering group, and I am personally committed to ensuring that it is implemented as fully and effectively as possible. I think that the strategy, it is fair to say, also recognises some of the wider determinants in our drinking culture, such as social networks; the media; the alcohol industry; licensing legislation; working conditions; upbringing; housing; employment; education; and the criminal justice system, all of which have an impact and influence.

In Health, we are driving forward a number of initiatives to intervene early with those who are at risk or at harm. The term "passive drinking" was coined to highlight the impact that alcohol misuse has on wider society, including harm to the unborn foetus; acts of violence, vandalism, assault, child abuse, domestic violence; and the burden carried by the health service and friends and families who care for those damaged by alcohol. The term "passive drinking" resonates with me because it clearly highlights the fact that alcohol misuse is not just about individuals. Much like passive smoking, we also need to act to protect others from the health and social impact.

As I said, this is where I tend to differ somewhat from what the industry says about alcohol misuse. I recognise the contribution that the industry is making and has made to tackle the agenda. It is taking very positive steps through its corporate social responsibility agenda. Indeed, representatives from the industry sit on and are members of the new strategic direction steering group. However, as I said, the focus on individual drinking behaviours rather than on the inherent risks that alcohol poses is where I differ. I think that it places too much emphasis on personal responsibility and on tackling those specific behaviours rather than on taking a population health approach.

I have often heard and have often been asked the question, "Why should those who drink responsibly suffer for those who do not?", but the absolute key to preventing alcohol-related harm is to promote low-risk drinking. While education and information can help — a number of schemes are in place — the evidence shows that it is more important that we create the right environment through licensing and regulation to signal to people that they should be consuming alcohol appropriately. If you walk down a street and see one bar after another, or if you attend a sporting or entertainment event sponsored by an alcohol producer, it feels like alcohol is the norm. If you walk into a supermarket and see stacks of alcohol sold at rock-bottom prices, alcohol can seem like it is a part of daily life, and that can give the impression that excess alcohol consumption is the norm. It should not be, and it cannot be.

Availability, promotions, advertising and wider licensing regulations are all important. I am very supportive of many of the proposals set out in the legislation by Minister Givan, as I indicated. I believe that they will send out a clear message that alcohol is different and should be treated in a way that recognises that. I am not going to cover all the points in the clauses, but I particularly welcome the proposals on the alignment of liquor, entertainment and refreshment provision; the delivery of intoxicating liquor to young persons; a notice displaying licensing conditions in restaurants and guest houses; the prohibition on self-service and sales by vending machines; the restriction of off-sales drinks promotions in supermarkets; and the codes of practice. While some of the other measures on opening hours would seem to increase the availability and accessibility of alcohol, as an overall package, it seems a balanced and proportionate approach.

I am unsure about the proposal to extend drinking-up time. I can see how that might allow for a crowd to disperse over a longer period, thus allowing better management of safety issues. However, in practice, it might simply lead to more individuals purchasing larger quantities of alcohol at last orders, staying in the premises for longer and then delaying the impact on our police and our health service until later in the evening. I very much welcome the proposal to keep this under review and the inclusion of a sunset clause, so that we can monitor its impact before deciding if it works.

I have some concerns about the underage functions, the extension of the premises to sports clubs and allowing young people in licensed areas later. Generally, I am against underage functions being held in licensed premises. It perpetuates the norm that functions for everything, from christenings through to funerals, formals to weddings, must be celebrated in licensed premises and that alcohol is at the heart of all these events. I am uneasy about the link between alcohol and sport, which suggests a link between alcohol and sporting success and normalises alcohol consumption, particularly among young people. I think that, if an event is to be held at a sporting club, the bar should be closed. There is some evidence that membership of sporting clubs can lead to increased excess alcohol consumption, particularly among men. I do not think that alcohol and sport is a good mix. While I appreciate that many clubs depend on their bar and entertainment for income, we should try to limit the links between them as far as possible.

