SHAAP
SCOTTISH HEALTH ACTION ON ALCOHOL PROBLEMS
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#MUP saves lives
Research and Policy Briefing
№ 10 May 2016

Welcome to the 10th research and policy briefing published by SHAAP – Scottish Health Action on Alcohol Problems.

SHAAP provides a coordinated, coherent and authoritative medical and clinical voice on the need to reduce the impact of alcohol related harm on the health and wellbeing of people in Scotland.

Our aims are:

- To raise awareness and understanding of the alcohol-related health problems with health practitioners, policy makers and the public.
- To evaluate current research and identify strategies to reduce alcohol-related health damage based on the best available evidence.
- To work together with key organisations in the alcohol field in Scotland, the rest of the UK and worldwide, in tackling alcohol misuse.

SHAAP was set up in 2006 by the Scottish Medical Royal Colleges, through their Scottish Intercollegiate Group (SIGA). We are governed by an Executive Committee made up of members of the Royal Colleges.

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MUP update

On 23rd December 2015, the European Court of Justice (ECJ) delivered the judgement that Scotland's minimum unit price for alcohol legislation is legal and does not per se contravene EU law.

The ECJ stated that it is for the national court to determine whether measures other than that provided for by the Scottish legislation, such as increased taxation on alcoholic drinks, are capable of protecting human life and health as effectively as the current legislation, while being less restrictive of trade in those products within the EU. If that is not the case, MUP is justified.

The case has now been referred back to the Scottish courts where all the evidence provided by the Scottish Government, including considering the information that was available when the Scottish Parliament approved the legislation, will to be examined and analysed.

On 28th January 2016 a Procedural Hearing was held in the Scottish Court of Session in Edinburgh where it was agreed that the Court would take more evidence on the case. Industry actors argued that this was unnecessary and that no new material for the case should be put forward. The Court was not persuaded by this argument and instead the following next steps were agreed:

- 6th May 2016 – Deadline for Scottish Government to lodge new material
- 15th May 2016 – Deadline for industry/SWA to lodge new material
- 15th May 2016 – Deadline for notes of argument
- 7&8th June 2016 – Hearing in the Inner House of Court of Session

This is a provisional timetable and so subject to change.

Background information: The legal process to date

Legislation to introduce a binding Minimum Price per unit of alcohol of 50p was passed unopposed by the Scottish Parliament in May 2012. The

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legislation was due to come into force in May 2013 but has been delayed by a legal challenge brought by a consortium of alcohol producers, led by the Scotch Whisky Association (SWA), Spirits Europe and the Comité Européen des Entreprises Vins (CEEV). The opponents of the Scottish legislation have sought inaccurately to frame this as a Bureaucracy v Industry issue, rather than as a vital life- saving measure. It is notable that the measure has had strong support from other trade bodies based in Scotland.

A first legal challenge by the alcohol trade bodies was rejected by the Scottish Court of Session in 2013. The alcohol industry consortium launched an appeal and as part of a second appeal hearing, the Scottish court referred a number of questions to the Luxembourg-based European Court of Justice (ECJ) in May 2014. The questions broadly referred to two particular issues:

- Whether MUP legislation is compatible with the EU's common market organisation for wine; and the Treaty on the Functioning of the European Union's (TFEU) provisions of free movement of goods.
- Whether, under EU law, it is permissible for a member state to implement a new measure like MUP in preference to using existing powers to raise alcohol taxation.

Article 34 of the Treaty on the Functioning of the European Union (TFEU) concerns the free movement of goods. Generally, Member States are not allowed to breach this Article. However, if they can show that there are valid public policy grounds, in this case: public health, to do so, they can refer to Article 36. This is the Treaty provision that lays down the exceptions and justifications for breaches of Article 34. In order to do so they have to show that the measures do not discriminate against imported goods and respect the principle of proportionality – i.e. does the measure do just what is needed to accomplish its aims and does not go beyond.

On 3rd September 2015, the ECJ Advocate General, M. Bott, offered his preliminary opinion on the Scottish case, the main contents of which have now been endorsed by the court's final judgement.

Twenty Scots die every week because of alcohol. Alcohol death rates in Scotland are about twice what they were in the early 1980s. Hospital admissions for alcoholic liver disease have more than quadrupled in the past 30 years and Scotland now has one of the highest cirrhosis mortality rates in Western Europe.

