Dear Dr Simpson

Please find attached NHS Health Scotland's response to the above consultation.

Regards.

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Labour Consultation 'Shifting the Culture' Response

Tightening Quantity Discount Ban in Alcohol etc. (Scotland) Act 2010

Q1) Do you think the further restriction on quantity discounting proposed would be beneficial? What disadvantages might there be? Do you think there is a case for going further?

From a public health perspective, we strongly support the prohibition of alcohol promotions based on reduced price. We therefore believe that the proposed further restriction on quantity discounting would be beneficial. It is consistent with the primary purpose of the legislation: consumers would not be encouraged to purchase more alcohol than they would otherwise have bought. This is, however, inconsistent with the suggestion that quantity discounting should not apply to the same alcoholic drink sold in different container sizes. If, for example, a 35cl half bottle of spirits is sold at more than half the price of a 70cl bottle of the same spirits, consumers may be encouraged to buy more than they initially intended. As such, we think there is a case for going further with this specific exclusion. However, we agree that different types of containers (e.g. a can and a bottle) should be treated as different alcoholic products, enabling their contents to be sold at different prices per volume.

A significant concern regarding quantity discount ban legislation is that retailers may offer straight discounting of alcohol products as an alternative pricing approach. NHS Health Scotland supports the Minimum Unit Pricing Bill as its implementation will prevent substantial straight discounting.

Public Health Interest and Child Protection

Q2) Do you believe that Ministers should be required to issue guidance on these two licensing objectives?

We agree it would be helpful for Ministers to issue guidance on these objectives. It has been clear to us that there is great variation in how Licensing Boards are responding to these objectives with, in some cases, little sign they are doing anything different with the aim of meeting them[7]. Such guidance could cover how the objectives should be interpreted, what data are available and should be used to understand the existing problems in the local area, what actions could be taken to help meet the objectives, and how progress could be monitored.

Q3) Do you believe that Ministers should be required to report to the Parliament once per session, and what should such a report be required to cover?

We think it would be sensible for Ministers to report on implementation of this guidance, and indeed on progress in addressing all the licensing objectives. Health Scotland could contribute to such a report through additional studies that would be part of its evaluation of the Alcohol Strategy as a whole (MESAS)

Restrictions on Alcohol Marketing

Q4) Do you believe that the proposed restrictions on advertising are proportionate or necessary?

Q5) Are there further measures you feel should be introduced?

From a health perspective, we believe that the proposed restrictions on advertising should be extended further if they are to have sufficient impact on reducing alcohol consumption and alcohol-related harm. There is strong evidence for the effectiveness of restricting the volume of advertising, exposure to advertising, and advertising bans on reducing consumption at population level and consumption of alcohol by young people[1,2,3].

We agree that alcohol should not be advertised in places or at times when young people under the age of 18 are likely to see it. This should include sponsored events. The extent to which major music and sporting events in Scotland are sponsored by the alcohol industry is in our view entirely inappropriate.

Caffeine Limit in Pre-mixed Alcohol Products

Q6) Do you believe that there should be restrictions on caffeinated alcohol products? If so do you believe the proposed caffeine limit of 150mg/litre on pre-mixed products is appropriate?

Combining two or more psychoactive substances is always likely to increase the risk of unforeseen adverse consequences. There remains little published evidence that combining alcohol with caffeine increases the risk of aggressive or violent behaviour. This may be because appropriate research has not been done rather than because there is no link and therefore further well-designed research would be helpful. However, the effect on alcohol related harm of restricting the amount of caffeine in combination products is likely to be small, achieving limited benefit that would be outweighed by the difficulties in introducing and enforcing any proposed limit, particularly if it were only required in Scotland. Such a limit would not prevent the combined use by the customer of separate alcoholic and high caffeine drinks or the use of alcohol in combination with other drugs such as tranquillisers or cocaine where the risk of adverse effects is much higher. It is also clear that alcohol alone, in particular social contexts, contributes to far more violence and other anti-social behaviour than a combination of alcohol and other drugs including caffeine.

Alcohol Education

Q7) Is there a role for further alcohol education and public information campaigns in changing alcohol culture?

It is important that young people understand the consequences of over-consumption of alcohol. Unfortunately, thorough reviews of the extensive published research literature on alcohol education fail to show it has more than a small and temporary effect at best on young people's drinking behaviour[2,3,4,5,6]. In practice, the young people who are least likely to be influenced by such educational efforts are those most likely to engage in excessive drinking from a young age: those with low levels of parental supervision and/or educational attainment.

