**DATE: 29 June 2012**

**RESPONSE OF: Scottish Health Action on Alcohol Problems**

**RESPONSE TO: Shifting the Culture: A Member's Bill Consultation by Dr Richard Simpson MSP & Graham Pearson MSP**

For further information please contact: Rebecca Middlemiss on 0131 247 3667 e-mail shaap@rcpe.ac.uk

Scottish Health Action on Alcohol Problems (SHAAP) was established in 2006 by the Scottish Medical Royal Colleges and Faculties to provide an authoritative medical voice on reducing the negative impact of alcohol on the health and well-being of the people of Scotland. Members of SHAAP include consultants in accident and emergency medicine, gastroenterologists, psychiatrists, public health specialists, general practitioners and nurses - all with first-hand experience of the adverse affect that alcohol can have on individuals and our health services. SHAAP is a member of the Alcohol Health Alliance UK, an alliance of medical bodies, patient representatives and alcohol health campaigners working together to highlight rising levels of alcohol health harm in the UK.

Part One: Health

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?**

We support the principle that there should not be a price advantage or buying alcohol in larger quantities. The Bill's proposals means that this would bring the present arrangements closer to that principle, but would still allow, for instance, the 1.5l vodka bottles now regularly seen on shelves, to be sold at less than twice the price of two 750ml bottles. We would welcome the exploration of an approach to end this anomaly.

The introduction on minimum unit pricing will, of course, prevent this practice at the cheap end of the market, which is one of the reasons SHAAP advocated and supported this measure.

Public Health Interest and Child Protection

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

We welcome the recognition in the consultation that there should continuing support and guidance for licensing boards to assist in protecting and improving public health and the protection of children from harm and that these objectives should increasingly inform licensing decisions.

We also recommend that guidance could be given so that the density of alcohol outlets continues to be taken into account in planning or licence applications. Studies have identified that greater alcohol outlet density is associated with increased alcohol consumption and harms, including injury, violence, crime and medical harm. (Grubesic & Pridemore, 2011; Livingston, 2011a; Connor et al., 2011; Livingston, 2011b).

In SHAAP's report with AFS "Rethinking Alcohol Licensing" we recommended that licensing boards "should determine the locality for an assessment of overprovision that is appropriate to the licensing objectives." We are concerned that Boards may assess overprovision over too small a geographical area, and pay insufficient attention to the impact of all licensed premises, for instance, by focusing the assessment on pubs and neglecting the impact of off-sales. It would also be helpful to have some guidance on the definition of capacity.

The recent decision of Edinburgh Council to refuse two licence applications on the grounds of public health is welcomed and should set a precedent for future decisions. The refusal of these licences shows that to make a difference boards need to be informed by good local data, to include those in their licensing policy and link decisions to the policy. Local health information, such as alcohol-related hospital admissions, should be informing decisions made by licensing boards.

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

Yes. Ministers should be required to give a full comparative report of licensing decisions across all Local Authorities in Scotland. This should include analysis of density and capacity of alcohol outlets,

particularly in areas of deprivation. A full and robust assessment should also be required of the impact on public health and of protection of children of the changes to licensing legislation in Scotland and the effect these are having on reducing alcohol-related harm and health inequalities, based on local health data in licensing policies.

Restrictions on alcohol marketing

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

We support the view of the BMA and Alcohol Marketing Monitoring in Europe that alcohol advertising, including sponsorship should be banned. We believe that the Scottish Government should work with the UK Government to tackle the negative impact of marketing and advertising but we believe a more vigorous UK wide approach is required. The current system of co-regulation with the ASA and the Portman Group is ineffective and the Commons Health Committee has concluded it is failing young people (House of Commons Health Committee 2010). Regulation should be independent of both the alcohol and advertising industries. We therefore agree that that the restrictions on advertising suggested in the consultation are at minimum both proportionate and necessary.

**Q5. Are there further measures you feel should be introduced?**

See above.

