IMPROVING
SCOTLAND'S
HEALTH

Alcohol Framework 2018: Preventing Harm

next steps on changing our relationship with alcohol

Scottish Government
Riaghaltas na h-Alba
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Ministerial Foreword

I am proud of progress since our internationally acclaimed *Changing Scotland's Relationship with Alcohol: A Framework for Action* in 2009. We have taken bold action. On 1 May 2018, we implemented the world's first minimum unit price for alcohol, set at 50 pence per unit. Intervening in the alcohol sales market was necessary: affordability tackles consumption, which directly drives health harms.

While minimum unit pricing will contribute towards the step-change we need to see in Scotland's levels of alcohol-related harm, we have always been clear that it was not a 'silver bullet'. Rather, we have a comprehensive package of measures delivered under the 2009 strategy, which I am refocusing in this updated *Framework*.

We have already banned multi-buy discounts and irresponsible promotions, reduced the drink-driving limit and supported a nationwide alcohol brief interventions programme. These are positive changes which have attracted international acclaim.

Since 2008/09, we have spent over £746 million on addressing higher-risk alcohol and problematic drug use which includes £53.8 million for this year; and we are also providing an additional £20 million each year for frontline alcohol and drugs services for the lifetime of this Parliament.

However, the facts speak for themselves. Alcohol-specific deaths totalled 1,120 in 2017. Taken together with the 934 drug-related deaths in Scotland in 2017, that totals 2,054 lives lost as a result of these harmful consumption behaviours.

Let me be clear – each and every one was preventable. Scotland's families and communities are paying too high a price, we need concerted efforts; across Government, across the public and voluntary sectors, across Parliament; to turn around the harms associated with higher-risk alcohol consumption and problematic drug use.

This document sets out our national prevention aims on alcohol: the activities that will reduce consumption and minimise alcohol-related harm arising in the first place. An overarching strategy for prevention and treatment of alcohol and drugs, setting out our support for individuals, for families and for communities, will follow.

I believe there is more to do in order to protect children and young people, and to address health inequalities.

I am passionate about giving children a fair chance to flourish, in this Year of Young People and beyond. That means creating an environment which supports and enables positive health behaviours, protecting all children from alcohol-related harm. I will therefore begin consultation and engagement, in 2019, looking at the exposure of children and young people to alcohol marketing in Scotland and considering whether Scotland

should put regulation of alcohol marketing on a mandatory footing. Through this work, I will be mindful of those in recovery, too. I will also urge the UK Government to act now to limit children's exposure to broadcast alcohol advertising – or else devolve the necessary powers, so that the Scottish Parliament can take action in our children's best interests.

There is a stark inequalities gradient to alcohol harm. Tackling poverty and inequality, as well as providing good quality and accessible support on mental health, is paramount to reducing recourse to alcohol and drugs. I will work across government to tackle head-on the inequalities in our society which can mean vulnerable people suffer most. Minimum pricing will help us do that; however, all our policies must enable us to further reduce health inequalities.

I will work towards a Scotland where less harm is caused by alcohol; where we put in place bold measures to prevent harm, and reach out with the right support for all those who need it. When we do so, it should be without judgement, and with kindness and understanding.

For too long, the stereotype of the 'hardened Scots drinker' has prevailed. No more. It's time for a cultural shift towards a more balanced relationship with alcohol across our society. This updated *Framework* begins the next stage in that journey.

JOE FITZPATRICK
Minister for Public Health, Sport and Wellbeing

Summary of Actions

Our actions are described according to their impacts as follows:

Protecting Young People	**PYP**
Tackling Health Inequalities	**THI**
Improving National Systems	**INS**
Whole Population Approach	**WPA**

Overarching commitment

Number	Action	Responsibility	Timing	Contributes to
1	We will put the voices of children and young people at the heart of developing preventative measures on alcohol. This will involve encouraging and seeking the views of children and young people.	Scottish Government	Ongoing	**PYP**

Reducing consumption: affordability and sales

Number	Action	Responsibility	Timing	Contributes to
2	We will evaluate the impacts of minimum unit pricing during its first five years of operation.	Scottish Government, with NHS Health Scotland	2018 to 2023	**WPA** **THI**
3	We will review the minimum unit price following two full years of operation, after 1 May 2020.	Scottish Government	From 1 May 2020	**WPA** **THI**
4	We will scope research into online and telephone alcohol sales to better understand these growing markets and any issues arising as a result.	Scottish Government, with NHS Health Scotland	Beginning in 2019	**WPA** **INS**

Reducing consumption: availability and licensing

Number	Action	Responsibility	Timing	Contributes to
5	We will update the statutory guidance on the Licensing (Scotland) Act 2005 to provide clarity for Licensing Boards on implementing the five licensing objectives, including the public health objective, and the overprovision statement. A full public consultation will be held in 2019.	Scottish Government	2019	**INS** **WPA**
6	We will keep the licensing system under review to ensure it can deliver for public health, commissioning research as necessary. Once new Licensing Policy Statements have bedded-in, from 2019 we will revisit the findings of the 2013 MESAS study, *An evaluation of the implementation of, and compliance with, the objectives of the Licensing (Scotland) Act 2005*, focusing on evaluating the operational effectiveness of the public health licensing objective in light of the changes made since to alcohol licensing.	Scottish Government, with NHS Health Scotland and Alcohol and Drug Partnerships	Ongoing – and from 2019 for evaluation of public health objective effectiveness	**INS** **WPA**
7	We will continue to support Alcohol Focus Scotland to build awareness at a local level so that local communities, Health and Social Care Partnerships and Alcohol and Drug Partnerships can be effective in influencing the licensing regime.	Scottish Government, Alcohol Focus Scotland, Health and Social Care Partnerships and Alcohol and Drug Partnerships	Ongoing	**INS** **THI**
8	We will work with the alcohol industry on projects which can impact meaningfully on reducing alcohol harms; but not on health policy development, on health messaging campaigns or on provision of education in schools and beyond the school setting.	Scottish Government	Ongoing	**PYP** **WPA**

Positive attitudes, positive choices: attractiveness – marketing and advertising

Number	Action	Responsibility	Timing	Contributes to
9	We will press the UK Government to protect children and young people from exposure to alcohol marketing on television before the 9pm watershed and in cinemas – or else devolve the powers so the Scottish Parliament can act.	Scottish Government	From 2018 and on an ongoing basis	**PYP**
10	We will consult and engage on the appropriateness of a range of potential measures, including mandatory restrictions on alcohol marketing, as recommended by the World Health Organization, to protect children and young people from alcohol marketing in Scotland.	Scottish Government	Beginning in 2019	**PYP** **WPA**

Positive attitudes, positive choices: education, awareness raising and behaviour change

Number	Action	Responsibility	Timing	Contributes to
11	We will revise and improve the programme of substance use education in schools to ensure it is good quality, impactful and in line with best practice.	Scottish Government, with Education Scotland	Beginning in 2019	**PYP**
12	We will develop education-based, person-centred approaches that are delivered in line with evidence-based practice to aim to reach all of our children and young people including those not present in traditional settings, such as Youth Groups, Community Learning and Development, looked after and accommodated children, excluded children and those in touch with services.	Scottish Government, with Education Scotland	Beginning in 2019	**PYP**
13	We will develop our current online resources to ensure they provide accurate, evidence-based, relevant and up-to-date information and advice, around alcohol and drug use; and how to access help.	Scottish Government, with partners	Beginning in 2019	**PYP**
14	We will initiate national marketing work, with partners, promoting the messages of the UK CMOs' lower-risk drinking guidelines during 2018, and we will launch this campaign nationwide in 2019.	Scottish Government, with a range of national and local partners, including Health and Social Care Partnerships, Alcohol and Drugs Partnerships and third sector partners	Launch in 2018-19, with ongoing support in future years	**WPA**

Positive attitudes, positive choices: education, awareness raising and behaviour change – *continued*

Number	Action	Responsibility	Timing	Contributes to
15	We will press alcohol producers to place health information on physical product and packaging labels – and will be prepared to consider pursuing a mandatory approach in Scotland if the UK Government's deadline of September 2019 is not met.	Scottish Government	Beginning in 2018	**WPA**
16	We will work with partners to raise awareness of the links between alcohol consumption and cancer.	Scottish Government, with partners	Beginning in 2018	**WPA**
17	We will review evidence on current delivery of Alcohol Brief Interventions to ensure they are being carried out in the most effective manner, look at how they are working in primary care settings – where the evidence is strongest – and whether there would be benefit in increasing the settings in which they are delivered.	Scottish Government, with NHS Health Scotland	Beginning in 2018	**WPA** **THI**

Supporting families and communities: Fetal Alcohol Spectrum Disorder – prevention, diagnosis and support

Number	Action	Responsibility	Timing	Contributes to
18	We will continue to prevent and reduce the harm caused by alcohol consumption in pregnancy through increased awareness of the risks, increased awareness of, and improved diagnosis and support for, Fetal Alcohol Spectrum Disorder.	Scottish Government, with partners	Various timescales	**WPA** **INS** **THI**

Supporting families and communities: positive alternatives and safer communities

Number	Action	Responsibility	Timing	Contributes to
19	In recognising the link between community safety and alcohol, we will continue to work with partners to build awareness and resilience to both reduce harm and improve life choices.	Scottish Government, with partners	Insert various timescales as above	**PYP** **THI**

Supporting families and communities: preventing alcohol-related violence and crime

Number	Action	Responsibility	Timing	Contributes to
20	We will continue to work with partners to reduce alcohol-related violence and crime, through a combination of enforcing legislation, prevention work and early intervention activity.	Scottish Government, with partners	Various timescales	**PYP** **THI**

Section 1 - Introduction

Updating the 2009 *Framework for Action*

1. Scotland's 2009 alcohol strategy, the *Framework for Action*[1], is well established. Many of our original actions have been completed, with others continuing and evolving. We have taken, and will continue to take, an evidence-based approach to our alcohol strategy. This updated *Framework* retains three central themes, which are well accepted and understood:

   - **Reducing consumption**
   - **Positive attitudes, positive choices**
   - **Supporting families and communities**

2. This document sets out our national prevention aims on alcohol: the activities that will reduce consumption and minimise alcohol-related harm arising in the first place. This is consistent with *Public Health Priorities for Scotland*[2] where one of the priorities is a "Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs." An overarching strategy for prevention and treatment of alcohol and drugs, setting out our support for individuals, for families and for communities, will follow.

Scotland's alcohol policy on the world stage

3. With the introduction of minimum unit pricing on 1 May 2018, Scotland has truly become a world-leader on alcohol policy. We will continue to share our experiences within Europe and internationally. In 2015, Scotland hosted the Global Alcohol Policy Alliance Conference[3]; the only European country asked to host the conference. In 2016, Scotland was awarded the inaugural European Reducing Alcohol Harm[4] Award at the 7th European Alcohol Policy Conference (EAPC) in Slovenia, and we are delighted to be hosting the 8th EAPC[5] in November 2018, in Edinburgh. The United Nations (UN) recognised the Scottish Government's contribution towards tackling non-communicable diseases with a UN Interagency Task Force Award[6] for its work on minimum unit pricing in 2018.