Q8) Would it be beneficial for Ministers to be made directly accountable to the parliament for their policy in this area, as proposed.

Given the lack of evidence for the effectiveness of alcohol education and public information campaigns, we do not think it would be helpful to require Ministers to make a statement to each Parliament about the measures of this type that they propose to take and subsequently evaluate and report on their effectiveness .

Alcohol Discrimination Against Under-21 Year Olds in Off-Sales

Q9) Do you support a ban on Licensing Boards requiring off-licenses to restrict sales on age-grounds alone, or are there circumstances where this could be justifiable?

Consistently strict enforcement of the age of purchase of 18 years with a requirement for proof of age and streamlining the prosecution of offenders are likely to be effective in reducing under-age drinking. We are unsure if the existing powers enabling Licensing Boards to raise the age of purchase to 21 years on a case-by-case basis or the proposal to prevent them from doing this will have any significant effect. We think attention needs to be paid to the apparent increase in under 18s having alcohol purchased on their behalf by over 18s and to a possible loophole where home deliveries of alcohol ordered over the internet where the purchaser's age may not be checked .

Community Involvement in Licensing Decisions

Q10) Do you believe that community neighbours should be consulted and their views taken into account when licences are being renewed or extended or when special licences are being issued?

Q11) Do you believe that the New Zealand model is an appropriate one to emulate, if not what, changes should be made?

Preliminary findings from the first stage of the evaluation of the Licensing (Scotland) Act 2005 indicate that information on new licence applications, guidance on how to object and downloadable objection forms is made available to the public via Licensing Board websites[7]. Licensing Standards Officers may also have direct contact with the general public, primarily in response to complaints. Although some of those interviewed in the first year of the evaluation felt that the legislation had made the process of raising an objection more transparent and straightforward, it was also suggested that levels of awareness among the public of their right to object were low. We believe that there is scope for more promotion and raising awareness of the existing routes that individuals can utilise to object or challenge licence applications.

We think that the New Zealand system which requires a licence to be regularly renewed is worthy of further consideration if there is evidence that it has resulted in reductions in alcohol related harm that would justify the significant extra administrative burden.

National Licensing Forum

Q12) Do you believe that there is a role for a National Licensing Forum in addition to the existing local forums? If so:
- Should it be funded through licensing fees or central Scottish Government funding?
- What would its membership be, and who would appoint them?
- To whom would it be accountable?
- What would its functions be?

An evaluation of the Licensing Act is currently underway, and in its first stage report[7] some of the Board respondents interviewed did suggest that there could be a value in establishing a National Licensing Forum. A new forum could potentially provide a platform for cross-Scotland dialogue and learning to promote the realisation of the licensing objectives.
We would support, therefore, a consultation on whether the National Licensing Forum should be re-established, focussing on the role, remit and membership of any new forum.

Alcohol Bottle Tagging

Q13) Is there sufficient evidence to justify legislation allowing Licensing Boards to make participation in a bottle tagging scheme a licence condition, or are current voluntary arrangements adequate?

There remains little published evidence on the effectiveness and cost-effectiveness of alcohol bottle tagging schemes on reducing alcohol consumption and alcohol-related harm. With this in mind, we would support further pilots which are robustly evaluated with an outcomes focused approach, rather than any legislative change at this stage.

Alcohol Fine Diversion

Q14) Should Fine Diversion be made available, on a statutory basis, throughout Scotland, if the further pilot is successful?

Irresponsible drinkers are by definition those least amenable to education, voluntary measures or efforts to bring about cultural change. Research strongly suggests that the most effective measures are increasing price and reducing availability, combined with strict enforcement of existing legislation on age of purchase and drink driving and other alcohol related offences[1,2,3,4,5,6.]

There remains little published evidence on the effectiveness and cost-effectiveness of alcohol fine diversion interventions on reducing alcohol consumption and alcohol-related harm. With this in mind, we would recommend that any further pilots established are robustly evaluated with an outcomes focused approach, to inform any future policy decisions.

Drinking Banning Orders

Q16) Should drinking banning orders be introduced in Scotland? If so should they be piloted in one Sheriffdom?

There are strong links between alcohol and crime, in particular violent crime. Alcohol problems are also more common in offenders than in the general population. These may or may not be linked to their offending.