There are another couple of areas, either included in previous consultations or in the wider consultation but not the current version of the Bill, and they may be missed opportunities. First, measures to increase structural separation in supermarkets and off-licences had previously been consulted on. Those measures, including the provision of alcohol-only tills, could be very useful and should perhaps be reconsidered, if not in this Bill, in the future. Secondly, I believe that public health should be a key consideration under our licensing regime. That has been the case for some time in Scotland, and it allows health organisations and community and voluntary groups to make representations about the impact on public health in an area of the granting and renewal of licences. That could, for example, pick up issues in relation to alcohol outlet density. We know that a higher alcohol outlet density has been shown to be associated with higher alcohol consumption, higher frequency of drinking and various aspects of alcohol harm, including accidents, self-reported injuries, suicide, alcohol-related road traffic accidents and fatalities.

Finally, I believe that we can do more to limit alcohol offers and promotions. To me, rather than being a nanny state measure, that would be a victory for consumer choice. Instead of buying and drinking three bottles of wine to receive a discount, consumers could have received the same value by buying just one bottle. Evidence in Scotland may indicate that this has reduced overall consumption. Perhaps this measure could be looked at in the future.

In conclusion, this is a shared problem across all these islands and, indeed, further afield. Benefits can be accrued from sharing our experiences, from research and practice, and where possible by taking forward joint or aligned action. Over the past few years, I have been making the case that many of the factors that support good health sit outside the control of Health and Social Care. I am grateful for the opportunity to speak before another Department's Committee and provide an example of how we can effectively engage with our wider stakeholders and continue to build a health-in-all-policies approach. We are seeking to challenge our own and other people's drinking behaviours, at both an individual and population level, and we need to ensure that the wider environment creates the circumstances that support lower-risk consumption. As I said, overall, I welcome the Bill, and I support its progress through the Assembly. At this point, I am very happy to discuss any of the points I have set out so far or in my written evidence.

The Chairperson (Mr Eastwood): Thank you very much, Dr McBride. That was a very broad and, at times, very specific presentation. We all agree with you on the harm that alcohol does. What we are trying to focus on in the time today is what we can do through the issue of licensing. What we hear, and from our own learned experience, is that most alcohol is consumed having been bought at a supermarket, at times bought more cheaply than water. We have loads of controls over licensed premises, and maybe we should have more, but then we have large multiples basically giving the stuff away. It is going to be very difficult for us to deal with the real issues around alcohol consumption if we cannot get to the point of dealing with minimum pricing. That is outside the scope of this Bill, but it is important to note.

I can see how alcohol outlet density would be important in a residential area, but how does that affect a city or town centre?

Dr McBride: There is good evidence that the density of alcohol outlets in areas is directly correlated to self-reported injuries related to alcohol, assaults, road traffic accidents, and, in the communities adjacent to those areas of high alcohol density, deaths by suicide, and, indeed, other harms as a consequence of alcohol.

There is good research from Scotland that demonstrates that there may be a preferential drift of off-sales into areas of deprivation, for instance, where we know that alcohol consumption is higher and the adverse health consequences of alcohol are greater, as I said in my opening comments. I am not

suggesting a rationale for that, but there is evidence, particularly in one study, that deaths and injury from road traffic accidents can be reduced as a consequence of a direct intervention to reduce alcohol outlet density.

In Scotland, for some time, public health bodies and organisations have had the opportunity to influence decisions around the renewal or issuing of licences. There is absolutely no doubt that where you have higher alcohol outlet density, you have more problems related to excess consumption of alcohol. If you take steps to reduce the alcohol outlet density, you can reduce some of the consequences of excess alcohol consumption.

The Chairperson (Mr Eastwood): I understand your point, but I am thinking about Belfast city centre. How or why would you want to do that if we are accepting that people go to pubs? We know that pubs or clubs tend to locate beside each other, as many other types of business do, because that is how the industry works. I can see your point if you are saying, "There's a large housing estate there; let's not fill it full of pubs and off-licences".

Dr McBride: Indeed.