The Scottish MUP policy sets a 'floor price' below which alcohol cannot be sold, based on the amount of alcohol contained in the product. In parts of Canada, where minimum price has been consistently and rigorously implemented, a 10% increase in average minimum price of alcohol has been associated with a 9% reduction in alcohol-related hospital admissions and a 32% reduction in wholly alcohol related deaths.

Both Scottish Health Action on Alcohol Problems (SHAAP) and the Scottish Government remain committed to MUP as an effective evidence-based approach to tackling alcohol-related health harm in Scotland and believe that the Scottish courts will rule in favour of MUP, enabling the long overdue legislation to be implemented.

Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) Final Annual Report

In March 2016, the final annual MESAS report was published. The report evaluates Scotland's alcohol strategy over the last five years, analysing the core legislation implemented by the Scottish Government and a range of external influencing factors, to offer a comprehensive evaluation of the impact of the strategy in reducing alcohol-related harms in Scotland. England and Wales are used as comparison throughout the report.

Key Findings

In 2014, 10.7 litres of pure alcohol was sold per adult in Scotland, equivalent to 20.5 units per adult per week. This represents a flattening of the recent downward trend seen until 2012. By market sector, in 2014, off-trade sales accounted for 72% of all alcohol sold, compared to 28% in the on-trade. In 2014, 52% of all off-trade alcohol sold in Scotland was sold below 50p per unit. Since 2008, per adult alcohol sales have been 18-20% higher in Scotland than in England and Wales. The majority of this difference is due to higher per adult off-trade sales in Scotland.

Alcohol-related mortality rates in Scotland in 2014 were 49% higher than in 1981. Since 1981, male alcohol-related mortality has remained approximately twice the female mortality rate. Mortality rates have been consistently highest amongst adults aged 55-64 in Scotland and were eight times higher in the 10% most deprived than in the least deprived areas in 2014, a clear persistence of health inequalities. Compared to England and Wales, mortality rates remain significantly higher in Scotland.

Between 2008/09 and 2014/15, an estimated 569,792 Alcohol Brief Interventions (ABIs) were delivered in Scotland. This is 145% of the national target set for the programme. Of this figure, it is estimated that 25% are repeat interventions and that the programme has successfully reached 43% of hazardous and harmful drinkers since 2008. Most ABIs were delivered in primary care settings. The report argues that the introduction of the ABI target has contributed to embedding the delivery of ABIs within the NHS in Scotland.

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Education programmes to increase knowledge and shift attitudes are known to have little impact on individual behaviour but are important in terms of ensuring people have the information necessary to make informed choices about risk. In 2013 around 50% of adults had a good awareness of the unit content of drinks and two fifths were aware of the relevant guidelines at the time for their gender. Knowledge of awareness of alcohol units among the whole population has changed little over time.

There was increased recognition among the Scottish population of the harm that alcohol causes in Scotland. In 2013, 60% identified alcohol as the drug causing the most harm. This view was not shared by those living in the most deprived communities.

In 2013, more people supported MUP (41%) than opposed the policy (35%). Around one in five (22%) are neither for nor against the idea of having a minimum price for alcohol. Support for the policy was higher among those who thought alcohol caused a 'great deal of harm' in Scotland and those who thought the amount people drink in Scotland is something we should be concerned about.

Key Recommendations

The report outlines a number of recommendations for the continuing success of Scotland's alcohol strategy:

- The current refresh of the alcohol strategy continues to be informed by the evidence that the most effective (and cost effective) interventions to reduce alcohol consumption and related harm involve action to reduce alcohol price, availability and exposure to marketing. Consideration should be given as to how alcohol consumption and related harm can be addressed within the context of wider socioeconomic determinants of health.
- Effort is made to improve implementation of existing components of the strategy, particularly those with the potential to reduce the availability of alcohol and to incorporate the learning on implementation facilitators when developing new interventions. There is a need to improve the completeness and consistency of local data collection so that how an intervention is being implemented, by whom, reaching whom and with what immediate impact is better understood.
- Monitoring key trends in alcohol price, affordability, sales and alcohol-related mortality and morbidity continues to ensure any consistent increase in alcohol affordability, consumption, or related harm is spotted early. Where possible and feasible new interventions should be planned to enable robust evaluation before integration of the policy. Better collection, collation, accessibility and use of national and local data on delivery could improve implementation.