It is notable that, despite being available since 2009, relatively few 'drinking banning orders' (DBOs) have been issued in England and Wales. Moreover, there has been no evaluation (to date) conducted by the Home Office as to the effectiveness of DBOs. Indeed, the limited number of DBOs which have been issued challenges the potential of any future evaluation. Should DBOs be piloted in Scotland, we strongly recommend that they are robustly evaluated with an outcomes focused approach.

Alcohol and Drug Treatment and Testing Orders (ADDTO)

Q17) Do you believe extending DTTOs to become ADTTOs would add value to the existing range of disposal? What differences of context between drugs and alcohol would need to be taken into account?

We agree that the prisons are not best placed to tackle recidivist offenders whose primary problem is alcohol. Our own recent research showed that alcohol problems among prisoners are under-detected, under-recorded and under-treated, both in prison and the community (http://www.healthscotland.com/topics/health/alcohol/offenders.aspx). We also highlighted the limited evidence base in relation to effective interventions for offenders with alcohol problems. The use of Alcohol Treatment and Testing Orders is an example of such an intervention with little or no published evidence of effectiveness.

There are a number of differences of context which make any transition from DTTOs to ADTTOs challenging. Primarily, the nature of offences and type of offenders they will involve will be inherently different. A DTTO is a high tariff sentence. DTTOs were developed for those with a history of frequent offending behaviour, usually acquisitive crime, which is linked to their need to acquire drugs for their dependency. It is an intensive and invasive disposal and requires commitment and motivation from the offender to engage. By contrast, frequent alcohol related offending is related to anti-social behaviour, violence or crimes where alcohol is directly involved such as drink driving or drunkenness. Although the offender may well have an alcohol use disorder such as hazardous or harmful drinking, they may not necessarily have clinical alcohol dependency amenable to specialist treatment. Interventions (through community sentencing options) such as a programme requirement to address offending behaviour may be more appropriate. These differences in offender characteristics also highlight the potential increases in the number of individuals requiring orders as a result of any expansion toward ADTTOs, and the additional resources required to adequately manage them.

A second issue relates to how alcohol is metabolised within the body. Unlike drugs, which can be traced for a longer period of time, alcohol is metabolised rapidly (7gm per hour, i.e. just under a unit an hour) and therefore it is unfeasible to monitor individuals using direct tests of blood alcohol levels. Various alternative biochemical markers of alcohol use with a longer

window of assessment have been investigated. However, each of these tests have their limitations[8].

Finally, there are ethical issues to be considered if imposing mandatory testing for any substance that an individual is legally entitled to consume, particularly if the intent is to enforce abstinence. These could possibly be mitigated if the individual provides informed consent to be tested.

Collectively, we believe the factors identified would present significant obstacles to any extension of DTTOs to ADTTOs.

Alcohol Arrest Referral

Q15) Do you believe that Arrest Referral schemes for Alcohol (as well as Drugs) should be a statutory requirement within each Community Justice Authority area?

Research in Scotland has shown that Arrest Referral (AR) can be successful in terms of identifying individuals with significant drug and alcohol problems whose offending behaviour is linked to substance misuse, and also for linking arrestees into appropriate services[9]. There is, however, limited evidence to date which shows that AR improves the outcomes of reducing alcohol consumption and/or related harm.

On this basis, we believe that AR schemes for Alcohol (as well as Drugs) should not be a statutory requirement within each Community Justice Authority area.

Alcohol Offences Information Sharing

Q18) Do you believe that notifying a GP about a patient's conviction for an alcohol-related offence would be beneficial? Should it apply only in cases of conviction, or in other circumstances as well?

We are in favour of good communication and referral to appropriate alcohol treatment services between the Courts, the Police and the Health Service (not just primary health care teams). However, any likely improvement in such arrangements could be expected to only have a marginal effect at best on alcohol-related harm.

There are major risks attached to notifying GPs of individual offences. Firstly, it could negatively affect the doctor-patient relationship. Trust between patients and their GP is central to the relationship working effectively. There is a clear difference in the direction of information being shared between the suggested change to legislation and rare circumstances where GPs are obliged to disclose patient information to the police (where there is risk to others of serious harm or death). However, the perception that information sharing is taking place between the criminal justice system and the GP may have a negative impact on the level of trust between an individual and their GP. The extension of the legislation may well exacerbate this. We are not aware of any other offences where legislation requires GPs to be informed of criminal convictions. Demanding this level of additional information sharing would result in potentially less access, evasion and avoidance of interventions by those who are disproportionately affected through deprivation and exclusion and where engagement with health services is already difficult.