The Chairperson (Mr Eastwood): I am just trying to work out how this would work in practice in a town or city centre that is probably heavily reliant on the night-time economy.

Dr McBride: I think there is balance in that. You mentioned night-time economy. There is balance in all of this. I am here to give members the evidence of the health consequences.

Many of us have been in many cities and towns, not only here in the North but elsewhere, where every second premises you go past seems to be an off-sales or on-trade premises. We can take steps to ensure that we are taking a rounded view of the consequences of how high alcohol outlet density might impact on communities and the adverse consequences of alcohol. A mechanism through licensing or applications for renewed licensing would allow for a more-informed view of some of the risks and hazards. That is notwithstanding the fact that premises that sell alcohol form an important part of the night-time economy; indeed, they tend to concentrate in city centres, as you described.

The Chairperson (Mr Eastwood): We had evidence from Addiction NI. They were not sure about the idea of throwing children out of a wedding after a certain time because it creates a mystique around alcohol that might make it more attractive to them than if they were around it in a benign environment. Have you a view on that?

Dr McBride: I suppose that it depends on the sorts of weddings you go to. We need to bear it in mind that children learn their attitudes and behaviours around alcohol from how they hear us speak about alcohol and see us behave around alcohol. There is no doubt that, if we expose children, at a very early stage, to situations that give them the impression that alcohol is just part of a normal social interaction and that all social events are orientated around the use of alcohol and if, indeed, we allow them to stay, perhaps, in premises late into the evening — whether it is a social event, a wedding or a family event or not — and they see people consuming excess alcohol and perhaps being intoxicated as a result, that is not a good environment for any young child to be exposed to, and it creates a lasting impression.

There is evidence that young people develop their attitudes and behaviours around alcohol from observing how adults consume and talk about alcohol. Yes, it can be a positive influence, in some instances, but, in other instances, if alcohol is consumed to excess, it is not a positive. I understand the point that is being made in the evidence that you heard from Addiction NI, but I would be very guarded about exposing young children to that sort of environment.

The Chairperson (Mr Eastwood): One of the practical difficulties that we heard about at a previous session is that the whole of a hotel is a licensed area. I am not asking you to answer this question, because it is outside your remit. If kids are staying in the hotel, and you put them to bed, they are technically within the licensed area. There are difficulties around how we actually manage that.

Dr McBride: There are, but I suppose there are practical solutions to that in removing the children from an area that is adjacent to the bar and seating them in a separate area. It is about observing how people are using alcohol, or perhaps misusing it, at whatever event that might be, whether it is a social or family event or any other event.

Ms Mallon: Thank you, Michael. You said that you are opposed to — I quote from your written submission — "significant increases to opening times" beyond that currently provided for in the draft Bill. Can you quantify that? Is there a figure that you have in mind beyond the proposals in the current draft Bill?

Dr McBride: No. The evidence suggests, and let us keep it to the evidence, that if you increase the availability and accessibility of alcohol, you will increase consumption. By consequence of that, you increase the risks of harm. There is absolutely no doubt that increasing opening hours in that context would not seem to be consistent with reducing availability or access.

In caveating that response, I would say that there are a range of measures in the Bill that do address some of the challenges that we face around availability, sales and promotions of alcohol. Therefore, one can conclude that, on balance, the extended hours — 12 in total — that can be allowed, or indeed the special licence that can be granted by the PSNI, is not likely to make a significant difference. In terms of quantifying it, it was a loose use of the word "significant".

In general terms, I am not in favour of extending opening hours. I suspect, and I would anticipate, that what is proposed here is likely not to have a material impact, and I think that, taken with the range of other measures that are there, it is a proportionate and balanced proposed Bill, which I would support.

Ms Mallon: Michael, we have heard today — you have referenced it in your submission — about pointing to best practice in Scotland and having the protection and promotion of public health as a licensing objective. We were trying to tease out earlier how that might work in practice, and you have provided the example of alcohol outlet density. Beyond that, what other criteria might you use to assess that? If the evidence tells us that the availability of alcohol leads to an increase in consumption and the consumption of a significant volume of alcohol is harmful, how would you practically assess those criteria to determine a licence?