Scotland has the highest alcohol-related deaths in the UK: Office for National Statistics (ONS) – Alcohol-related deaths in the UK

New data published by the Office for National Statistics (ONS) in February 2016 shows that for both sexes, Scotland has the highest alcohol-related death rates in the UK in 2014. However, Scotland also experienced the fastest decrease in death rates since their peak in the 2000s.

In 2014, the age-standardised alcohol-related death rate for males in Scotland was 31.2 per 100,000 of the population. This rate is significantly higher than those of any other constituent country of the UK – Northern Ireland (20.3 per 100,000), Wales (19.9 per 100,000), and England (18.1 per 100,000). These rates are not statistically significantly different. Scotland had the highest alcohol-related death rates over the period 1994-2014, as well as the steepest increase in rates between 1994 and the 2000s. Despite this, compared with other countries in the UK, Scotland saw the most substantial decrease in male alcohol-related death rates between 2003, when it peaked at 47.7 per 100,000, and 2014.

The alcohol-related death rate is also highest among females in Scotland at 13.3 per 100,000. This is significantly higher than in England (9.1 per 100,000) and Northern Ireland (8.5 per 100,000) but not significantly different from the death rate in Wales (10.4 per 100,000). Rates in Scotland were significantly higher than those in England between 1994 and 2014. Compared with Wales and Northern Ireland, rates in Scotland were significantly higher until 2011, but not always significantly higher afterwards. The increase in death rates up to 2006 is noticeably steeper in Scotland than elsewhere.

Across the UK as a whole, in 2014, there were 8,697 registered alcohol-related deaths, an age-standardised rate of 14.3 deaths per 100,000 of the population. Alcohol-related death rates have fallen since peaking in 2008 at 15.8 per 100,000, but the 2014 rate is still higher than that observed in 1994 (9.1 per 100,000).

Between 1994 and 2014, alcohol-related deaths rate for males were typically double that of females. In 2014, there were 19.4 alcohol-related deaths per 100,000 males, compared to 9.6 per 100,000 females. The majority of alcohol-related deaths (65%) in 2014 were among males.

Alcohol-related death rates were highest among 55 to 64 year olds in 2014. For men in 2014, age-specific death rates were highest among those aged 60 to 64 (47.6 deaths per 100,000) and lowest in those aged 25 to 29 (1.8 per 100,000). For women, rates were highest among 55 to 59 year olds at 22.1 per 100,000, and

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lowest in 25 to 29 year olds (1.1 per 100,000).

Trends since 1994 show that alcohol-related death rates decreased among those younger than 60 since peaking in the 2000s. For men, age-specific rates initially increased in the majority of age groups, despite annual fluctuations, between 1994 and the 2000s when they peaked. The most noticeable increases were in age groups up to 55 to 59 years, where rates at their peak were double those observed in 1994. Rates in these age groups have significantly fallen to date, but in older age groups they have remained relatively stable. A similar picture was observed for women; however, only 40 to 44 year olds and 50 to 54 year olds experienced significant decreases in rates between the year they peaked and in 2014. Overall, despite improvements in the last decade or so, age-specific alcohol-related death rates were still higher in 2014 than in 1994.

New alcohol guidelines from Chief Medical Officers (CMOs)

In January 2016, the UK CMOs published their new alcohol guidelines, which recommend that both men and women should drink no more than 14 units of alcohol per week. The newly updated guidelines are based on the latest evidence which shows that there is no safe level of alcohol consumption for cancer risk; that alcohol provides no health benefits; and alcohol should be avoided by pregnant women or when trying to conceive.

The new guidelines state that people have a right to accurate information and clear advice about alcohol and its health risks; and that there is a responsibility on government to ensure this information is provided to citizens in an open way, so they can make informed choices.

The Chief Medical Officers' evidence-based guidelines recommend:

A new weekly guideline. Both men and women should not regularly consume more than 14 units per week, to keep health risks from drinking alcohol to a low level.

Alcohol free days. If you do drink as much as 14 units per week, it is best to spread this drinking over three or more days. If you have one or two heavy drinking sessions, you increase your risk of death from long term illnesses and accidents and injuries. You should aim for at least two alcohol free days per week.

No alcohol consumption during pregnancy. Women who are pregnant or planning a pregnancy should be advised that the safest approach is not to drink alcohol at all. There is no clear scientific evidence to support a quantified limit for drinking during pregnancy.