Caffeine Limit in Pre-mixed Alcohol Products

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

SHAAP do not agree that a restriction on pre-mixed caffeinated alcohol products is a priority. Experience of the effects and harm resulting from the combination of alcohol and caffeine is highly variable internationally and within Scotland. Different countries have identified issues with different sub cultural groups; in the US problems are described specifically with university athletes (Miller 2008) and have been claimed in Scotland with disadvantaged young men with high rates of criminality. We are not persuaded that there is conclusive evidence that caffeine itself is linked to aggression. We would welcome further research on this and on the links between alcohol use (with and without caffeine), anti-social behaviour and young people.

The young offenders' survey, 'the McKinley report' (McKinley, 2008) has previously been cited as justification for priority action on Buckfast wine. The findings show that Buckfast had been consumed by 43 of the 172 offenders in the study, 42 of the participants had consumed spirits, 38 cannabis, 37 Diazepam and 31 had consumed beer. The study did not describe how many had used more than one intoxicant. Of this range of substances: caffeine; cannabis; benzodiazepines and alcohol, alcohol is the drug most strongly associated with anti-social behaviour, violence and health harm and the focus should be on the reduction of alcohol consumption. Our interpretation of this data is that in those areas where consumption of caffeinated alcohol is prevalent, it is consumed as part of a cocktail with cheap spirits. We anticipate that minimum unit pricing will reduce cheap spirit consumption and reduce harm.

The BBC investigation cited in the consultation as justification for priority action on Buckfast gives no comparison with other alcoholic drinks. There were 955,708 crimes reported to Strathclyde Police in the period from 2006-2010. Although 5,638 crime reports mention the word Buckfast in some context there were a total of 69,733 crimes that mention 'alcohol'. Of the crimes that mention 'alcohol' 753 were violent crimes, Buckfast was mentioned in 11. In addition to this, the figures fail to account for the possibility of geographical variances and the differences between crime police report surveys and victim surveys.

SHAAP believes that focus on caffeinated product carries the risk of distracting attention from the harm which comes from alcohol in all its forms and therefore should not be a priority for policy action. We continue to have concerns that the public focus on caffeinated alcoholic drinks, and specifically Buckfast, creates a culture where consumption is expected to lead to violence. Expectancy is a major factor in behaviour while intoxicated and this publicity may serve to increase harm.

5. Alcohol Education

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

Education, communication, training and public awareness have been shown by the WHO to have the least impact in tackling alcohol-related harm and to be much less powerful than regulation. There is also considerable evidence that education as a standalone measure is ineffective and any effectiveness is as part of a multi-component approach. (Foxcroft 2004)

We are aware of no evidence that public awareness of alcoholic content of drinks reduces consumption, but draw attention to the increasing sales of stronger alcoholic drinks since ABV was included on labels. Heavy consumption is associated with a high level of consumer awareness of the alcohol content and this is consistent with observations in clinical practice.

We do support public education campaigns as part of an integrated approach to reduce harm. The relationship between "clunk-click" seatbelt campaigns is a good example of this. The campaign did not change behaviour, but built public support for a change in the law, which did.

The role of public education campaigns in changing culture should be seen as a preparatory process for effective interventions on price, availability and interventions. Care should be taken in drawing on work from alcohol industry groups, such as the International Centre for Alcohol Policies, whose publication is referenced in this section. Our experience is that these groups advocate education as an alternative to alcohol control measures and our recommendation is that these industry groups should not be central in determining public health messages.

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

We believe that the optimum accountability process would be one which recognises the complex relationships between public information, alcohol marketing and alcohol control measures. A separate accountability process for alcohol education and public information would not achieve this.

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

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

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) shows that the purchase of alcohol by under 18s has consistently fallen since 2000, age verification schemes do appear to be working. Supply to under 18s by "agents" such as friends or a family member has become the most common access for 15 and 13 year olds in Scotland. Schemes such as Challenge 21 or Challenge 25 will have no effect on this trend.