Dr McBride: Good work is going on between the PSNI and Health on assessing some of the impacts of excess alcohol. For instance, we are looking at a registry of individuals attending emergency departments who are intoxicated or attend with injuries as a consequence of being intoxicated and consuming excess alcohol, which would then be related back to the premises where they purchased or were served their alcohol. You can begin to build up a picture or profile of intelligence that will point to particular outlets that are selling alcohol when perhaps individuals have had too much alcohol or, indeed, pick up hotspots in particular areas where individuals are consuming too much alcohol. From that, you can begin to inform through some other intelligence that, for instance, the Public Health Agency would have on health-related harms as a result of alcohol. We have very good data from the Northern Ireland Statistics and Research Agency (NISRA) that looks at population by ward etc across Northern Ireland and some of the major health challenges that we face. By triangulating various data sources, you could very quickly form an informed picture, based on an analysis of the evidence that we have, that would give us an impression of particular pockets where we had real harm to the local population, and we could correlate that with areas of alcohol density. It is obviously not for public health to make the determination, but, when applications are made for new licences or the renewal of licences, that information could be taken into consideration.

Ms Mallon: I have one final question. Michael, we have very clear parameters in terms of the mechanism that is before us in the Bill to tackle this very harmful societal issue. The Chair has been strict in saying that we must stick to the Bill, but, considering the briefings that we have had — particularly this morning — it would be remiss of us if we did not mention the issue of the minimum unit pricing of alcohol. Previous speakers, particularly from the health sector, have said that, while you need a multifaceted response, that is a game changer. What is the Department doing or what are its intentions in implementing that?

Dr McBride: As you know, in July 2013, along with the then Department for Social Development (DSD), we commissioned the University of Sheffield to do specific research that looked at the impact of a minimum unit price in Northern Ireland. We also worked very closely with colleagues in the Republic of Ireland, who did similar research at that time — we recognise that we share a land border and that taking an approach in the North and not taking a similar approach in South may end up just shifting the business across the border.

We completed that work, and, if we have time, I will go through some of the stats. You may be interested in them. It showed that some 19·4% of the total adult population here drink at hazardous or

harmful levels, and they spend 56% of the total spend on alcohol and consume 67% of the total alcohol in Northern Ireland. I can give you the figures for those who drink at harmful levels.

That report looked at the impact of imposing a 35p to 75p minimum unit price for alcohol and demonstrated that that would be a highly effective mechanism for reducing excess alcohol consumption, particularly in those who drink at harmful or, indeed, hazardous levels. For instance, if we introduced a 50p minimum unit price, 39% of all products would be impacted. For low-risk drinkers, only 22% of the units that they currently purchase would be impacted, compared with 37% for hazardous drinkers and 49% for harmful drinkers. That provides a very targeted, evidence-based approach to ensuring that those who drink most and have the greatest harm from excess alcohol consumption are impacted. There is good evidence from other parts of the world that minimum unit pricing is an effective mechanism to reduce excess alcohol consumption, particularly among those who drink at hazardous levels.

The researchers calculated that, if we were to introduce a 50p minimum unit price, by year 20, we would prevent 60 deaths and 2,400 admissions to hospital annually. In the first year, it would reduce crimes by 5,300 and days absent from work by 35,000. The total cost reductions over 20 years were £59 million directly for health, £0·3 billion for crime and £46 million for workplace absence, which, in total, is £1 billion. I know what I would like to do with that £1 billion, and I am sure that Committee members know what they would like to do with it.