One of the key messages emphasised in the revised guidelines is that there is no safe level of consumption in relation to cancer risk. The risk of developing a range of cancers increases directly in line with consumption of any amount of alcohol. Alcohol causes cancer from the first drink. Cancers caused by alcohol include breast, mouth, oesophagus, larynx, colon and rectum. The incidence of all these cancers is highest amongst the most socially deprived groups in Scotland. The CMO guidance has shown a clear link between alcohol and cancer from the first drink.

The new guidelines also bring the rest of the UK in line with Scotland on advice for pregnant women. Previously, Scotland was the only country in the UK to advise women that there is no 'safe' amount of alcohol that can be drunk during pregnancy so the best approach is not to drink at all. That advice is now reflected UK-wide.

These guidelines further emphasise the need to continue to implement evidence-based policies to tackle issues of price, availability and marketing of alcohol in Scotland, policies like minimum unit pricing (currently under review in the Scottish Courts), to support and strengthen the effectiveness of the new recommendations.

Alcohol Identification and Brief Advice Lesbian, Gay, Bisexual & Trans people – Public Health England Briefing

In January 2016, Public Health England published a briefing document discussing early interventions to reduce alcohol-related harm for lesbian, gay, bisexual and transgender people. The briefing focuses on service provision in England and discusses how such services can work better for the needs of LGB&T people.

The briefing outlines evidence which shows that LGB&T people are more likely to be drinking more, and more frequently, than the population as a whole and thus are at a higher risk of harm. Research undertaken by The Lesbian and Gay Foundation (LGF) and Stonewall shows that alcohol use is consistently high across the sexes, sexual orientation and age groups. A third of lesbian and bisexual women and 42% of gay and bisexual men drink three or more times a week compared to 25% of women and 35% of men in general. This pattern is also visible in binge drinking where 29% of lesbian and bisexual women and 34% of gay and bisexual men binge drink at least once a week compared to 15% of women and 19% of men respectively in general. Identifying these individuals and offering brief advice to help reduce drinking to safer levels can make a significant difference to the increased risk for this group. An alcohol IBA (Identification and Brief Advice) is a brief intervention for alcohol. It is aimed at identifying risky drinking

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and providing some brief information or a referral to reduce risk and has a strong evidence base to support its effectiveness. This may involve providing information about alcohol units, longer-term health risks associated with alcohol, and/or tips to help reduce consumption.

There are several and varying reasons why consumption is higher in LGB&T groups. Many LGB&T social activities tend to centre around the bar and club scene and this is often the place where many LGB&T people first explore their sexual and gender identity with others. It has also been suggested that because LGB&T people often face higher levels of discrimination or harassment, alcohol may be used as a coping mechanism. The briefing also reported evidence that LGB&T people cited negative experiences when accessing healthcare. In the recent NHS GP Survey, lesbian, gay and bisexual people were found to be twice as likely to rate their GP as poor or very poor than heterosexual people. Such barriers mean that traditional settings for delivering Identification and Brief Advice (IBAs) such as GP surgeries or NHS services may not reach many LGB&T people. Thus, to be effective, it is important that healthcare staff conducting IBAs should be aware of this increased risk which may be faced by LGB&T people whilst also being mindful of approaches which may create new and/or further enhance existing barriers to engagement or disclosure of information. LGB&T people may benefit from IBAs being conducted in LGB&T settings such as community support organisations and charities.

The briefing argues that the main issue relating to the delivery of IBAs for LGB&T people is what it calls cultural competence in delivery. While delivering an IBA offers an opportunity to identify potential risk within a population, some factors may deter or even prevent engagement or disclosure, such as how confident and safe LGB&T people feel in the service they are accessing. To increase LGB&T cultural competence, training can be provided on awareness of LGB&T healthcare issues, and attitudes which may deter them from engaging or disclosing. Another mechanism explored in the briefing which can give LGB&T people confidence to engage and disclose is ensuring they feel visible in healthcare settings. This can include displaying posters in services and inclusive monitoring of sexual orientation and gender identity at initial assessment. Such mechanisms help to convey the message that the service has considered LGB&T people when planning its work and service delivery.

LGB&T settings provide an additional opportunity to deliver IBAs and to identify potential risk or dependence within a high-risk group. Any LGB&T organisations delivering IBAs should record data on these which helps to increase their use in LGB&T community settings and which can then be used to inform local needs assessments and commissioning. In this way, services can also be better adapted and targeted to the specific needs of LGB&T people, and can thus help to have an impact in reducing alcohol-related health harms.