We do not share the view that the Scottish pilot schemes, such as that in Armadale, were unsuccessful and note the view of Central Scotland police that these were effective in dealing with a specific set of local circumstances.

International evidence is that countries which have raised their legal drinking age have reduced rates of alcohol related harm. We recognise that the proposal for a higher legal purchase age in off sales did not achieve public support in Scotland. We anticipate that other countries may test out split-age purchase arrangements and we should be willing to learn from these.

We note the Bill's support for Licensees being able to set a higher legal purchase age if they identify a reason to do so and believe that Licensing Boards should also have this option. We would therefore not support a proposal which limits the flexibility of Boards.

Community Involvement in Licensing Decisions

SHAAP and Alcohol Focus Scotland jointly published 'Rethinking Alcohol Licensing' last year and we would be happy to discuss the recommendations with any interested parties.

Part Two: Justice

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?**

Bottle tagging suffers from the same limitations as last drink surveys in that narrow data is gained from the results. This is largely due to the differences in the function of enforcement mechanisms. The success of bottle tagging depends on how enforcement is undertaken and this will vary by jurisdiction and day of the week.

Progress has been made tackling underage drinking and the Tayside scheme is a good localised example of effective collaborative working between the police and licensed premises. However, there is so far no full assessment of how successful pilots have been and what the limitations of this pilot are. We believe there is not sufficient evidence to justify legislative change.

The task of reducing proxy purchase, where alcohol is bought by a person of legal purchase age and passed onto a young person, is a complex one. Achieving progress is likely to require a combined approach of public information, server training, effective policing and price controls.

The recognition of the importance of proxy purchase is relatively recent, and at the present stage of knowledge a range of evaluated pilot projects would be the best way to establish best effective practice.

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

We welcome the acknowledgement of the major contribution of alcohol to offending in Scotland. There are many opportunities for effective intervention in the criminal justice system and an increased range of options for effective help would be welcome.

There has been increasing evidence on which to base a response to alcohol misuse in criminal justice settings such as the Criminal Justice Research Programme. The Prison Health Needs Assessment sets out a model of care for detection, intervention and signposting into treatment for prisoners with alcohol problems. We support the implementation of this in Scottish Prisons. We also support maximising the opportunities in the community justice setting. The recent SIPS research in England has shown the effectiveness of alcohol brief interventions in both reducing alcohol consumption and reducing re-offending. We think that further Scottish based research and evaluation is necessary before adopting as national policy.

The priority should be to design a stepped care approach starting with an effective and efficient response within criminal justice services and including joint working with specialist services in the statutory and voluntary sector as required. This employs the same principles as those adopted for the development of screening and brief interventions in health settings.

Further piloting of Fine Diversion should be undertaken before any legislation is proposed.

**Q15. Do you believe that Arrest Referral schemes for Alcohol (as well as drugs) should be a statutory requirement within each community?**

We do not believe arrest referral schemes should be a statutory requirement, they are already in place and there are significant questions over their effectiveness. The Home Office have recently published their evaluation of the effectiveness of Alcohol Arrest Referral Schemes in England. The purpose of Arrest Referral schemes is primarily to detect those with alcohol problems and signpost into treatment. They are not an intervention. A measure of success would therefore be whether offenders enter and complete treatment with a successful outcome. The evaluation found that overall there was no strong evidence to suggest that delivering alcohol interventions following arrest could impact on criminal justice outcomes, namely reducing re-offending. The intervention appeared to be ineffective for the client group in terms of reducing re-arrest and there was limited evidence of reduced alcohol consumption among the intervention group. Average costs per intervention varied from £62 to £826 and only one scheme appeared to demonstrate a sufficient reduction in arrest to break even.

The evaluation identified that brief interventions delivered in a custody suite are not an effective way to reduce alcohol-related offending and that the intervention also did not sufficiently address the criminogenic needs of those arrested. In addition to this, insufficient screening was undertaken to target the clients most likely to respond positively to a brief intervention. The re-arrest rates for alcohol-related offending are low, meaning that this is not a prolific group of offenders and therefore it would be harder to make any impact on the re-arrest rate.

