National Alcohol Strategy Refresh

1 Background


1.2 They propose not to re-write the strategy but rather identify where further work is required, or where there are gaps. As a result, they do not plan to formally consult but have sought advice directly from ADP stakeholders.

1.3 Due to the short deadline offered the Chair and ADP Lead, it was not possible to determine the wider views of the ADP. However, the intention was to publish the refresh by now but following receipt of stakeholder feedback, the due date has been pushed back to late summer 2017 providing time for wider views to be gathered.

2 Aim

2.1 The purpose of this paper is to advise the ADP on the response offered (see Appendix A) and invite members to supplement this with additional views so a fuller response can be offered.

3 Conclusions

3.1 ADPs are tasked with implementing national alcohol and drug strategy at a local level. It’s therefore important that the ADP influence the content of new or revised strategy to ensure their operational insights are taken into consideration.

3.2 ADP Members are invited to note the contribution offered so far and identify ideas that may have been missed or items offered that they don’t agree with so that a more representative ADP view can be offered to Government.

Wayne Gault
ADP Lead Officer
March 2017
Appendix A: Initial Aberdeenshire Response to Government

The following email was set to Louise Feenie, Alcohol Policy Team Leader at Scottish Government on 8 February 2017.

Dear Louise,

Thank you for the opportunity to comment on your alcohol refresh. My comments are roughly in the order of the actions within the original strategy. Sorry for the length of this email but there is a lot to say!

First of all, at a general level, I can’t help but note that many of the principles and intentions in Changing Scotland’s Relationship appear to be reflected at a more generic level in things like the new National Health and Social Care Delivery Plan. That strikes me as a very healthy endorsement of the original thinking.

Given the sensitivities of the alcohol issue and limited local access to the big levers for change, local areas have to rely on changing our relationship with alcohol on a community by community basis. This means obtaining a local mandate for change by revealing the community’s expectations and aspirations. We’re of the view that such a mandate can only be obtained through sharing real, localised information that enables an informed contextualised discussion within that community. We can increasingly do that with reference to various alcohol harms and licensing density information. However, we can’t access local alcohol supply and consumption information. I’d hope that the refresh went some way to reflecting on whether the current Scottish Health Survey alcohol consumption data is sufficient to inform local action at a community level (we don’t think it is because of a lack of resolution) and whether this needs to be supplemented by access to supply data. As you know, retailers are not required to provide unit sales data (unless supplied via a home delivery). I’d hope that this could be addressed in a consolidated licensing bill. In Aberdeenshire’s case, this would be very useful to help us understand better why we’ve achieved recurrent reductions in alcohol related hospital admissions but yet have seen an increase in alcohol related deaths over the past 6 years.

Despite the focus on prevention and early intervention promoted in ADP National Outcomes, the Christie Commission, H&SC Statutory Outcomes and prevention outcomes from Local Outcome Improvement Plans, in a time of considerable budget pressures, it is inevitable that ADPs prioritise investment in service delivery, waiting times and quality standards. Government should protect long term prevention activities around alcohol, the outcomes of which will not be seen within a 3 year funding cycle, through expressing much more clearly and beyond ABI targets, what they expect to see locally in terms of prevention and early intervention. Coupled with that, we would welcome much stronger national leadership
on the whole population approach rather than relying on a piecemeal ADP by ADP approach. For example, coordinated national awareness campaigns, evidence based anti-stigma campaigns and national guidance and activity around social media campaigns would be welcomed, especially where their design was based on national coordination with local customised implementation. The success of the ‘Challenge 25’ scheme is an example of such an approach.

The potential for ABI remains valid, however, many areas have witnessed a deterioration in ABI activity. In our case, this is undoubtedly due to reductions in activity in General Practice due to significant pressures on the service due to patient demand and recruitment/retention issues. We’d hope that a nationally led refresh of Scotland’s approach to ABI could be conducted to determine if there is a better way of doing brief intervention. For example, greater penetration might be achieved if ABI were incorporated into a more generalised health behaviour change strategy that included a much wider range of public facing workers. In any case, due to turnover, it would be helpful if ABI train the trainer courses could be laid on.