Dead on Arrival? Evaluating the Public Health Responsibility Deal for Alcohol

In November 2015, the Institute of Alcohol Studies (IAS) published an evaluation of the UK Government Public Health Responsibility Deal for alcohol. The Public Health Responsibility Deal was launched in 2011 as a voluntary partnership between the government, commercial organisations, public bodies, academics and NGOs to promote public health goals. Although a non-binding set of pledges, these actors – in particular the industry – are expected to take steps to reduce health harms. There are 11 pledges in the Deal related to alcohol.

The report evaluates the effectiveness of the Responsibility Deal in reducing alcohol related health harms and assesses the overall value of a voluntary code of practice as a public health policy approach. The report argues that the Responsibility Deal has failed and outlines a number of reasons why this is the case.

The report argues that the Responsibility Deal lacks legitimacy as it is not endorsed by academics or the public health community. Despite being designed as a cooperative partnership, the formulation of the eleven alcohol-related pledges was deemed to privilege the alcohol industry. The report argues that the UK government's decision to withdraw their commitment to introduce MUP in England exemplified that the Responsibility Deal was simply being used as a substitute for legislation and so undermined commitments of the Deal to a more comprehensive public health policy agenda. Furthermore, the Responsibility Deal has continued to pursue initiatives known to be ineffective in reducing alcohol-related harm. Such initiatives include information on drinking guidelines, awareness raising, and education campaigns which unsurprisingly are the types of interventions favoured by industry.

The report argues that there is limited evidence on the effectiveness of the Responsibility Deal due by and large to ambiguous goals and poor recording practices deliberately designed to ensure that it is challenging to determine if industry activities have had any effect on improving public health outcomes. A case in point is the industry's highly publicised claim that it has removed more than a billion units of alcohol from the UK market. It is impossible to know how much of this decline in alcohol consumption (represented by the one billion units) is the result of deliberate industry action rather than

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simply resulting from a change in underlying consumer trends. Further evidence also shows that, whilst the compliance rate with the Deal is around 89% among the major brands, it is only 57% among more minor brands, suggesting that fragmentation of the industry is a significant obstacle to enforcing industry commitments.

The IAS report argues that even where it can be shown that alcohol companies have adhered to the letter of the regulations, they regularly and continuously flout the spirit of these regulations. The report cites research which has shown that the average font size for health information on product labels is 8.17 which is well below the 10-11 point considered optimal for legibility. 60% of labels analysed displayed health information in smaller font than the main information on the label, contrary to official guidelines. Pregnancy logos were also significantly smaller on products targeted at women than those aimed at men and the information was most frequently grey in colour.

Although none of the above arguments show that the Responsibility Deal is positively harmful, it does appear to have the negative consequence of obstructing more effective policies for addressing alcohol harm. The report states

> *"the most effective evidence-based strategies to reduce alcohol-related harm are not reflected consistently in the RD alcohol pledges. The evidence is clear that an alcohol control strategy should support effective interventions to make alcohol less available and more expensive".*

These recommended measures have been continually opposed and resisted by the alcohol industry. By supporting the Responsibility Deal, the UK government is choosing to give the drinks industry an opportunity to show what it can do voluntarily, rather than enforcing more effective statutory measures.

The report concludes that the Public Health Responsibility Deal has failed in its objective to reduce health harms as it has systematically focused on relatively ineffective interventions which are unlikely to reduce alcohol consumption and associated health harms. The report argues that the Deal circumvents public health outcomes in favour of industry interests. The alcohol industry continues to fail to take responsibility for public health. As a result, the Responsibility Deal has in many ways worsened the health of the nation and must be considered a failure.

Alcohol's impact on the emergency services – an Institute of Alcohol Studies report

In October 2015, the Institute of Alcohol Studies (IAS) published a report on the impact of alcohol on the emergency services. The report analysed the existing evidence on the impact of alcohol and drew on views and opinions of emergency service personnel gathered via a survey. It found increasing evidence of alcohol having a significant impact across all emergency services and calls for real and measured policy change to minimise and reduce alcohol-related harm.

Alcohol places a significant and unnecessary strain on emergency services. The existing evidence suggests that up to 80% of arrests at weekends are alcohol related, and just over half of all crime is committed under the influence of alcohol. In 2009/10, there were 1.4 million ambulance journeys attributable to alcohol. This represents 35% of the total. Estimates for the number of emergency department attendances due to alcohol are more uncertain, but figures suggest it could be anywhere from 40% to 70% at peak times. Alcohol is also typically found to be involved in 10-30% of all fires. Furthermore, fires which involve alcohol are generally worse. Fifty percent result in casualties compared to 14% for other fires, and also cost up to five times as much.