A *balanced* approach

4. The Scottish Government's focus is on preventing and reducing alcohol-related harm. Tackling higher-risk alcohol use forms a significant part of reducing alcohol-related harm. We define *higher-risk alcohol use* as drinking above the lower-risk maximum amounts advised in the UK Chief Medical Officers' (CMOs) guidelines[7]. This means that *higher-risk* is

1 *Changing Scotland's Relationship with Alcohol: A Framework for Action*, http://www.gov.scot/Publications/2009/03/04144703/0
2 *Public Health Priorities for Scotland*, https://beta.gov.scot/publications/scotlands-public-health-priorities/
3 http://globalgapa.org/index.php/gapa-events/11-2/
4 http://www.eurocare.org/library/updates/scotland_receives_the_european_award_for_reducing_alcohol_harm_earah
5 https://www.8eapc.eu/
6 http://www.who.int/ncds/un-task-force/events/2018-awards/en/
7 *Communicating the UK Chief Medical Officers' Alcohol Guidelines*, https://www.gov.uk/government/publications/communicating-the-uk-chief-medical-officers-alcohol-guidelines

a broad range which covers those who drink marginally above the guidelines to those who drink significantly above them. The guidelines were revised across the whole of the UK in 2016 after a thorough evidence review, because that is the best way to minimise risk of harm for the people of Scotland. A summary of the guidelines is provided at **Annex A**. They recommend a maximum of 14 units of alcohol per week for both women and men to keep health risks low, preferably spread over three or more days, with no drinking at all during pregnancy.

Lower-risk drinking guidelines for men and women

14 units of alcohol a week, which is:

6 pints of beer (4% strength)
OR

6 glasses of wine
(13% APV strength, 175ml)
OR

14 single shots of spirits
(40% strength)

5. We will continue to work with a wide range of stakeholders to reduce alcohol-related harms, including Health and Social Care Partnerships, Alcohol and Drug Partnerships, other local partners and the third sector. We will also work jointly with industry, where that is appropriate. Where we do so, we will set the bar high and collaborate only on projects which can impact meaningfully on reducing alcohol harms. The Scottish Government will not work with the alcohol industry on health policy development, on health messaging campaigns or on provision of education in schools and beyond the school setting. Our approach to joint work with the industry will be based on the principles of the World Health Organization (WHO) *Global Strategy* to reduce the harmful use of alcohol, which recognises industry's role as developers, producers, distributors, marketers and sellers of alcohol products[8].

A *'whole population'* approach

6. We continue to take a whole population approach which aims to reduce alcohol consumption and the risk of alcohol-related harms across a population, because Scotland's consumption remains too high. In 2017, Scots bought enough alcohol (10.2 litres of pure alcohol) for everyone aged over 16 to drink 19.6 units of alcohol every week[9]. This is equivalent to 40 bottles of vodka, or around 100 bottles of wine, per adult each year. This is 40% more than the lower-risk CMO

8 *Global status report on alcohol and health 2018, World Health Organization*, p135, http://www.who.int/substance_abuse/publications/global_alcohol_report/en/

9 *MESAS Monitoring Report 2018*, http://www.healthscotland.scot/publications/mesas-monitoring-report-2018

drinking guidelines of 14 units. Sales data provide information on how much we are drinking in totality whereas the *Scottish Health Survey* is useful for providing information on our pattern of drinking. The latest *Survey* (2017[10]) shows that 24% of adults drank above the lower-risk guidelines, which is down from 34% in 2003; and the proportion of adults saying they did not drink alcohol increased from 11% in 2003 to 17% in 2017. These figures are encouraging, however, as self-reported survey estimates of consumption are typically lower than estimates based on sales data, it is the sales data that provide a more accurate picture of how much we are drinking as a nation.

7. Alongside a whole population approach, we continue to progress interventions targeted at those at most risk, such as Alcohol Brief Interventions and a suite of treatment options. Our approach is aligned with WHO[11] and Organization for Economic Co-operation and Development (OECD)[12] strategies to tackle the harmful use of alcohol. Prevention measures are key, and we follow the WHO approach of placing the three prevention 'A's front and centre: **Affordability, Availability and Attractiveness**.

8. Building on the 'three As', in September 2018, WHO launched its new *SAFER* initiative[13], which is backed by a range of partners including the United Nations. *SAFER* is a package of five evidence-based, high impact strategies which WHO recommends governments should prioritise to tackle alcohol-related harm.

> **S**trengthen restrictions on alcohol availability.
>
> **A**dvance and enforce drink driving countermeasures.
>
> **F**acilitate access to screening, brief interventions, and treatment.
>
> **E**nforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion.
>
> **R**aise prices on alcohol through excise taxes and pricing policies.

The Scottish Government fully endorses the new *SAFER* initiative, and will work to support and promote this approach within Europe and worldwide.

A *well-connected* approach

9. It is crucial that government understands people's motivations for drinking. The same is true for all public and private sector actors who seek to influence alcohol behaviours. We also need to recognise that some cultural norms around drinking have become so deeply embedded that they cannot be turned around through short-term action. Two consistent threads run through this document: (i) our actions must reduce

10 *The Scottish Health Survey 2017*, https://www.gov.scot/Resource/0054/00542077.pdf

11 *Global Strategy to Reduce the Harmful Use of Alcohol*, http://apps.who.int/iris/bitstream/10665/44395/1/9789241599931_eng.pdf?ua=1&ua=1

12 *Policy Brief: Tackling Harmful Alcohol Use*, https://www.oecd.org/els/health-systems/Policy-Brief-Tackling-harmful-alcohol-use.pdf

13 *World Health Organization SAFER initiative*, http://www.who.int/substance_abuse/safer/launch/en/

health inequalities; and (ii) our actions must protect children and young people. The evidence on the effects of alcohol on the developing adolescent brain is strong[14], and we now know that brain development continues until the mid-twenties so we need to be mindful of this when developing policies to protect young people.

10. Where we strive to change behaviours, we need to enable positive and sustainable changes in the conditions that can drive behaviours in the first place. It is vital to recognise and address the wider, social determinants of health in policies across government. To maximise the impacts of our updated alcohol strategies, we must connect into the policies and programmes that are tackling some of the fundamental issues of our times. This includes, but is not limited to, enabling and supporting positive mental health; reducing poverty and tackling inequalities at source; providing good quality housing and ending homelessness; enabling the best starts in life for our children, including recognising the impact of adverse childhood experiences; improving the life circumstances of children, young people and families at risk; improving social connectedness, community cohesion and safety and evolving our justice system to improve outcomes for individuals, families and communities. NHS Health Scotland's work illustrates the importance of 'place' to health[15].

Scotland's progress

11. We have already:

- changed the way alcohol is marketed with the introduction of the quantity discount ban, associated with a 2.6% reduction in consumption[16];
- banned irresponsible promotions, so consumers are not encouraged to drink more than they intended;
- introduced restrictions on where alcohol and associated marketing can be displayed by retailers to curb impulse purchases;
- rolled out a nationwide programme of alcohol brief interventions, delivering over 834,000 since 2008/09;
- worked to protect our children and young people from alcohol-related harm through the introduction of a mandatory age verification policy, such as Challenge 25, to make it harder for young people to obtain alcohol;
- continued work to equip our young people to make better decisions through improved substance use education and access to positive alternative activities;
- worked to make our communities safer through a range of initiatives to tackle alcohol-related violence and crime and to encourage safer drinking environments;
- legislated to crack down on those who supply to under-18s: the Air Weapons

14 *Alcohol and the Developing Adolescent Brain: Evidence Review*, http://www.shaap.org.uk/images/shaap_developing_adolescents_brain_press.pdf

15 *NHS Health Scotland: Impact of social and physical environments*, http://www.healthscotland.scot/health-inequalities/impact-of-social-and-physical-environments/place

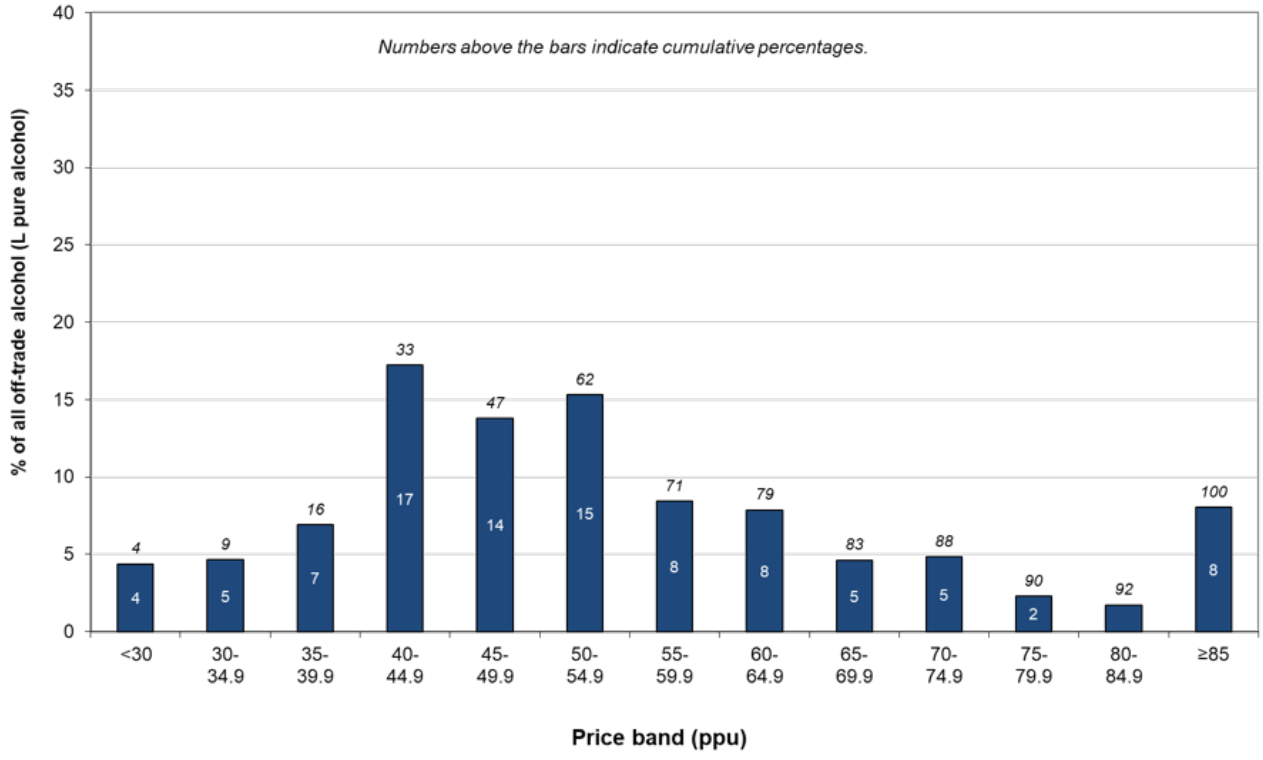
16 *NHS Health Scotland: The Impact of the Alcohol Act on off-trade alcohol sales in Scotland,* http://www.healthscotland.com/documents/21101.aspx

and Licensing (Scotland) Act 2015[17] (the 2015 Act) made it an offence to supply alcohol to under-18s in a public place, giving police the power to address the problem of groups of underage people drinking in public;

- further protected young people through the 2015 Act, which broadened the 'protecting children from harm' licensing objective to include young persons aged 16 and 17, rather than just those under 16, allowing Licensing Boards to more appropriately consider the range of issues involving children and young persons; and
- made our roads safer with the introduction of a lower drink drive limit, bringing Scotland into line with the majority of other European countries.

12. Most recently, we have introduced minimum unit pricing for alcohol on 1 May 2018, which will save lives and reduce hospital admissions. In 2017, 47% of alcohol sold in the off-trade was sold at less than 50 pence (Figure 1). Minimum unit pricing is a structural pricing intervention in the alcohol sales market.

Figure 1: Price distribution (%) of pure alcohol sold off-trade in Scotland, 2017[18]



17 *Air Weapons and Licensing (Scotland) Act 2015*, http://www.legislation.gov.uk/asp/2015/10/contents

18 *Op. cit.*, http://www.healthscotland.scot/publications/mesas-monitoring-report-2018

13. Modelling by the University of Sheffield[19] estimates that the new minimum price of 50p per unit from 1 May 2018 is estimated to result in 58 fewer alcohol-related deaths and 1,299 fewer alcohol-related hospital admissions in the first year. That accumulates to 392 fewer alcohol-related deaths and 8,254 fewer alcohol-related hospital admissions over the first five years. For some illnesses that are associated with drinking alcohol, it will take a long time to see the full benefit of drinking less. It may take 20 years for all the benefits of the policy to be realised. After 20 years, it is estimated there could be 121 fewer deaths and 2,042 fewer hospital admissions each year. That accumulates to 2,036 fewer alcohol-related deaths and 38,859 fewer alcohol-related hospital admissions over the 20 years.