Recently published evidence from England has found that successful implementation of alcohol screening and brief intervention can be achieved in Criminal Justice settings with good CJS management support as part of a steeped care approach with specialist alcohol services (SIPS 2012) This suggests that these services are best seen as integral to the criminal justice service response, rather than as "bolt on "services.

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

Drink Banning Order's (DBO's) are available in 50 local justice areas in England but figures available show that as of November 2011 only 313 had been issued. Until the impact of the effectiveness of DBO's has been measured by the Home Office we do not recommend their introduction in Scotland.

Alcohol related disorderly behaviour can be addressed adequately by the existing law and the disposals available to courts when sentencing offenders. DBO's would increase resourcing pressures on police budgets due to the difficulties of enforcement. The consequences of a breach of an order could place further pressure on the criminal justice system and they do nothing to meet the demand for more alcohol treatment options to be available to offenders.

**Q17 Do you believe extending DTTO's to become ADTTO's would add value to the existing range of disposal? What differences of context would need to be taken in to account?**

DTTO's are a very expensive form of disposal and the numbers receiving them for alcohol would be potentially huge. As stated before, we believe that priority should be given to those seeking help. The DTTO II pilot highlighted that there are significant differences in how these disposals work in relation to the type of offence committed. Women are more likely to commit low level offences, if expense restricts ADTTO's to high level offences, as with DTTO's, this will further entrench significant equalities issues in relation to women offenders. There are also likely to be human rights issues associated with imposing mandatory testing for any substance that an individual is legally entitled to consume particularly if the intent is to enforce abstinence. This could possibly be mitigated if the individual gave informed consent to be tested.

Alcohol is metabolised relatively quickly (7gm per hour, just under a unit) so it would be possible to consume large amounts of alcohol and still test negative the following day. It would be difficult to accurately measure reductions in alcohol use or be certain that an individual was not drinking unless testing was very frequent. This would be costly and time consuming (particularly if lab verification testing was required) and may render it impractical. Alcohol levels can be measured by a breathalyser (blood testing is too invasive and urine alcohol concentration is a crude measure).
The Bill mentions the use of supervised Disulfiram in the context of Alcohol and Drug Treatment and Testing Orders. There needs to be considerable more detail provided on the proposal before any view can be taken on the ethical framework or potential clinical effectiveness of such a measure.
Similarly, the establishment of alcohol consumption is a complex issue and an approach based on breathalysing or blood testing would not be simple to effectively implement. SHAAP is aware of some testing work underway on "sobriety bracelets" but this is at a preliminary stage and could not be a basis for a national programme at the present stage of knowledge.

A DTTO is a high tariff sentence. Drug Treatment Testing Orders 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 often related to offences for anti-social behaviour such as breach of the peace. 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. More appropriate interventions (through community sentencing options) such as a programme requirement to address offending behaviour may be more appropriate. For those with established dependency, and where the offender consents to treatment, an alcohol treatment requirement can be imposed.

Alcohol Treatment Requirements have been recently introduced as part of Community Payback Orders. These are at an early stage of development and there needs to be improved joint working between Sheriffs, Community Justice Authorities and alcohol treatment services in order to explore the best way to realise the potential benefits of this approach for the wide range of offenders with drinking problems. This planning should include consideration of the best way to fund such programmes.

At present we believe that there remains considerable work to be done to determine the role, if any, for Alcohol Treatment and Testing Orders.

**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 do not agree that informing GPs of a patients' conviction for an alcohol related offence is likely to increase the chances of an offender receiving appropriate treatment for an alcohol problem. We would like to see improvement in early identification and appropriate intervention through the criminal justice system. This may, in turn, increase the likelihood of the offender seeking help through their GP.