Survey respondents reported that dealing with alcohol can take up to as much as half of their time. This was particularly the case for police, who reported that 53% of their total workload is alcohol-related. Such a significant number of alcohol-related incidents come at a significant cost to the taxpayer. The report estimates that alcohol costs the police and justice system £1.7 billion every year. Alcohol costs the health service £696 million in Accident and Emergency Departments and a further £449 million is spent on ambulance services. The fire service also spends an estimated total of £131 million dealing with alcohol-related fires.

Physical, verbal and sexual abuse by individuals under the influence of alcohol towards emergency service personnel is widespread. Police and ambulance crews suffer the worst with three quarters of police respondents and 50% of ambulance survey respondents having been injured in an alcohol-related incident. Between a third and half of all service people in the survey reported suffering sexual harassment. Ambulance staff in particular were at risk, with 51% reporting they have experienced this type of behaviour. Many emergency services feel stretched due to increasing numbers of alcohol-related incidents combined with tightening budgets and cuts to frontline services. Nearly all police (92%) and ambulance staff (90%) in the survey said they had performed duties which belonged to another emergency service, as did the majority of fire service personnel (63%).

All emergency service personnel in the report are calling for policy action to reduce alcohol harm. However, although there was agreement on the need for policy action, respondents disagreed on what the best and most effective policy responses would be. Police staff were generally supportive

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of stronger control and regulation policies, particularly around licensing and price. Fire service respondents' views were very similar in terms of controlling the night time economy by affecting availability and price of alcohol. Although health service staff also emphasised the need for policy action, there was disagreement over whether this action should be focused at individual or whole population level. More than three quarters of ambulance staff believed that users should pay for call outs which resulted from their own irresponsible drinking. Only 50% of emergency department respondents, however, favoured this view. Those opposed expressed strong opinions arguing that such a move would undermine the founding principle of the NHS being free at the point of delivery.

The findings from the report present a strong case for policy action to reduce alcohol-related harm. Alcohol takes up a disproportionate share of emergency service time and costs taxpayers billions of pounds each year. Policies and services such as Alcohol Brief Interventions, lowering the drink driving limit, limiting the availability of alcohol through stronger licensing controls, and reducing the affordability of alcohol with policies like minimum unit pricing, could all help to reduce alcohol-related harms and reduce the increasing burden of alcohol on our emergency services.

Scotland leading the way in Alcohol Policy. Four Nations: How evidence-based are alcohol policies and programmes across the UK? report

Scotland is leading the way in alcohol policy among the four nations of the UK, according to new research. The report, *Four Nations: How evidence-based are alcohol policies and programmes across the UK?* published in November 2015, assesses the alcohol policies of each of the four nations to determine what extent they are evidence-based in each jurisdiction. Drawing on the recommendations set out in the Health First strategy[1], the report examines current policies in each of the four nations and argues that the Scottish strategy is most strongly based on evidence-based interventions. The establishment of the Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) programme put into a place a comprehensive evaluation programme which monitored and evaluated to what extent the measures outlined in the alcohol strategy contributed to reducing alcohol-related harm; which groups are most affected and how they are affected; and what changes could be made to the implementation of the strategy to improve its overall effectiveness. Through this strategy, the report argues, Scotland has the strongest approach to evidence-based policy and is most closely aligned with the Health First recommendations.

The report assesses a range of policies including pricing, availability, marketing, involvement of industry and licensing, and compares them in each nation.

Scotland

The Scottish Government's Alcohol Strategy – Changing Scotland's Relationship with Alcohol: A Framework for Action – was the first in the UK to clearly outline a whole population approach to tackling alcohol problems, explicitly rejecting the industry's suggestion of a targeted approach focusing on specific groups in society.

Scotland has a current strategic framework that best reflects the current evidence base in relation to alcohol policy. Bulk buy discounts like buy-one-get-one-free and unlimited happy hours are banned across all on and off licenced premises in Scotland.

Scotland has also legislated to introduce a minimum unit price for alcohol. The legislation was passed in the Scottish Parliament with a clear majority in 2012; however, its legality has been challenged by the drinks industry and is currently being reviewed by the courts.