The creation of the ‘low-risk’ alcohol consumption guidelines has been welcomed but this only goes so far in helping people understand their consumption in an informed way. The terms ‘hazardous’, ‘harmful’, ‘dependent’, ‘moderate’, ‘excessive’ all need to be revisited in the context of the new guidelines. Doing so would help consumers understand risk better, tackle critique of alcohol control policy due to attribution biases, help ADPs understand their population level consumption better and address a range of areas of ambiguity such as travel insurance industry exclusions around claims involving ‘excess’ consumption.

I believe that the 3 licensing boards in Aberdeenshire would like to address the off-sales supply part of the agenda but they still feel unable to do so due to what they would see as limitations in the law. A consolidated alcohol bill that at the very least commenced the provisions that have been approved to date would be a worthy development. I’d hope that the proxy supply provisions of the air weapons act could be expanded beyond public places to include supply of alcohol in one household to the children of another household without their parents consent. Also, the law should be updated to address the fact that no licensing board currently has jurisdiction for web based alcohol sales occurring in their area from a supplier out with that area or of alcohol sales and presence of intoxicated people on the public transport network. Boards that do have web retailers in their area are not entitled to consider the impact of those sales out with their area. Given the unprecedented increase in web sale companies that we are aware of, this is an issue we should anticipate will be significant in the future.

Our licensing boards, in keeping with many others, have found it difficult to obtain evidence to their liking of a relationship between availability and excess consumption that would enable them to effectively introduce appropriate controls on supply. The evidence for this statement is the
Appendix A: Initial Aberdeenshire Response to Government

observation that despite Scotland’s unenviable record of alcohol related harm, there has been no reduction in the quantity of off-sales alcohol outlets in Scotland. Government may wish to reflect on whether it is actually feasible, even with a consolidated bill, for Licensing Boards to introduce appropriate controls on supply with the current level of evidence available. Aberdeenshire’s Local Licensing Forums are of the view that policies seeking to reduce alcohol supply would be best pursued through courageous leadership at a national level. The actions at a national level on tobacco control and the positive impact this has delivered offers an example of how successful this approach could be.

Government may be wise to revisit consideration of alcohol only checkouts given the continued growth in off-sales. Additionally, we need to revisit the impact that the routine high profile positioning of alcohol in supermarkets has on the normalisation of alcohol and unintended additional alcohol purchases by consumers. Feedback from people in recovery regularly includes the impact high visibility of alcohol in supermarkets has on them. Government should act to ensure that alcohol is in a discreet part of the building in a shop and not in the central isle of a supermarket. This simple change would help both people struggling to control their consumption and it may also go some way to stopping the normalisation of alcohol in the weekly family shop.

Licensing forums were mentioned in the strategy. Government may wish to reflect whether forums have fulfilled the functions they were anticipated to deliver, and if not why not. I think that previous Health Scotland MESA reports accurately capture the issues.

Please find attached suggestions I previously made about following up aspects of the Youth Commission’s findings. I’d thoroughly endorse a revisit to the items relating to alcohol marketing. In particular, easy wins would appear to be ensuring that the Advertising Standards Authority proactively enforces the rules around cinema alcohol marketing in under-18 features (see attached for further information). I’d respectfully suggest that Government’s aspirations in the strategy for a co-regulatory approach to alcohol promotional activity were mistaken. Recent academic publications have endorsed this view. I’d hope the Scottish Government would resume discussions with the Westminster Government to establish better controls over alcohol advertising, even if just in Scotland.

Since the strategy was first published, the Children Act 2014 has come into being, enshrining GIRFEC into law. The commitment to review current advice to parents and carers around alcohol should be revisited in this context. For example, what is the state’s position regards parents who are intoxicated at home whilst having a child in their care? Whilst not necessarily a child safety issue, this may well be a child wellbeing issue, even if just at the level of normalisation of alcohol consumption.