The present picture

Sales

14. After a fall between 2009 and 2013, alcohol sales in Scotland have remained broadly stable up to 2017[20]. This more than likely reflects the economic climate over that period. The shift from purchasing alcohol in pubs, clubs and restaurants (on-trade) to supermarkets and shops (off-trade) has been dramatic – off-trade sales have seen a 42% increase since 1994. Of all alcohol sold in Scotland in 2017, 73% was sold through the off-trade. This means that we have gone from drinking in a social, regulated environment in pubs and clubs to now drinking in a largely isolated, non-regulated environment at home. Since the 1980s, we have seen substantially increased alcohol consumption in Scotland and, consequently, high levels of alcohol-related harm.

Harms

15. Alcohol-related hospital admissions have reduced 20% since 2007/08, but are still over four times higher than in the early 1980s (Figure 2). Overall, mortality rates have fallen 30% from a 2003 peak, but are still over twice as high as in 1981 (Figure 3). We also recognise that, within a whole population approach, some groups are affected more than others: those in the most deprived areas are impacted more than those in the least deprived[21]; adult drinkers aged 45 to 64 reported the highest mean weekly consumption in 2016[22]. Although men overall drink almost twice as much as women, there is more stigma attached to women drinking[23]. The LGBTI community experiences significant health inequalities around higher-risk alcohol use[24]. And we need to remember that harms are not experienced solely by the drinker, but also by family and friends, communities and employers[25].

19 *Model-based appraisal of the comparative impact of Minimum Unit Pricing and taxation policies in Scotland: An adaptation of the Sheffield Alcohol Policy Model version 3*, https://www.sheffield.ac.uk/polopoly_fs/1.565373!/file/Scotland_report_2016.pdf

20 *Op. cit.*, http://www.healthscotland.scot/publications/mesas-monitoring-report-2018

21 *Ibid*

22 *Op. cit.*, http://www.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey

23 *Women and Alcohol: Key Issues*, http://www.shaap.org.uk/images/women-and-alcohol-web.pdf

24 *The social context of LGBT's people drinking in Scotland*, http://www.shaap.org.uk/images/shaap-glass-report-web.pdf

25 *Alcohol Focus Scotland, Unrecognised and under-reported: the impact of alcohol on people other than the drinker in Scotland*, https://www.alcohol-focus-scotland.org.uk/media/59857/Unrecognised-and-under-reported-summary.pdf

Figure 2: Alcohol-related hospitalisation rates, Scotland, 1981-2016/17[26]

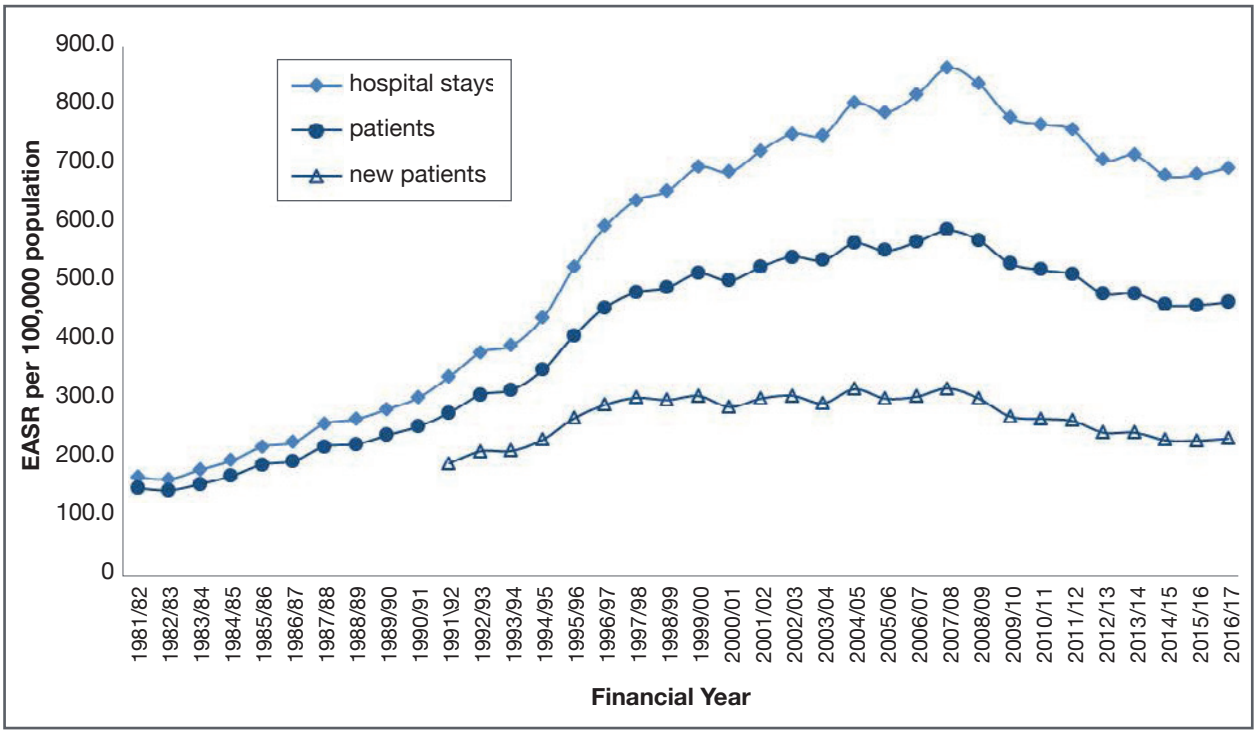
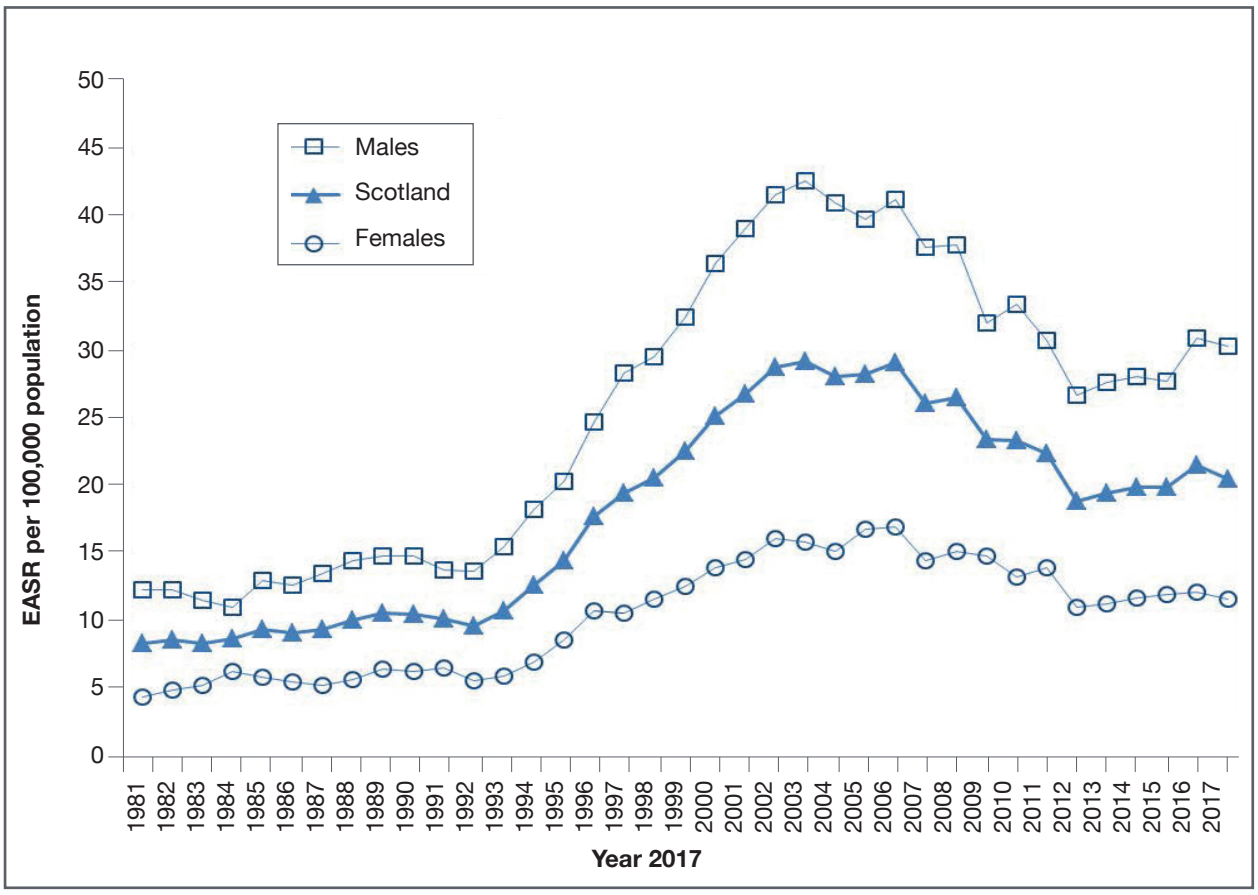


Figure 3: Alcohol-specific death rates overall and by gender in Scotland 1981-2017[27, 28]



26 *Alcohol-related hospital statistics Scotland 2016/17*, https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2017-11-21/2017-11-21-ARHS-Report.pdf

27 *Op. cit.*, http://www.healthscotland.scot/publications/mesas-monitoring-report-2018

28 *Age standardised death rates calculated using the European Standard population*, https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/age-standardised-death-rates-calculated-using-the-esp#Tables

16. Our *Framework* is having an impact, as demonstrated by the *MESAS Final Report 2016*[29]. There are some encouraging trends, particularly regarding young people with the proportion of 13 and 15 year olds who drank alcohol in the last week being at its lowest since 1990[30]. And the introduction of minimum unit pricing will see a step change in saving lives and preventing hospital admissions. However, Scotland requires a sustained focus on alcohol harm reduction. The present population-level harms, of 22 deaths[31] and 697 hospital admissions[32] on average per week due to higher-risk alcohol use, are simply too high.

17. So, too, is the economic cost. Alcohol misuse costs Scotland far too much in financial terms – in 2010, this was found to be a staggering £3.6 billion each year, using 2007 data[33]. To put this into perspective, that's an average of £900 for every adult. The total includes estimated annual costs to the NHS of some £140 million - £400 million each year. We are presently updating these data; however, with the enduring levels of harm we experience as a nation, this is likely to continue to point towards a very substantial national burden.