Scotland added a fifth licensing objective in 2005 under the Licensing Act - that of protecting and improving health. The Act introduced for the first time a duty on licensing authorities to assess whether any given area in their remit is currently overprovided with licensed premises of any type. This is intended to enable and empower local authorities to refuse grant applications where they deem an area to be overprovided. However, there is no legal or established definition of overprovision. Alcohol licensing authorities are required to publish statements of licensing policy every three years. The report argues this is largely consistent with the recommendations in Health First, although it is evident that the public health objective does not necessarily ensure that local authorities are able to control availability. Each local authority is also mandated to have a strategic, multi-agency partnership made up of representatives from the NHS, police, local authority and third sector organisations. Known as Alcohol and Drug Partnerships, they are required to submit local strategies to deliver improvements in seven core and additional local area outcomes and are accountable for the decisions to achieve these.

Scotland has also led the way in delivering Alcohol Brief Interventions (ABIs) and has reduced the legal drink driving limit from 80 to 50mg/ per 100ml, in line with the Health First recommendations.

Why Scotland leads the way

The report outlines some theories to explain why Scotland led the way in public health-related alcohol policy.

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Firstly, the report cites research from 2006 which argues that Scotland has experienced a steep increase in rates of liver cirrhosis in recent years and now has one of the highest rates in Western Europe, arguing that Scotland acted first and took greater action because it faced the biggest problems.

A further theory explored is that the Nationalist government have worked to distinguish Scotland as a nation from the rest of the UK. Related to this is the smoking ban which was introduced first in Scotland by the previous Labour/Liberal Democrat coalition and was subsequently introduced into all the other nations of the UK. As a result the SNP government wanted to create a similarly ground-breaking broader health policy legacy. The report also suggests that an explanation can be found by examining studies of industry lobbying. The three main Westminster parties have been and continue to be targeted and influenced by sustained long-term lobbying activity by the alcohol industry keen to protect their own interests. This close involvement of the industry in Westminster politics may help explain why the government reversed its support for MUP. In contrast, the report argues that the landslide election of the SNP was somewhat of a surprise. The industry did not see them coming and did therefore not have time to establish the kind of relationships with politicians and civil servants to influence policy in Scotland as they did in Westminster.

Finally, the devolved nations of the UK are much smaller with politicians who are easier to access serving smaller populations. These factors have helped to facilitate and enable third sector advocacy organisations, public health professionals, and academics to more easily reach, access, inform and influence governments in the devolved administrations.

From the evidence examined and discussed, the report makes a number of recommendations for the production of effective evidence-based alcohol policies to reduce alcohol-related harms:

- There is a need for Governments to more fully embrace the value of experimentation as there are inevitably gaps in evidence about what will work, where, how and with whom, and whether there are un-intended consequences.
- The Scottish Government should continue to seek the powers necessary to take legislative action in line with the evidence, in particular in relation to alcohol advertising and sponsorship. Wales and Northern Ireland should also continue to lobby in support of their already stated policy positions, and for the devolution of further powers to implement them, if the UK Government is unwilling to take evidence-based action on all outstanding issues.
- The UK Government should reverse its opposition to MUP and all of the administrations should state their support for a change in EU law to allow for directly proportionate taxation by strength. In the meantime, the UK Government should reverse recent tax cuts on alcohol and reintroduce the 'duty escalator' in order to prevent further falls in the affordability of alcohol.
- All administrations should stop engaging with the alcohol industry except in relation to their role as producers and retailers of alcohol, in particular, avoiding any involvement of the industry in public health policy in relation to alcohol.
- All administrations should ensure that alcohol policies and programmes are clearly outlined in one easily navigable online resource that is continuously kept up to date. This should articulate the administration's overall strategic approach, draw together all actions, developments, plans and policy positions relating to the issues outlined in Health First.

[1] **www.stir.ac.uk/media/schools/management/documents/Alcoholstrategy-updated.pdf**

Forthcoming events

Adolescent binge drinking in Chile: Does it matter which school they go to?

Tuesday, 14th June 2016

Francisca Maria Roman, University College, London

About our people

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Jennifer started working at SHAAP in July 2015, having previously worked with Skills Development Scotland, the National Trust for Scotland and Diabetes UK Scotland. Jennifer has an MSc in Policy Studies from the University of Edinburgh and an MA in Politics and Public Policy from the University of Glasgow.

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