I’m not aware of what progress was made on the social responsibility fee. This is still worthy of pursuit and would be analogous to the notion of ‘polluter pays’ under the Environmental Protection act 1990. When, as is
hoped, Minimum Unit Pricing takes effect, such a responsibility fee would be essential in countering the view that MUP will increase profit for retailers rather than contribute to other harm reduction initiatives. However I was aware of the Public Health Supplement, targeted at retailers of both alcohol and cigarettes. Government were to be congratulated for their vision and foresight to launch such an innovative scheme but its potential was never realised due to being set too low to affect retailer practice; the proceeds not finding their way into prevention investments and ultimately Government giving in to intense retailer lobbying and scrapping the scheme after only 3 years.

FASD remains an issue requiring more work to support efficient and effective diagnosis. Since the strategy was published, I suspect there has been an increase in the consumption levels of some women of child bearing age, increasing the risk of FASD before they know they are pregnant.

ADPs would benefit from knowing the outcomes of the actions proposed in item 27 of the action plan to develop workplace programmes within Scottish Government. I’m not aware of any of the lessons learned so have not been able to apply these locally.

Product labelling continues to be an area requiring progress. This is emphasised by producers continuing to display outdated recommendations and not acknowledge the link to serious illnesses. Indeed, it’s unclear whether there has been any progress on labelling since the strategy was published. Also, there are no arrangements for checking that the ABV labelled actually reflects the contents. Recent research suggests that some manufacturers deliberately under record how much alcohol is present in their wines. This shows that consumers could unwittingly consume much more than they thought they were due to the variances in wine ABV labelling. My understanding is that introduction of mandatory warnings on alcohol products is within the competency of Holyrood.

The investment in treatment services in 2008/09 made a considerable difference in bringing alcohol services into parity with drug services enabling us to meet the HEAT waiting time targets. However, our services operate beyond capacity and only just meet the targets. We anticipate capacity continuing to be a challenge, given current demand and anticipated additional budget cuts. Despite our alcohol related death rate having steadily increased over the past 6 years to a level never seen since before 1979, we estimate that only between 7-14% of dependent drinkers are engaged with specialist substance misuse services. This is too low to significantly contribute to reducing avoidable demand on wider public services. We need a much more systematic approach to caring for patients before they become emergency patients as envisaged by the National Health and Social Care Delivery Plan. We believe we need to engage more people in service to arrest our increasing alcohol related death rate and are developing wider partnership working and assertive outreach capabilities to do so. This is entirely in keeping with one of the goals Government has for the health and social care system of “moving away
from a ‘fix and treat’ approach to one based on ‘anticipation, prevention and supported self-management’. However, the price of success will undoubtedly be lengthening treatment waiting times unless additional investment is provided for alcohol treatment services. It is essential that the strategy refresh speaks to this challenge.

Since the original strategy was published, there has been an increasing awareness of trauma and the link with alcohol as a means of self medicating. Whilst ADPs require all services to be ‘trauma informed’, more work is required to develop what ‘trauma informed’ services look like, ensuring each ADP area has an appropriate matrix of support for people with alcohol issues who have experienced trauma with a focus on safety and recovery.

Aberdeenshire CPP has adopted alcohol as one of its three Local Outcome Improvement Plan priorities. This has enabled discussions to progress with partners that may result in commitments more ambitions than those of the ADP delivery plan. A summary of the sorts of things being considered is attached. Whilst generally supportive of the arguments behind the whole population approach, partners consider that this must be supplemented by a targeted approach to people in difficulty and communities in areas of deprivation.

Of note, the following items are considered to be beyond the scope of the CPP and ideally would be reflected in work at a national level:

- Taking alcohol out of plain sight in off-sales premises.
- Controls on advertising and labelling.
- Structurally separate alcohol from non-alcohol retail.

Finally, government may wish to reflect on the extent to which our nation’s unhealthy relationship with alcohol is related to how we personally manage change, uncertainty, stress or anxiety. The strategic role of other policy areas such as mindfulness, physical activity, activities which bring people together and increase mental wellness should be recognised and promoted as an important element of reducing our reliance on alcohol as a ‘crutch’ in Scotland.

Hopefully you’ve found my comments helpful and informative. I’d be happy to offer an ear should you wish to ‘test’ any of your thoughts.

Regards,

Wayne