International comparisons

18. Scotland has high rates of alcohol-related harm in international terms[34], as does the UK. In 2016, the latest year for which comparable figures are available, total alcohol consumption in the UK (11.4L) was more than 16% above the European regional average (9.8L[35]). Even though only half the world's population drinks alcohol, it is the world's third leading cause of ill health and premature death[36]. Prevalence of Chronic Liver Disease and cirrhosis (closely associated with heavy alcohol consumption) remains high by comparison with other European countries. Where data are available, Scotland, along with Hungary and Finland, had the highest Chronic Liver Disease mortality rates in 2014[37]. Although they have decreased since

29 *MESAS final report 2016*, http://www.healthscotland.scot/publications/mesas-final-report

30 *Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) 2015*, http://www.gov.scot/Topics/Research/by-topic/health-community-care/social-research/SALSUS

31 *National Records of Scotland, Alcohol-specific deaths*, https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/alcohol-deaths/alcohol-specific-deaths-new-definition/main-points

32 *Op. cit.*, https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2017-11-21/2017-11-21-ARHS-Report.pdf

33 *The societal cost of alcohol misuse in Scotland for 2007*, http://www.gov.scot/Publications/2009/12/29122804/0

34 *Scotland and European Health for All Database 2012*, http://www.scotpho.org.uk/comparative-health/scotland-and-european-hfa-database

35 *WHO (2018) Global Status Report on Alcohol and Health 2018*, p298, http://www.who.int/substance_abuse/publications/global_alcohol_report/en/

36 *WHO (2012) European action plan to reduce the harmful use of alcohol 2012–2020*, http://www.euro.who.int/en/health-topics/disease-prevention/alcohol-use/publications/2012/european-action-plan-to-reduce-the-harmful-use-of-alcohol-20122021

37 Where data are available, Scotland, along with Hungary and Finland, had the highest Chronic Liver Disease mortality rates in 2014.

peaking in 2003, rates remains 20-40% higher than in Austria, Germany and Poland; over twice that experienced in Spain and Sweden; and almost six times that of Norway. Closer to home, per adult sales were 14% higher in Scotland than in England and Wales in 2017[38].

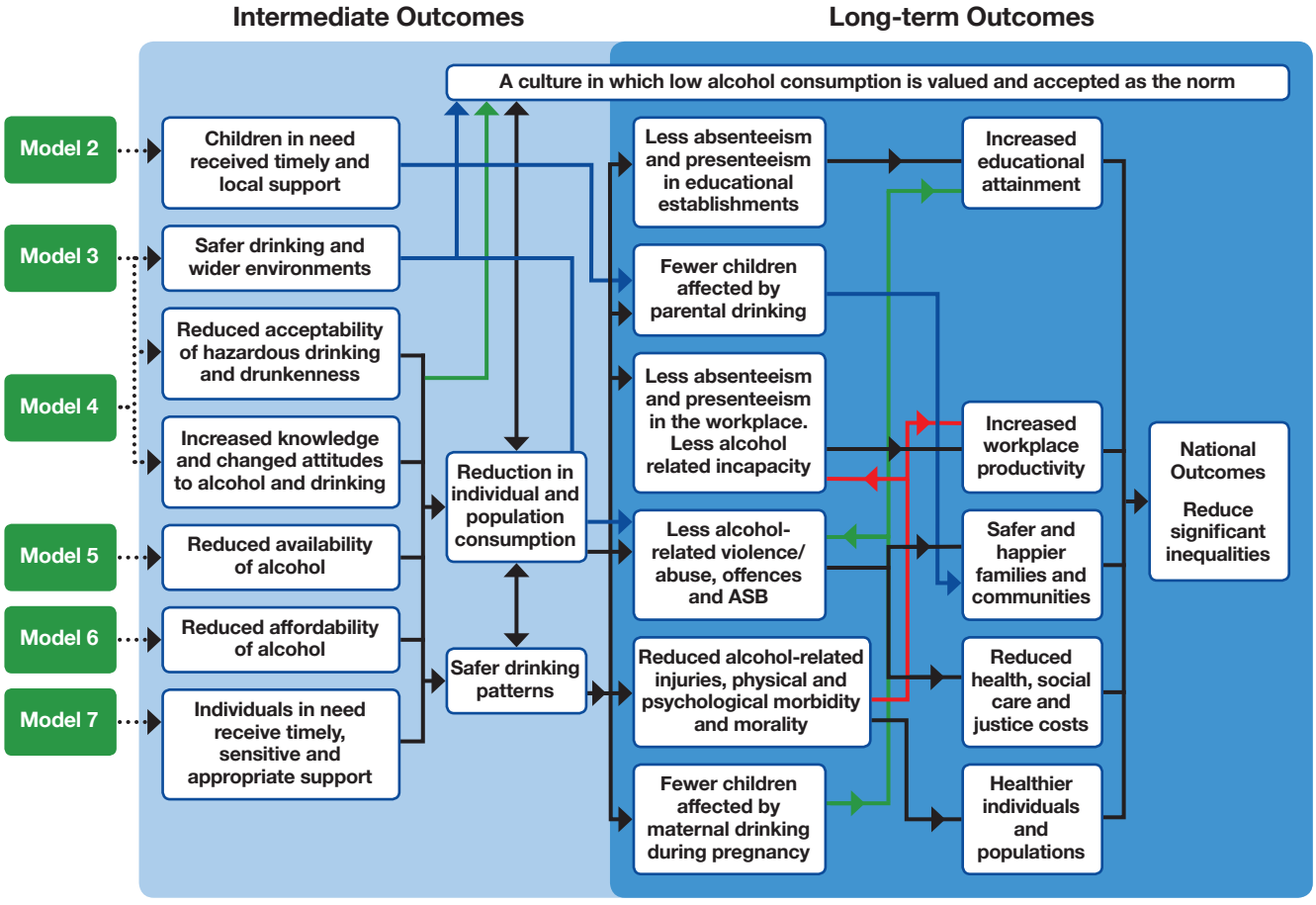
38 *Op. cit.*, http://www.healthscotland.scot/media/1863/mesas-monitoring-report-2018.pdf

Section 2 – Outcomes

Our ambition is a Scotland where less harm is caused by alcohol.

19. As set out in the Introduction section, our approach is evidence-based and aligned with the WHO approach of placing the three prevention 'A's front and centre: **Affordability, Availability and Attractiveness**. Our approach also aligns with WHO's new *SAFER* initiative[39]. In preparing the 2009 *Alcohol Framework*, we consulted upon the evidence base and the performance measures we should set. We produced a series of logic models which remain current and continue to underpin our work[40] (Figure 4).

Figure 4: Scotland's Alcohol Logic Models: Logic Model 1 (strategic level)



39 *Op. cit.*, http://www.who.int/substance_abuse/safer/launch/en/

40 http://www.healthscotland.com/ofhi/alcohol/logicmodels/lm_01.html

20. Our logic models set a number of intermediate and long-term outcomes. Some of these (for example, logic models 2 and 7) relate to treatment and support services, for adults and children, and they help to underpin the overarching alcohol and drugs strategy. The intermediate and long-term outcomes which underpin this *Alcohol Framework* are:

Intermediate outcomes

- Safer drinking and wider environments
- Reduced acceptability of hazardous drinking and drunkenness
- Increased knowledge and changed attitudes to alcohol and drinking
- Reduced availability of alcohol
- Reduced affordability of alcohol

All leading to:

- A culture in which low alcohol consumption is valued and accepted as the norm
- Reduced individual and population consumption
- Safer drinking patterns

Long-term outcomes

- Less absenteeism and presenteeism in educational establishments
- Fewer children affected by parental drinking
- Less absenteeism and presenteeism in the workplace and less alcohol-related incapacity
- Less alcohol-related violence, abuse, offences and anti-social behaviour
- Reduced alcohol-related injuries, physical and psychological morbidity and mortality
- Fewer children affected by maternal drinking during pregnancy

All leading to:

- Increased educational attainment
- Increased workplace productivity
- Safer and happier families and communities
- Reduced health, social care and justice costs
- Healthier individuals and populations

All leading to:

- Achieved National Outcomes: and National Indicators (as updated in June 2018)[41]
- Reduced inequalities

Health inequalities and young people

21. In addition, we will ensure that **two consistent threads** run through all our work:

    (1) our actions must reduce health inequalities; and

    (2) our actions must protect children and young people.

reduce alcohol harm

reduce health inequalities	**protect children and young people**

Our actions will work towards reducing health inequalities:

22. There is a stark social gradient to alcohol-related harm and, whilst we have seen some improvements in alcohol-related health inequalities in recent years, deaths are nearly seven times higher in

41 *Scotland's National Performance Framework*, http://nationalperformance.gov.scot/

the most deprived decile compared to the least deprived decile, and hospital admissions are nearly nine times higher in the most deprived decile compared to the least deprived.

23. These statistics are unacceptable for any modern nation, and especially so given our strong ambitions to create a fairer country with opportunities for all, regardless of socio-economic background. Tackling alcohol-related harm – in itself – has the potential to help address Scotland's wider health inequalities.

24. Our actions must always work together to reduce health inequalities. In particular, work on minimum unit pricing, engaging in licensing, Alcohol Brief Interventions, positive alternative opportunities and safer communities and preventing alcohol-related violence and crime have substantive equity dimensions.

Our actions will protect children and young people:

25. Children's wellbeing sits at the heart of the Scottish Government's approach to *Getting it right for every child* (GIRFEC)[42]. By understanding the quality of children's and young people's wellbeing through eight indicators: Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included (SHANARRI), we offer a common language showing how we aim to improve outcomes for our children and young people. Through GIRFEC, we are determined that every child should be able to reach their full potential as an individual. In considering our approach to public health policies, it is incumbent upon us to do all we can to support children's health in positive ways, including taking preventative action at the national level where that is warranted.

26. Children's rights are enshrined in the *United Nations Convention on the Rights of the Child* (UNCRC)[43]. In Scotland, Ministers have a duty under the Children and Young People (Scotland) Act 2014[44] to keep under consideration whether there are any steps they could take to give further effect in Scotland to the UNCRC. The Act also requires Scottish Ministers to report to Parliament every three years on progress made in meeting these new duties, and on their plans for the following three-year period. The first report is planned for 2018.

27. Alcohol is an age-restricted product for good reason. The scientific evidence is clear that an alcohol-free childhood is the healthiest and best option. Children and young people are particularly vulnerable to the effects of alcohol. The earlier a young person begins to drink alcohol, the more likely they are to drink in ways that can be risky later in life. Underage drinking can cause short and long term harm to health, as well as put young people in dangerous situations. We must continue to take forward actions to

42 *Getting It Right For Every Child*, http://www.gov.scot/Topics/People/Young-People/gettingitright

43 *United Nations Human Rights: Convention of the Rights of the Child*, http://www.ohchr.org/en/professionalinterest/pages/crc.aspx

44 *Children and Young People (Scotland) Act 2014*, http://www.legislation.gov.uk/asp/2014/8/contents

prevent children and young people from gaining access to alcohol and therefore putting themselves in risky situations.

28. Children's right to be kept safe from alcohol harm includes the damage caused by parental or other familial drinking. The move towards most drinking being done in the home means children and young people are much more likely to be around alcohol and to witness adults' drinking, and potentially be exposed to its harmful effects[45]. This is even where drinking is within the lower-risk guidelines, showing that we should not assume that negative impacts of parental drinking are only associated with higher levels of consumption.

29. Policy can sometimes seem to place children and young people in something of a vacuum, thinking about them only in specific contexts or settings such as within schools. In reality, of course, children and young people are central to their families, their peer groups, their local 'places' and their wider communities.

30. Our actions must always protect children and young people. In particular, work on preventing underage drinking, marketing and advertising, education in schools, positive alternative opportunities and safer communities and preventing alcohol-related violence and crime all aim to protect children and young people.

31. In taking actions to protect children and young people we must ensure that measures are developed with them and not imposed upon them. As Article 12 of the UNCRC makes clear, children and young people, who are capable of forming a view, should be allowed to express their views on matters affecting them. We take this very seriously and utilise the *Child Rights and Wellbeing Impact Assessment* (CRWIA) in ensuring that our policies, measures and legislation protect and promote the rights and wellbeing of children and young people. In developing preventative approaches to alcohol harm, we will encourage young people to participate and influence the development of our policies at the earliest stage.

ACTION 1: we will put the voices of children and young people at the heart of developing preventative measures on alcohol. This will involve encouraging and seeking the views of children and young people.

45 *Like Sugar for Adults 2017*, http://www.ias.org.uk/uploads/pdf/IAS%20reports/rp28102017.pdf

Section 3 – Measuring Progress

32. The 2009 *Framework* has been underpinned by a comprehensive and robust approach to data and intelligence gathering to inform policy objectives, and we will ensure this continues, covering public health surveillance, research, evaluation and evidence synthesis.