SHAAP endorses the view of the BMA who have concerns about information on legal convictions being recorded on a person's medical record. Medical records are becoming more accessible to various agencies, for example insurance agencies and employers, this kind of information being available after limits on disclosure have lapsed is unlikely to be beneficial. GPs can require such information when it is relevant and appropriate to their clinical work. Anything other than information relevant to clinical treatment in records is inappropriate.

<u>General Questions</u>

**Q1. Do you support the general aim of the proposed bill?**

Although it contains several sensible proposals these are mainly in the areas of on criminal justice and there is little about health and other treatment services. Most people with alcohol problems have never offended and alcohol treatment population is a broad one if services are designed properly. Primary Care remains the key access point for treatment and the SBI programme needs to be supported. The framing of alcohol problems in the bill reflects a "problem drinker" perspective one which is often advocated by parts of the alcohol industry and there is an absence of a whole population approach. This over-emphasis on sub-groups ignores the evidence base for the need to address alcohol-related harm at a population level through measures that reduce per capita consumption (see Academy of Medical Sciences 2004; Babor et al 2003; Hobbs et al 2003; Room – 2004).

We need to continue to act on the chronic health harm. There has been much success in getting over the whole population message and this needs to remain the main focus. There are increasing numbers of people voluntarily seeking treatment through Primary Care after the success of the Screening and Brief Interventions programme and services in general hospitals. Meeting the needs of this population should be the priority for services.

There is clearly much unmet need for interventions in criminal justice settings and a stepped care approach of developing competencies in criminal justice staff and building pathways between generic and specialist services should be the underlying principle in order to meet the substantial demand for interventions.

**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.**

Since SHAAP was established by the Scottish Medical Royal Colleges and Faculties with Scottish Government support in 2006 we have worked to increase awareness of the range and extent of alcohol related harm in Scotland and to implement effective solutions to reduce harm.

SHAAP's view is that culture is the result of a complex and dynamic interaction of legislation, formal and informal controls, general and specific environmental influences and personal belief systems. Changing culture involves understanding as much about these factors as we can and identifying the determinants which can be most readily and effectively modified.

We believe that considerable progress has been made in Scotland since then with action such as the establishment of a national programme of screening and brief interventions in health settings, increased investment in specialist services, improved control on sales practices and tackling the price of the cheapest alcohol. (Wagenaar et el, 2009; Babor et al, 2010, Grunewald et el. 2006) All of these were early priorities for SHAAP. We are pleased that our work has also had an influence elsewhere in the UK. However, all of these areas will require continued progress. There remains a considerable unmet need for alcohol services, our retail sector continues to use alcohol as a "footfall driver" and our excise duty system requires revision.

More recently we have focused on improving the Licensing system contribution to public health, improving controls on alcohol marketing and increasing awareness of the links between alcohol and cancer within the health professions.

Our future priorities include increasing understanding of alcohol and liver disease, particularly Liver transplantation, alcohol and the brain (including the developing brain) and improving medical education in alcohol issues.

Continued progress on reducing harm depends on good information and assessment. We support the work of Health Scotland and others on monitoring and evaluating Scotland's alcohol strategy (MESAS.) There is much valuable data held by the drinks industry on sales patterns, marketing effectiveness and public attitudes and this should be shared in the public interest.

We welcome progress on drinking and driving with the prospect of a lowering of the drink drive limit in Scotland.

According to the 2012 World Health Organization report on Alcohol in the European Union, over the five years from 2006-2010, policy that got stronger in European Union countries were based on education and community action. The policy areas identified that did not get stronger, but got weaker, were pricing and advertising. According to the evidence on what makes a difference to drinking behaviour and consequent harms this is the wrong way round.

**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.**

None of the proposals have a direct financial effect on SHAAP. We believe that the economic impact of alcohol in Scotland has been well reviewed over the period since the first national strategy in 2002 and the economic benefits of reducing alcohol related harm should be now well understood.

**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 this might be minimised or avoided.**

Alcohol related problems disproportionately affect our poorer communities and alcohol is a major factor in health inequalities. Action to reduce alcohol-related harm will reduce health inequalities.

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