We have been watching very closely the challenge by the Scotch Whisky Association in Scotland, and you will be aware of the decision by the Scottish Court of Session last Friday to overturn the association's appeal and uphold the original decision that the introduction in Scotland of minimum unit pricing was a proportionate, evidence-based mechanism to reduce excess alcohol consumption. That was just last week. We are looking at and studying that ruling very closely. It will have implications for our proposed approach in Northern Ireland, as the then Minister indicated that he was minded to propose legislation that would introduce minimum unit pricing in Northern Ireland. Now that that decision has been made, we will work very closely with our colleagues in Scotland and the South to reactivate the work that we had previously undertaken. I suspect that that decision may be appealed again. We will have to wait and see.

Ms Mallon: Thank you.

Ms Gildernew: Thanks, Michael. You are very welcome. I want to bring it back to the Chair's point about alcohol outlet density and to think about the remit of the Bill. Let us say that, for argument's sake, of the night-time economy, the pubs and clubs in the city and town centres represent 20%. We have ascertained that 20% of drinking is done in pubs and restaurants and 80% is done at home. The 80% is the more harmful element and is the one that affects most people where the high density of off-licences, hot food places and bookies shops is in the more socio-economically deprived areas. That would fit with your report, a number of years ago, about life expectancy and the bus journey. Carál raised that point earlier, and I am raising it now, because I think that she would want to have raised it with you.

My more focused point is on your point about underage functions. You are aware of the issues last year when a nightclub in Cookstown was closed down. We then had a huge spike in underage drinking in Dungannon. There was a well-supervised, properly run teenage disco for years. It was not about the fact that it was a nightclub or that there was alcohol — the alcohol was screened off. It was the lights, the sound system and the environment that young people wanted to go to. Young people do not want to go to an auld tatty community hall that we went to when we were teenagers. They want to go somewhere that has the proper light and sound systems, that attracts the DJs and all the rest of it. It was not about the alcohol; it was about everything else. That was a really well run disco. We then saw children — not teenagers — drinking in parks. Their parents dropped them off on a Friday evening at the cinema, and they then walked across the road to a park and got completely inebriated and out of their mind on drugs. We went from a situation in which 13-, 14- and 15-year-olds could go out and enjoy themselves without drink to one in which the only option available to them was to go to a park that was completely unregulated. We have talked before about balance, and I think that balance is really important in this, Michael.

Dr McBride: I absolutely agree with you. The law of unintended consequences applies, and we need to be very careful about what intended consequences might arise from any of our actions. You will be relieved to hear that drinking among children and young people is an improving situation. The recent figures suggest that. I can follow this up with specific detail, but the 2013 Children and Young

People's Survey demonstrated that 38% of our children and young people had consumed alcohol ever, which was a decrease from 47% the last time that the survey was conducted. That is good news. I caveat that by saying that, from memory, 57% of those young people were under 13 years of age, so we need to bear that thought. The proportion of young people who have ever been drunk has also fallen. The recent survey showed that 14% of children and young people had reported ever being drunk compared with maybe 30% in previous years. So, we are making progress on children and young people's drinking.

You are absolutely right: I have the figures here, but something like 29% of children and young people have been able to purchase alcohol whilst under the age to purchase alcohol legally. Again, that is a troubling concern. On the specific point, there is no doubt that we need to provide alternatives for young people. As a result of observing what we, their role models, do around alcohol, young people have come to associate many social functions with alcohol consumption. As a matter of fact, you cannot have a social function without alcohol. I am very conscious of that. My daughter's formal is this evening. We are in the formal season, and we know all that is associated with that. We need to bust the myth that you cannot have fun and enjoy yourself without consuming alcohol. If we are going to take steps to limit access to sites where alcohol is being sold and to have young people enjoying an evening's entertainment, we have to provide alternatives. There is a very good model in Enniskillen. I have forgotten the name of the building, but it is a disco. It is a fantastic facility opposite the leisure centre — FUEL, I think it is called.

Ms Gildernew: Yes, it is.

Dr McBride: There is no alcohol allowed. Young people go along and enjoy themselves and have craic. They have a great time, and there is no alcohol. We need to think of alternatives and not create the unintended consequences that you have described.

The Chairperson (Mr Eastwood): Dr McBride, thank you very much. That was very useful.