We think it would be particularly problematic from an ethical and data protection perspective to "inform all GPs' surgeries in the area in which the offender is resident". This would result in a large number of people (both clinical and non-clinical due to access that administrative staff have to patient records) having access to this information in addition to the individual's GP. Particularly in close-knit communities this could have adverse consequences for the individual. There are also concerns about the stigma attached to individuals who have been convicted of alcohol-related offences, and the impact this may have on the way an individual is approached by healthcare staff.

The GP will already be aware of those who have experienced alcohol-related harm to health through existing health-related pathways of information sharing (e.g. alcohol related A&E admissions).

Therefore, we believe that the potential harms related to the legislation are likely to outweigh any benefits. The suggestion that the legislation may also apply to 'other circumstances' where there is no conviction (such as arrest and detention without charge) is likely only to increase the potential harms and reduce the benefits.

General Questions

Q1) Do you support the general aim of the proposed Bill? (as outlined above). Please indicate "yes/no/undecided" and explain the reasons for your response.

The title of the proposed bill is Shifting the Culture and its general aim is "about tackling both health issues and revising the criminal justice system to properly focus on those whose drinking is causing problems for themselves and others." We support new measures which are informed by good evidence or at the least have a clear rationale for reducing alcohol-related harm, without undue unintended negative consequences, or initiatives to increase the effectiveness of existing arrangements. We are thus supportive of the proposals to further restrict discount selling, issue guidance on achieving the public health and child protection objectives, further restrict alcohol marketing and improve the effectiveness and local accountability of the Licensing Boards. However, we are unconvinced that the legislative proposals in the bill relating to caffeine, bottle tagging, alcohol education, ADDTOs and information sharing would contribute significantly to shifting the culture or reducing alcohol related harm.

Q2) Are there further legislative (or non-legislative) changes that you would recommend, beyond those outlined in this consultation, in order to further its general aims of tackling Scotland's culture of excessive alcohol consumption?

The evidence is clear that increasing price is one of the most effective ways to reduce population levels of consumption and harm. Thus, we think it would be helpful for the proposed bill to recognise this and suggest additional measures to address the price of alcohol, particularly those that would target the high strength, low cost drinks favoured by heavy and young drinkers.

There is also evidence for effectiveness of regulating and limiting the hours and days of sale, numbers of alcohol outlets, and restrictions on access to alcohol in reducing both alcohol use and alcohol-related problems. Much of this is addressed within the current licensing legislation but there is perhaps room to go further. There is strong evidence that privatisation of retail

alcohol sales leads to increases in excessive alcohol consumption[10], and that state-run, off-sales monopolies can limit alcohol consumption and alcohol-related problems[3].

In addition, it is well known that harmful alcohol use is more common in populations where there is greater inequality and poverty, where unemployment is high and where there is multiple deprivation. Policies to address this social context are likely to be an important backdrop to an effective alcohol policy

Q3) What is your assessment of the likely financial implications (if any) of the proposed Bill to you or your organisation? What (if any) other significant financial implications are likely to arise?

The Bill is not likely to have any financial implications for our organisation. A number of the interventions proposed require to be piloted/researched, though, which will have financial implications in terms of conducting appropriate evaluation studies.

Q4) Is the proposed Bill likely to have any substantial positive or negative implications for equality? If it is likely to have a substantial negative implication, how might this be minimised or avoided?

The relationship between alcohol and social and health inequalities is complex. The different proposals within the Bill may have differing impacts but it is unclear from the evidence base what these impacts are likely to be.

A review of current evidence[11] suggested that interventions with the following characteristics are more likely to reduce health inequalities; structural changes in the environment, legislative and regulatory controls, fiscal policies, income support, reducing price barriers, improving accessibility of services, prioritising disadvantaged groups, offering intensive support, and starting young. Conversely, interventions with the following characteristics are less likely to reduce health inequalities; Information based campaigns, Written materials, Campaigns reliant on people taking the initiative to opt in, Campaigns/messages designed for the whole population, Whole school health education approaches, Approaches which involve significant price or other barriers, and Housing or regeneration programmes that raise housing costs.

The proposal put forward in Q7 – 'Is there a role for further alcohol education and public information campaigns in changing alcohol culture?' – would fall into the 'Less likely to reduce health inequalities' category.

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