33. The Scottish Government continues to use a range of targets and indicators to measure health outcomes, including a Local Delivery Plan (LDP) standard[46] for Alcohol Brief Interventions. We will continue to closely monitor alcohol-related hospital admissions, alcohol-specific deaths and alcohol-related deaths. In particular, we will look at deaths due to Chronic Liver Disease and cancer. Chronic Liver Disease mortality rates decreased from a peak in 2003 until 2012. Thereafter, the rate remained relatively stable until 2015, and a 12% increase was observed in 2016[47]. The *Hospital admissions, deaths and overall burden of disease attributable to alcohol consumption in Scotland* study[48] found that, in 2015, there were 3,705 alcohol-attributable deaths, 28% of which were due to cancer.

34. We will also continue to ask the population about alcohol consumption in the annual *Scottish Health Survey*[49]. Although, as previously mentioned, the consumption data in this are self-reported, and underestimates actual consumption, (in common with all surveys on consumption) it is valuable in providing data on trends and drinking patterns. We will continue to work with NHS Health Scotland to use retail sales data[50] to provide a fuller picture of the total amount of alcohol being sold in both the on and off-trade. This provides valuable information on how much alcohol is being purchased, with consumption for potentially drinking at home increasingly making up the largest share of total sales, since at least 2000.

35. Through our work with NHS Health Scotland, we will continue to track affordability of alcohol, because this is a direct driver of consumption and alcohol-related harm. We will also look further, with NHS Health Scotland, at the data we may measure on availability of alcohol, and on marketing of alcohol, and how these relate to consumption and alcohol-related harm.

36. We will continue to monitor alcohol-related statistics arising from the criminal justice system, for example alcohol-related offences, and use these to inform and tailor our ongoing approach.

46 *Scotland Performs: NHSScotland*, http://www.gov.scot/About/Performance/scotPerforms/NHSScotlandperformance

47 *Chronic Liver Disease: Mortality,* http://www.scotpho.org.uk/health-wellbeing-and-disease/chronic-liver-disease/data/mortality

48 *Hospital admissions, deaths and overall burden of disease attributable to alcohol consumption in Scotland*, http://www.scotpho.org.uk/media/1597/scotpho180201-bod-alcohol-scotland.pdf

49 *Op. cit.*, http://www.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey

50 *Op. cit.*,http://www.healthscotland.scot/publications/mesas-monitoring-report-2018

MESAS: Monitoring and Evaluating Scotland's Alcohol Strategy

37. In 2016, NHS Health Scotland published the final in a series of independent assessments from the MESAS programme – Monitoring and Evaluating Scotland's Alcohol Strategy[51] – which together evaluated the impact of the 2009 alcohol strategy.

38. This report, providing conclusions on the work to date as of early 2016, set out a number of recommendations about our approach to inform future thinking. It suggested the Scottish Government should:

- ensure actions are based on evidence of the most effective (and cost-effective) interventions;
- take account of the wider socioeconomic determinants of health;
- persevere with difficult actions, such as on pricing and availability;
- incorporate the learning on implementation facilitators when developing new interventions;
- improve local data collection; and
- ensure effective and proactive monitoring of data.

39. The *MESAS Final Report* also recommended that the Scottish Government focused its future research on:

- strengthening the use of natural experiment designs to evaluate policy;
- better understanding of the differences in drinking between Scotland and England & Wales and the relationship with harm;
- understanding the linkages between policy intent, legislation, social attitudes and changing social norms;
- understanding the mechanisms underpinning a 'vulnerable cohort';
- understanding the factors that facilitate initiation and continued engagement with specialist alcohol treatment and care services; and
- examining the relationship between alcohol price, consumption and harm within Scotland and the rest of the UK.

40. The Scottish Government accepts these recommendations and will consider how best to give them effect during this next phase of the *Framework*.

51 *Op. cit.*, http://www.healthscotland.scot/publications/mesas-final-report

41. In 2019, NHS Health Scotland will conduct an evaluability assessment of this *Framework* and, subject to the outcome of that work, will continue to evaluate the actions in this document within the MESAS programme. At that time, NHS Health Scotland will also consider whether any changes or updates are required to the logic models and the outcomes. Future work will include the Scottish Government giving regular updates on progress, and NHS Health Scotland publishing an annual MESAS report which analyses relevant data. The MESAS programme will also include undertaking or commissioning work on specific commitments of this *Framework*.

42. NHS Health Scotland is also leading on the evaluation of minimum unit pricing as part of the ongoing MESAS programme. The minimum unit pricing evaluation is wide ranging, and comprises in-house elements and a number of commissioned studies. It is complemented by research and analysis being led by other academic organisations, such as the Medical Research Council Social and Public Health Sciences Unit at the University of Glasgow. The minimum pricing evaluation is being progressed in alignment with the Scottish Parliament's priorities, as set out in the Alcohol (Minimum Pricing) (Scotland) Act 2012 (the 2012 Act)[52].

43. The minimum pricing evaluation must consider the effects of minimum pricing on:

- the licensing objectives (set out in section 4 of the Licensing (Scotland) Act 2005[53]);
- sellers and producers of alcohol; and
- a range of people and stakeholders, potentially taking into account age, gender, social and economic deprivation and alcohol consumption.

44. The minimum pricing evaluation must include consultation with:

- representatives of sellers and producers of alcohol; and
- a range of people and stakeholders, including those working in health, crime prevention, education, social work and children and young people.

45. Scottish Ministers are required to report to the Scottish Parliament on the effects of minimum unit pricing after five years of operation; in other words, after 1 May 2023. If the Scottish Parliament wishes for minimum unit pricing to continue, it will need to make provision for this to happen before the sixth year of operation, i.e. by 30 April 2024.

52 *Alcohol (Minimum Pricing) (Scotland) Act 2012*, http://www.legislation.gov.uk/asp/2012/4/contents
53 *Licensing (Scotland) Act 2005*, http://www.legislation.gov.uk/asp/2005/16/contents

Section 4 – Action Plan

Reducing consumption

Affordability and sales

Minimum unit pricing of alcohol

46. In May 2012, the Scottish Parliament passed the Alcohol (Minimum Pricing) (Scotland) Act 2012 which provides for a minimum price per unit of alcohol. Its implementation was delayed by a legal challenge but, following a unanimous UK Supreme Court judgment in November 2017[54] which found minimum pricing to be lawful, the policy was implemented on 1 May 2018.

47. The Scottish Parliament set robust evaluation requirements for the policy, including a report to Parliament five years after implementation. Parliament will vote on the policy's continuation before its sixth year; this is known as the 'sunset clause'. The Scottish Government has asked NHS Health Scotland to oversee the minimum unit pricing evaluation programme, as part of its MESAS programme, working with a wide range of stakeholders. Further details can be found in Section 3. We recognise the calls, from the Health and Sport Committee and from across the Scottish Parliament Chamber, to ensure the minimum unit price remains appropriate. Indeed, many wished to see a higher initial unit price than 50 pence. We will keep the unit price under consideration, and monitor it regularly as indicated to Parliament at the time of implementation, and consider new data as they become available. We will then review the unit price following two full years of operation, in other words, after 1 May 2020.

ACTION 2: we will evaluate the impacts of minimum unit pricing during its first five years of operation (2018 to 2023).

ACTION 3: we will review the minimum unit price following two full years of operation, after 1 May 2020.

Online and telephone sales

48. The way we buy alcohol has evolved in recent years, with online and telephone sales providing new channels for alcohol purchase. We will therefore carry out new research in order to better understand the shape of this growing market, and any particular issues which may arise for national policy.

ACTION 4: we will scope research into online and telephone alcohol sales to better understand these growing markets and any issues arising as a result.

54 https://www.supremecourt.uk/cases/docs/uksc-2017-0025-judgment.pdf

Availability and licensing

Improving implementation of overprovision policy

49. Scotland has a well-established licensing regime which regulates alcohol sales. It is underpinned by five licensing objectives, one of which is protecting and improving public health.

50. Licensing Boards must publish a licensing policy statement which, amongst other duties, requires Boards to promote the five licensing objectives, and to make a proactive assessment of overprovision in their area. Following local government elections in 2017, licensing policy statements are currently being updated and are due to be published in November 2018.

51. The *MESAS Final Report*[55] found that, while the public health objective and overprovision statements have influenced practice, they have proven difficult to operationalise. This was informed by an earlier, in-depth look at licensing as part of MESAS in 2013*: An evaluation of the implementation of, and compliance with, the objectives of the Licensing (Scotland) Act 2005*[56].

Recent changes

52. The Scottish Parliament made a number of changes, through the Air Weapons and Licensing (Scotland) Act 2015[57] (the 2015 Act), to improve the operation of the licensing regime.

53. The 2015 Act amended the period of a policy statement to ensure that it aligns better with local government elections. This enables new Boards to take stock, gather evidence and set a policy statement that reflects their own views and aspirations.

54. The 2015 Act made clear that Boards could assess overprovision for their whole geographical Board areas, not just for smaller localities, given that health indicators are most often demonstrated over entire Board areas. Furthermore, the 2015 Act made it possible for Licensing Boards to take into account the licensed hours of licensed premises in localities, when assessing if there is overprovision.

55. Through the 2015 Act, the Scottish Parliament legislated to ensure Licensing Boards provide greater clarity about how they carry out their business. As well as imposing a duty on Boards to report annually on their income and expenditure, Boards must also now publish an annual report on the exercise of their functions. We are sympathetic to the calls made for industry to be required to provide alcohol sales data to Licensing Boards to help inform local licensing policies and decisions. The minimum unit pricing evaluation includes a study which is analysing licensing data. We will be interested to see findings from this work, because access to good quality data on licensing is important both for local areas and to inform the national picture.

55 *Op. cit.*, http://www.healthscotland.scot/publications/mesas-final-report

56 *An evaluation of the implementation of, and compliance with, the objectives of the Licensing (Scotland) Act 2005*, http://www.healthscotland.com/documents/21321.aspx

57 *Op. cit.*, http://www.legislation.gov.uk/asp/2015/10/contents

Updating statutory guidance

56. With the changes made following the 2015 Act, the necessary toolkit is now in place to allow local Licensing Boards to take decisions informed by public health drivers. The statutory guidance which accompanies the Licensing (Scotland) Act 2005 does not now reflect the current legislative position, so we are updating this guidance and will consult on its content.

ACTION 5: we will update the statutory guidance on the Licensing (Scotland) Act 2005 to provide clarity for Licensing Boards on implementing the five licensing objectives, including the public health objective, and the overprovision statement. A full public consultation will be held in 2019.

57. The Scottish Government is keen to observe the impacts of the new licensing policy statements in 2018. We will keep the licensing system under review to ensure Licensing Boards have the tools they need to take health harms into account when making decisions about their local areas. We recognise that the availability of alcohol within our communities has a considerable impact on work to help tackle inequalities.

ACTION 6: we will keep the licensing system under review to ensure it can deliver for public health, commissioning research as necessary. Once new Licensing Policy Statements have bedded-in, from 2019 we will revisit the findings of the 2013 MESAS study *An evaluation of the implementation of, and compliance with, the objectives of the Licensing (Scotland) Act 2005*, focusing on evaluating the operational effectiveness of the public health licensing objective in light of the changes made since to alcohol licensing.

Empowering communities

58. Local communities have an important voice in local licensing decisions. However, the regime itself is not easily understood, formal in many instances and can be seen as bureaucratic.

59. The Scottish Government funds Alcohol Focus Scotland to work on the ground with local communities to try to improve their interaction with the licensing system and to support a range of partners to engage effectively. Alcohol Focus Scotland has produced the *Alcohol Licensing in Your Community* toolkit[58], which provides practical advice for people who want to have a say about how alcohol affects their community. This is part of our wider funding for Alcohol Focus Scotland to help improve awareness of the licensing system and to support an availability work programme.

58 *Alcohol Licensing in your Community: How you can get involved*, http://www.alcohol-focus-scotland.org.uk/media/133477/Community-licensing-toolkit.pdf

This will include analysing the new Statements of Licensing Policy and Annual Functions Reports in 2019.

60. The Community Empowerment (Scotland) Act 2015[59] requires Community Planning Partnerships (CPPs) to produce Local Outcomes Improvement Plans (LOIPs). CPPs have a key role to play in tackling the social determinants of health. This provides a further opportunity for local areas to consider the impacts of alcohol and work towards the changes that they wish to see.

61. The Local Government and Communities Committee of the Scottish Parliament held an evidence session about local community engagement in licensing on 23 May 2018[60]. We will be ready to consider the Committee's views during any future consideration it may give the matter.

ACTION 7: we will continue to support Alcohol Focus Scotland to build awareness at a local level so that local communities, Health and Social Care Partnerships and Alcohol and Drug Partnerships can be effective in influencing the licensing regime.

Voluntary measures on availability

62. Alongside the licensing system, the Scottish Government also works with the alcohol industry on voluntary measures from time to time. For example, we have worked jointly to increase availability and awareness of the 125ml wine measure in the on-trade. Proactive promotion of 125ml measures is now being integrated into the Best Bar None scheme, which promotes good practice and safer drinking environments in the on-trade.

63. We also welcome industry initiatives which seek to prevent underage drinking, such as the *You're Asking For It* proxy purchase campaign, which began in Lanarkshire and is now expanding to many other areas across Scotland.

ACTION 8: we will work with the alcohol industry on projects which can impact meaningfully on reducing alcohol harms; but not on health policy development, on health messaging campaigns or on provision of education in schools and beyond the school setting.

59 *Community Empowerment (Scotland) Act 2015*, http://www.legislation.gov.uk/asp/2015/6/contents

60 *Local Government and Communities Committee, Alcohol Licensing, 23 May 2018, Official Report*, http://www.parliament.scot/parliamentarybusiness/report.aspx?r=11557

Positive attitudes, positive choices

Attractiveness: marketing and advertising

Alcohol marketing: children and young people

64. Restricting alcohol advertising is one of the three WHO 'best buys' to reduce alcohol consumption and related harms across the whole population. Restrictions on alcohol marketing ensure that vulnerable groups, such as children and young people, and those recovering from alcohol dependence, are specifically protected from the impacts of alcohol marketing. There is a compelling case for taking an approach to alcohol marketing which protects children. We know that, in Scotland, children as young as ten can readily identify alcohol brands, logos and characters from alcohol advertising[61]. Evidence shows that alcohol advertising seen by children and young people is associated with both the initiation of drinking and with heavy drinking. Reviews of longitudinal and cohort studies[62] observing children provide the strongest evidence for the impact on alcohol consumption of alcohol marketing. These studies report consistently that exposure to alcohol marketing is associated with an increased likelihood that children will start to drink or – if they already drink – drink greater quantities. This evidence supports policies that seek to protect children from exposure to alcohol marketing.

65. We know that children still spend large amounts of time watching television[63]. A recent study demonstrates that UK prime time television remains a constant source of exposure to alcohol imagery for young people and that commercial adverts for alcohol are commonly aired before the 9pm watershed[64]. In the UK, children can see alcohol adverts in cinemas before films which are certified as suitable for children (i.e. below certificate 18+), despite alcohol being an age-restricted product.

66. Unfortunately, powers over broadcast advertising are reserved to the UK Parliament. We have urged the UK Government to develop an approach which protects children and young people from exposure to alcohol advertising, but the changes we would like to see have not been delivered. The UK Government has committed to consulting on introducing a 9pm watershed on television advertising of products high in fat, sugar and salt

61 *Children's recognition of alcohol marketing*, http://www.drugs.ie/resourcesfiles/ResearchDocs/Europe/Research/2015/ChildrensRecognitionOfAlcoholMarketingBriefing.pdf

62 Anderson P, de Bruijn A, Angus K, Gordon R, Hastings G. *Impact of alcohol advertising and media exposure on adolescent alcohol use: a systematic review of longitudinal studies,* Alcohol & Alcoholism 2009; Vol. 44 pp. 229-243 ; Smith L A, Foxcroft D R. *The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young people: systematic review of prospective cohort studies*. BMC Public Health 2009; 9:51; Jernigan D, Noel J, Landon J, Thornton N, Lobstein T. *Alcohol marketing and youth alcohol consumption: a systematic review of longitudinal studies published since 2008.* Addiction 2016; DOI: 10.11111/ add.13591

63 *Ofcom Children and Parents: Media Use and Attitudes Report, 2017*, https://www.ofcom.org.uk/data/assets/pdf_file/0020/108182/children-parents-media-use-attitudes-2017.pdf

64 *A Content Analysis of Alcohol Content in UK Television, Oxford Academic Journal of Public Health, 2018*, https://academic.oup.com/jpubhealth/advance-article/doi/10.1093/pubmed/fdy142/5078451

as part of *Childhood Obesity: a plan for action Chapter 2*[65]. We would ask that our children and young people are protected from alcohol advertising in the same manner. We will continue to press for the changes we believe are required and, if the UK Government remains unwilling to act, we will press for the powers to be devolved to the Scottish Parliament.

ACTION 9: we will press the UK Government to protect children and young people from exposure to alcohol marketing on television before the 9pm watershed and in cinemas – or else devolve the powers so the Scottish Parliament can act.

67. There is certainly scope to take action to protect children and young people within the powers currently available to the Scottish Parliament. In the UK at present, there are industry-run self-regulatory codes which seek to limit children's exposure to alcohol marketing and advertising across various media. These work on the basis of preventing advertising placement where 25% of the audience of, for example, a publication or event comprises children.

68. These codes still permit large numbers of children and young people to be exposed to alcohol marketing, and they do not apply to public spaces where exposure is entirely indiscriminate, because in public spaces children are considered to comprise less than 25% of the overall population. While it has been welcome that some alcohol businesses have undertaken not to place marketing and advertising within certain distances of schools, the reality is that children and young people travel around their neighbourhoods, villages, towns and cities for many reasons. As they do so, they are exposed to alcohol marketing and advertising in public spaces.

69. Everyday alcohol has become the norm in Scotland, and that is true of all kinds of settings where children and young people are present. We have more thinking to do in Scotland, on how we can all contribute to giving children alcohol-free spaces to grow up, and to thrive, free from alcohol-related harms, and pressures in childhood. Part of this could include further promoting alcohol-free events such as mindful drinking festivals and non-alcohol events at colleges and universities. Consultation and engagement would take place on the appropriateness of a range of potential measures.

70. While public spaces seem an obvious starting point for reducing children and young people's exposure to alcohol marketing, we are mindful of the vast range of marketing channels they experience, including digital and online routes.

71. We recognise that the marketing landscape has undergone substantial change due to the increasing prevalence of the internet and the frequency of social media usage. This has presented new more interactive methods that advertisers can utilise, such as games, rewards and

65 *Childhood Obesity: a plan for action* Chapter 2, UK Government, 2018, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/718903/childhood-obesity-a-plan-for-action-chapter-2.pdf

giveaways, peer to peer sharing and personalised messaging. Our young people tend to spend increasingly more time online and are far more likely to be active on social media specifically. In order to protect them from this harmful exposure, we will ensure that we are taking account of current international policy approaches and will consider the potential for digital marketing being an area where restrictions may be required, and what sort of measures or restrictions would be appropriate.

Good practice

72. There are many examples of good practice in other European countries. Norway has a long standing comprehensive ban on alcohol advertising, whilst Finland and Estonia have recently made bold and innovative progress on regulating digital advertising. Most recently, Ireland has taken progressive steps towards restricting alcohol marketing, passing the Public Health (Alcohol) Act 2018[66] in October 2018.

73. We hear the calls for restriction of alcohol sponsorship of events, and sporting activities in particular. The Scottish Women's Football Team is an exemplar here, taking a stance against alcohol sponsorship. We applaud the Team for the stance they have taken and would encourage other sports teams to diversify their sponsorship away from the alcohol industry. The Irish legislation is another good example of addressing alcohol promotion within the sporting world, including sports areas within its outdoor advertising ban.

ACTION 10: we will consult and engage on the appropriateness of a range of potential measures, including mandatory restrictions on alcohol marketing, as recommended by the World Health Organization, to protect children and young people from alcohol marketing in Scotland.

Education, awareness raising and behaviour change

Alcohol and Drug Education Programmes

Education in schools

74. Our approach to providing substance use education is the same for both alcohol and drugs. We must give the next generation the tools they need to make healthy choices about substances. Through the Health and Wellbeing component of *Curriculum for Excellence*[67], Scottish schools aim to provide helpful, engaging information about substances, and, crucially, empower children and young people to make positive decisions about their health. It is also important that education includes the impact of alcohol on sexual risk taking, and focuses on the need to be confident that consent has been given for any sexual activity[68].

66 https://www.oireachtas.ie/en/bills/bill/2015/120/

67 *School curriculum and qualifications*, http://www.gov.scot/Topics/Education/Schools/curriculum

68 *The Sexual Offences (Scotland) Act 2009* specifically recognises that consent for sexual activity cannot be given where a person is incapable due to the effect of alcohol or any other substance to do so, https://www.legislation.gov.uk/asp/2009/9/contents

75. Health and wellbeing indicators have an important place within the *National Improvement Framework for Scottish Education*[69], and we will continue to look at how we can best emphasise their importance going forwards. Following work with stakeholders, in 2017 Education Scotland published health and wellbeing benchmarks for schools, including substances[70]. These benchmarks set out clear statements about what learners need to know and be able to do to achieve a particular level of learning. More recently, Education Scotland has published a report on the findings of a thematic inspection carried out as part of the review of Personal and Social Education (PSE) in schools[71]. This initially indicates improvements could be made in providing PSE within *Curriculum for Excellence*.

76. Around 68% of 15 year olds say they have received lessons or discussions in class on alcohol[72]. While this is encouraging, there is still room for improvements to increase the number of 15 year olds that have access to a learning experience which is based on best practice.

77. The Scottish Government is committed to taking steps to ensure that Initial Teacher Education (ITE) prepares students to enter the profession with consistently well-developed skills to teach areas such as literacy, numeracy and health and wellbeing. The initial phase of this work is being taken forward through the development of a new self-evaluation framework to support universities to evaluate their ITE. The General Teaching Council for Scotland is also reviewing its Professional Standards for Registration to work as a teacher in Scotland, which includes reference to the requirement for teachers to understand and apply the curriculum as it applies to health and wellbeing.

78. In the last few years, we've seen some encouraging trends regarding alcohol use among young people. In 2015, SALSUS[73] (Scottish Schools Adolescent Lifestyle and Substance Use Survey) reported the proportion of 13 and 15 year olds who drank alcohol in the last week was the lowest since the survey series began monitoring drinking behaviour in 1990 (4% of 13 year olds and 17% of 15 year olds). However, we know there is more to be done and we are taking forward a range of activities to make further progress.

69 *2018 National Improvement Framework and Improvement Plan*, https://beta.gov.scot/publications/2018-national-improvement-framework-improvement-plan/

70 *Education Scotland, Benchmarks: Personal and Social Education*, https://education.gov.scot/improvement/documents/hwbpersonalsocial%20educationbenchmarkspdf.pdf

71 *Education Scotland, Thematic inspection of personal and social education/health and wellbeing in Scotland's schools and early learning and childcare settings, August 2018*, p24, https://education.gov.scot/Documents/EducationScotlandPSEReportAug2018_.pdf

72 *Op. cit.*, http://www.gov.scot/Topics/Research/by-topic/health-community-care/social-research/SALSUS

73 *Ibid*

79. We have continued to take forward substance use education work in Scottish schools through *Curriculum for Excellence* and the *Choices for Life*[74] programme. In these, children and young people learn about a variety of substances including alcohol, medicines, tobacco, solvents and other drugs and explore the impact risk-taking behaviour has on life choices and health. *Choices for Life* is primarily a schools-based education programme on alcohol, drugs and tobacco, funded by the Scottish Government and delivered in partnership with Police Scotland and Young Scot. The programme includes an information website for young people and their parents, teachers and carers.

80. In December 2016, the Scottish Government published a literature review on '*What works' in drug education and prevention*[75]. The key findings are consistent with other reviews of the evidence of effectiveness of substance use prevention programmes. The publication acknowledged that some popular and well-meaning approaches, for example using lived experience testimonials, are associated with no, or negative, preventative outcomes. Stand-alone, mass media campaigns are also considered ineffective. The literature review found that children and young people benefit from prevention models that are delivered in a supportive environment, which use non-fear arousal techniques, and which provide the freedom to learn about alcohol and drug use within a broader conversation about choice and risk, rather than standalone input.

81. In addition, for those most at risk from harm, targeted prevention interventions are most effective, alongside a whole school approach. These are most effective in interactive structured sessions, with booster sessions over several years, and should be of sufficient intensity and duration to influence change. Approaches that combine social and personal development and resistance skills with normative education techniques have also been shown to be effective.

82. The research highlighted increasing interest in peer led models and the use of social influence methodology. This is supported by research conducted in partnership with the Scottish Youth Parliament, and has also shown that the tone of substance use education should be neutral, based on fact and that young people should be involved in the design, development, and dissemination of the information as young people are more likely to respond better to advice and information from their peers[76]. This has provided an informed basis for our overall approach to prevention activity both in and outwith schools.

74 *Choices for Life*, http://young.scot/choices-for-life/

75 Warren, F(2016) *'What works' in drug education and prevention?* Scottish Government, Edinburgh, http://www.gov.scot/Publications/2016/12/4388

76 *Tackling New Psychoactive Substances*, https://www.syp.org.uk/tackling_new_psychoactive_substances

83. Following the *What Works* report a rapid review mapping exercise[77], conducted in 2017, concluded that the quality of substance use education and local practice in education had to be made more consistent throughout Scotland. To help achieve better consistency the Scottish Government has produced a guidance summary of key findings[78] to support commissioners and practitioners in developing education and prevention strategies in line with the evidence.

84. Also following the *What Works* report, the Scottish Government commissioned a review of *Choices for Life* and found that although the programme engaged with large numbers of young people, there were variations across Scotland and inconsistencies in both the delivery, setting and frequency of sessions. It was observed that there was some evidence of good practice, although ineffective approaches remained, alongside a lack of structured delivery guidance or lesson plans.

85. Taking all of this into account, the Scottish Government considers a new approach is required to universal substance use education for young people in schools.

ACTION 11: we will revise and improve the programme of substance use education in schools to ensure it is good quality, impactful and in line with best practice.

Broadening our universal approach

86. Our education system provides a window of opportunity to equip our children and young people with the life skills to make informed choices relating to their health and wellbeing. However we recognise that, for some, traditional education methods are not working or not appropriate and these children and young people can be more at risk. We need to go beyond classroom based interventions to ensure we provide a universal approach to alcohol and drug education that is delivered in different and innovative ways. This includes, but is not limited to, considering Youth Groups, Community Learning and Development, looked after and accommodated children, excluded children and those in touch with services.

ACTION 12: we will develop education-based, person-centred approaches that are delivered in line with evidence-based practice to aim to reach all of our children and young people including those not present in traditional settings, such as Youth Groups, Community Learning and Development, looked after and accommodated children, excluded children and those in touch with services.

77 *Substance Misuse Education and Prevention Interventions in Scotland: Rapid Review Mapping Exercise*, https://www2.gov.scot/Resource/0052/00528562.pdf

78 *What works? In drug education and prevention, Summary of findings – what works?*, https://www.gov.scot/Resource/0052/00528567.pdf

Online and outreach education and information

87. The dynamic growth in digital platforms used by young people present new challenges and opportunities in substance use education and prevention. They are increasingly the route through which young people obtain information and misinformation, about alcohol and drugs, as well as a growing and constantly evolving supply route.

88. We have a responsibility to our young people to provide accurate and reliable information about the risks of substance use, as well as providing them with the skills and knowledge to question the information they find online and the resilience to challenge and resist misinformation and pressure through social media.

89. The *Choices for Life* programme includes an information website for young people and their parents, teachers and communities. The Scottish Government *Know the Score* website also provides advice on drugs and their risks. It is updated in partnership with Crew, a third sector drug service based in Edinburgh. The *Drinkline* website provides advice on alcohol and its risks. It is operated under contract with the Scottish Government.

ACTION 13: we will develop our current online resources to ensure they provide accurate, evidence-based, relevant and up-to-date information and advice, around alcohol and drug use; and how to access help.

Awareness raising – new national campaign

90. Awareness raising campaigns can be useful tools as part of a wider package of measures. We have, previously, taken forward a number of social marketing campaigns which have sought to empower and enable people to make informed choices about alcohol, by providing them with relevant information. We plan to develop a new campaign which promotes the messages of the UK CMOs' lower-risk drinking guidelines during 2018, and we will launch this nationwide in 2019.

91. We will ensure that national-level work can be tailored towards interventions that reflect local need, and will work with a range of national and local partners, including Health and Social Care Partnerships, Alcohol and Drugs Partnerships and third sector partners. As we work together to roll out components of our campaign work and support the ongoing delivery of health messaging at the local level, we will ensure that work is targeted in ways which can help us to reduce health inequalities.

92. We will continue to pursue opportunities to drive, and to participate in, social marketing work, collaborating with partners including the third sector. We will engage our local partners in all nationally commissioned social marketing work.

ACTION 14: we will initiate national marketing work, with partners, promoting the messages of the UK CMOs' lower-risk drinking guidelines during 2018, and we will launch this campaign nationwide in 2019.

Awareness raising – product labels

93. The health information presented on alcohol product labels and packaging is really important. This information can help consumers to make informed choices and to make positive health choices.

94. The Scottish Government's long-standing preference has been for a mandatory regime governing labeling. A level playing field, where information is provided and presented in a consistent way, would be most straightforward for consumers. However, to date, we have been supportive of the strengthened self-regulatory option within the UK, given that there has not been a consensus amongst the UK administrations in favour of legislation and that there are advantages for industry from a UK-wide approach.

95. We were supportive of the UK Government's Responsibility Deal pledge which aimed to ensure that over 80% of products on shelf will have labels with clear unit content, CMO guidelines and a warning about drinking when pregnant by December 2013. Whilst the pledge delivered improvements, results varied, the target was not wholly met, and there are no current plans for longer-term monitoring.

96. Crucially, it is important that this information is on-pack, where the consumer will clearly see it at the point of purchase, rather than online where it is far less accessible. Consumers are increasingly coming to expect this kind of information. It is right that we should expect the same degree of information provision as we do in the food sector.

97. Some Scottish and UK alcohol producers are now rolling out the new CMO lower-risk drinking guidelines[79] on product labels – namely C&C Group, which makes products like Tennents and Magners; Whyte & Mackay and supermarket own brand products. We commend these producers for taking the initiative and doing the right thing. We are clear that all alcohol producers should update to the revised CMO guidelines, placed physically on product labels and packaging. This should be accompanied by advice about not drinking in pregnancy, as set out on the Scottish Government website[80]. The UK Government has set a deadline for industry of September 2019 to update all labels with the revised guidelines.

98. Progress towards all product labels displaying the right information – including the CMO guidelines – has simply not been good enough. Too

79 *Guidance: Alcohol consumption: advice on low risk drinking*, https://www.gov.uk/government/publications/alcohol-consumption-advice-on-low-risk-drinking

80 https://news.gov.scot/news/new-alcohol-guidelines

many alcohol producers are finding ways to avoid placing the updated CMO guidelines on labels. Instead, they should be taking a responsible approach to informing consumers on physical labels, at the point of purchase, under their corporate social responsibility policies, *as the majority did in the past before the guidelines were updated*. For these reasons, while we would prefer to regulate on a UK-wide basis, if insufficient progress is made by the time of the UK Government's deadline of September 2019, the Scottish Government will be prepared to consider pursuing a mandatory approach in Scotland.

ACTION 15: we will press alcohol producers to place health information on physical product and packaging labels – and will be prepared to consider pursuing a mandatory approach in Scotland if the UK Government's deadline of September 2019 is not met.

99. We are supportive of voluntary initiatives from the industry to provide clear nutritional information on individual product labels and packaging, given many people do not realise the calorie content of alcoholic drinks.

100. In its March 2017 report[81], the European Commission recommended a self-regulatory approach to providing nutrition information on alcohol product labelling, suggesting a one-year time-frame for implementation. The European Commission is currently considering the alcohol industry's responses, which varied in approach. We will consider our approach further once the Commission's response is available.

Awareness raising – low-alcohol product labels

101. The Food Labelling Regulations (FLR) 1996 (as amended) set out in law the rules for describing alcoholic drinks containing 1.2% alcohol by volume (ABV) or less. These rules on the use of low alcohol descriptors aimed to protect and inform consumers. The FLRs were mostly revoked in December 2014. However, a sunset clause in Schedule 4 of the Food Information (Scotland) Regulations 2014 (as amended) provides for the continued use of the national measures for low alcohol descriptors contained in FLR. These remaining national measures are due to be revoked on 13 December 2018.

102. The four low alcohol terms/claims on drinks can be summarised as follows:

- Low alcohol – product must be 1.2 % ABV or lower;
- Non-alcoholic – cannot be used in conjunction with a name associated with an alcoholic drink except for communion or sacramental wine;
- Alcohol-free – product must be 0.05 % ABV or lower; and
- Dealcoholised – product must be 0.5 % ABV or lower.

81 http://europa.eu/rapid/press-release_IP-17-551_en.htm

103. Food Standards Scotland (FSS) has consulted Scottish stakeholders for their views on the future of these descriptors[82]. FSS will consider the responses and look at the relevance of these descriptors, their ease of being understood by consumers and potential methods of retaining these (or similar) terms after December 2018.

Awareness raising – relationship between alcohol and cancer

104. The relationship between alcohol consumption and seven types of cancer has been further established in recent years. The Committee on Carcinogenicity[83] concluded in 2016 that '*drinking alcohol increased the risk of getting cancers of the mouth and throat, voice box, gullet, large bowel, liver, of breast cancer in women and probably also cancer of the pancreas*'. These risks start from any level of regular drinking and then rise with the amounts of alcohol being drunk.

105. As noted in the Introduction section, the *Hospital admissions, deaths and overall burden of disease attributable to alcohol consumption in Scotland* study[84] found that, in 2015, there were 3,705 alcohol-attributable deaths, 28% of which were due to cancer. NHS Health Scotland will re-run this valuable analysis at regular intervals, to ensure we have the best intelligence available on the impact that drinking alcohol has on Scotland's incidence of cancer.

106. Scottish Health Action on Alcohol Problems (SHAAP) [85] produced a valuable guide on alcohol and cancer in 2013, which sets out information on the relative risks of alcohol consumption and opportunities for healthcare professionals to offer advice on those risks.

107. We recognise the importance of raising awareness of the very serious health risks that drinking poses; that is why our Cancer Strategy *Beating Cancer: Ambition and Action*[86], published in March 2016, highlighted alcohol risks and the importance of measures to encourage and support people to reduce their risk of cancer by living healthier lives.

108. Through the implementation and development of our public health actions on alcohol, we will work to change this perception and shift cultural attitudes towards alcohol as a cancer risk factor, as well as doing the same on smoking, poor diet and physical inactivity.

82 *Consultation on the national provisions in the Food Labelling Regulations 1996 regarding reserved descriptions for alcohol, cheese and cream*, https://consult.foodstandards.gov.scot/regulatory-policy/consultation-on-the-national-provisions-in-the-foo

83 *Guidance: Consumption of alcoholic beverages and risk of cancer*, https://www.gov.uk/government/publications/consumption-of-alcoholic-beverages-and-risk-of-cancer

84 *Op. cit.*, http://www.scotpho.org.uk/media/1597/scotpho180201-bod-alcohol-scotland.pdf

85 *Scottish Health Action on Alcohol Problems (SHAAP), Alcohol and Cancer Risks: A Guide for Health Professionals, 2013*, http://www.shaap.org.uk/images/shaap_cancer_risks_booklet.pdf

86 *Beating Cancer: Ambition and Action*, http://www.gov.scot/Publications/2016/03/9784

ACTION 16: we will work with partners to raise awareness of the links between alcohol consumption and cancer.

Behaviour change – Alcohol Brief Interventions (ABIs)

109. An Alcohol Brief Intervention (ABI)[87] is a short, structured conversation about alcohol consumption with an individual, that seeks in a non-confrontational way to motivate and support them to think about or plan a change in their drinking behaviour in order to reduce their consumption and/or their risk of harm.

110. ABIs are a Local Delivery Plan Standard[88] and are delivered across a range of settings. At least 80% of delivery is through priority settings: Accident and Emergency, Primary Care and Antenatal. The remaining 20% is delivered through wider settings which include but are not limited to: Criminal Justice, Keep Well service, Pharmacy, Dentistry and community services.

111. ABIs are an evidence-based and cost effective intervention and, since the beginning of the programme in 2008, we have seen over 834,000 interventions delivered across a range of settings.

112. Quality of delivery and impact are paramount. We have supported the expansion of the ABI evidence base and encouraged appropriate planning and delivery of ABIs in wider settings. We also support a focus on communities where deprivation is greatest. The evidence of effectiveness is strongest in primary care settings, and General Practice services in lower income areas have a crucial role to play in ABI delivery. Other settings can play a role too, and the expansion of ABI delivery to 20% in wider settings also includes Pharmacy, Dentistry and wider community services, facilitating a range of ABI routes into lower income communities.

113. Reducing health inequalities is a key priority and we recognise there is a link between excessive alcohol consumption and offending behaviour. We are encouraged to see a range of evidenced and informed frameworks and guidance, which includes substance use and ABI Delivery in Police Custody, Prison and Community Justice settings which creates opportunities for detection and interventions such as ABIs and signposting into treatment and recovery services.

ACTION 17: we will review evidence on current delivery of Alcohol Brief Interventions to ensure they are being carried out in the most effective manner, look at how they are working in primary care settings – where the evidence is strongest – and whether there would be benefit in increasing the settings in which they are delivered.

87 *Alcohol Brief Interventions resources*, http://www.healthscotland.scot/publications/alcohol-brief-intervention-resources
88 *Op. cit.*, http://www.gov.scot/About/Performance/scotPerforms/NHSScotlandperformance/ABI-LDP

Supporting families and communities

114. We are also publishing a new overarching strategy which brings together all our support for individuals, for families and for communities affected by alcohol and drugs. This means that much of the '*Supporting Families and Communities*' theme of the original 2009 *Alcohol Framework* is developed within that new overarching strategy, including all of our support for Health and Social Care Partnerships, Alcohol and Drugs Partnerships, justice partners, and a range of third sector organisations engaged in hands-on support for individuals, children and families. This includes support for Scottish Families Affected by Alcohol and Drugs[89], which supports adults aged over 16 years; provides a free national Helpline for anyone concerned about someone else's alcohol or drug use; provides workforce development support for alcohol and drugs professionals; and runs an asset-based community development programme.

Fetal Alcohol Spectrum Disorder – prevention, diagnosis and support

115. Fetal Alcohol Spectrum Disorder (FASD) is the leading known worldwide preventable cause of neurodevelopmental disorder, together with learning and behavioural difficulties, caused by maternal use of alcohol during pregnancy. It potentially has lifelong implications and not only affects babies and children but also young people and adults, and their families who will be living with the impact of the condition. Current prevalence data suggests at least 2% of the population[90] could be affected. Considerable work has been carried out over recent years in this area and, since 2012, the CMO message in Scotland has been that avoiding alcohol when trying to conceive and while pregnant is the safest option for the developing baby. This has now been endorsed by the other UK CMOs and reflected in the revised lower-risk drinking guidelines (published in 2016). Alcohol Brief Intervention methodology is being used to screen for alcohol use during pregnancy and referral for help to reduce intake is widely available.

116. We have undertaken a range of measures to reduce the harm caused by alcohol consumption in pregnancy across Scotland, through increased awareness of the risks and national training and awareness for professionals across multi-agency sectors and will continue to support local areas to develop appropriate diagnostic and treatment management provision.

89 *Scottish Families Affected by Alcohol and Drugs*, http://www.sfad.org.uk

90 *Global Prevalence of Fetal Alcohol Spectrum Disorder Among Children and Youth A Systematic Review and Meta-analysis*, Shannon Lange, MPH; Charlotte Probst, MSc; Gerrit Gmel, MSc; Jürgen Rehm, PhD; Larry Burd, PhD; Svetlana Popova, PhD JAMA Pediatr. 2017 Oct 1;171(10):948-956. doi: 10.1001/jamapediatrics.2017.1919 https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30021-9/fulltext

117. The Ayrshire FASD diagnostic pilot has been a really good example of positive work in one local area[91]. Rather than establishing FASD specific services and systems, our aim is to support the current system to be much more responsive to the needs of individuals, families and communities affected by FASD, through integrating FASD diagnosis and support through overarching neurodevelopmental pathways. We welcome the new SIGN guideline on FASD screening, identification and diagnosis which will be available shortly.

118. We aim to improve support for individuals and caregivers to give all children the best start in life and throughout their life course. We will continue to build on our progress to date and move to implement the next phase of actions which will include:

- Continuing to raise awareness and focus on prevention through national and local strategies including preconception messaging;
- Improving early identification, assessment and diagnosis through upskilling of all practitioners, professionals and partners working with women, children and families within 3 years;
- Working to set up a third sector hub that will focus on both preventing instances of FASD arising in the first place and supporting families following diagnosis;
- Standardising education and training provision and input to all health and social care professionals, education, third sector and across the youth and criminal justice system within 3 years;
- Improving recording of accurate alcohol use during pregnancy and supporting appropriate information sharing to aid diagnosis at any stage within 3 years;
- Improving surveillance through national and local data collection systems and methods;
- Commissioning research to determine the most effective approaches to prevention, along with initiatives to establish overall FASD prevalence, neurodevelopmental profiles, outcomes and the impact of early identification and support; and
- Including parents/carers, children and young people affected by FASD, along with front-line staff to improve their experience of multi-agency assessment and ongoing support to better meet their needs.

ACTION 18: we will continue to prevent and reduce the harm caused by alcohol consumption in pregnancy through increased awareness of the risks, increased awareness of, and improved diagnosis and support for, Fetal Alcohol Spectrum Disorder.

91 *NHS Ayrshire & Arran Fetal Alcohol Spectrum Disorder diagnostic service, Information for you*, https://www.nhsaaa.net/media/1581/20161109fasd.pdf

Positive Alternatives and Safer Communities

119. The link between alcohol consumption and the risk of injury is well documented[92]. Participatory and diversionary activities to engage, direct and support people into alternative lifestyles can make a significant impact in reducing the risks associated with and addressing higher-risk alcohol use.

CashBack for Communities

120. Over the last 10 years, the *Cashback for Communities*[93] programme has redirected the funds recovered from criminals under the Proceeds of the Crime Act back into our communities. An investment of over £92 million has delivered nearly two million activities and opportunities for young people across all 32 local authorities in Scotland. The *Cashback* programme supports young people to expand their horizons and increase the opportunities they have to develop their interests and skills. Working through partnerships with Scottish sporting, arts and business associations, the programme provides positive alternative activities for young people in our communities. The *Cashback* programme is changing lives for the better, and is having a direct impact on helping to steer vulnerable young people away from alcohol and drugs.

Reducing Unintentional Harm

121. Through our ambition to build safer communities across Scotland, we continue to work with partners to reduce unintentional harm, including: Police Scotland, Scottish Fire and Rescue Service, Royal Society for the Prevention of Accidents (ROSPA), Child Accident Prevention Trust (CAPT), the Scottish Community Safety Network, as well as COSLA and the local partnership networks. Through this ambition, we collectively share messages and support initiatives and approaches that focus on reducing unintentional harm. We know that families living in deprived areas are more likely to experience unintentional harm[94], which can be influenced by higher-risk alcohol use and problematic drug use. Our partnership work continues to try to address this inequality gap.

122. Over the last five years, we have provided ROSPA with almost £600,000 in funding to undertake work around home and community safety as well as supporting projects that help improve child safety. There have also been specific initiatives in the NHS Greater Glasgow and Clyde area. We also support the Child Accident Prevention Trust (CAPT) to deliver community education campaigns raising awareness of serious childhood accidents and how to prevent them.

92 See for example: https://www.scotpho.org.uk/media/1597/scotpho180201-bod-alcohol-scotland.pdf; *Alcohol and Injury in Emergency Departments: Summary of the Report from the WHO Collaborative Study on Alcohol and Injuries,* http://www.who.int/substance_abuse/publications/alcohol_injury_summary.pdf

93 *Cashback for Communities Annual Report 2016/17*, http://cashbackforcommunities.org/

94 *Strategic Assessment of Unintentional Harm, Summary Report* highlights that alcohol consumption is a contributory factor associated with unintentional harm in the home, and the higher prevalence of unintentional harm in more deprived areas may be due to higher levels of drug and alcohol misuse, http://www.bsc.scot/uploads/1/9/0/5/19054171/building_safer_communities_phase_2_-_national_strategic_assessment_for_unintentional_harm__summary_report.pdf

123. Looking ahead, we are working in partnership to develop and deliver an unintentional harm online hub that will gather and share examples of local activity that is directly reducing unintentional harm. This online tool is due to be launched in 2019 and will be available to partnerships in the first instance. In recognising the direct link between the impact of alcohol on keeping safe, the hub will provide a number of examples that can support healthier and safer living.

Supporting Community Capacity – Inspiring Scotland's Link Up programme

124. Inspiring Scotland's *Link Up*[95] programme is active in nine communities across Scotland that are experiencing significant inequalities. In adopting a people-centred approach to build the capacity of the most disadvantaged and vulnerable people and communities, it provides one to one support to help people become involved and to achieve sustainable change in their lives. Through increasing social interaction and connections, building trust and positive relationships within the local area and giving individuals the support, confidence and skills to choose alternative life-course, the programme has supported those most vulnerable and has brought a positive impact on reducing the harm from drugs and alcohol use.

ACTION 19: in recognising the link between community safety and alcohol, we will continue to work with partners to build awareness and resilience to both reduce harm and improve life choices.

Preventing alcohol-related violence and crime

Violent crime, alcohol and deprivation

125. WHO is clear that alcohol and violence are linked in a number of ways, with a strong association between alcohol consumption and an individual's risk of becoming a perpetrator or victim of violence. Our 2017 *Justice in Scotland: Vision and Priorities*[96] reflects this relationship.

126. The *Scottish Crime and Justice Survey* (SCJS)[97] collects data on whether victims believe offenders were under the influence of alcohol at the time of an offence. It indicates that offenders were believed to be under the influence of alcohol in just over two-fifths (42%) of violent crime incidents in 2016/17, where victims were able to say something about the offender, down from 63% in 2008/09 and 56% in 2014/15. However, it will be important to monitor these results in the future, as these findings are based only on incidents where the respondent could say something about the offender(s), which fell from 98% of incidents in 2014/15 to 87% in 2016/17.

95 https://www.inspiringscotland.org.uk/what-we-do/thematic-funds/link-up
96 *Justice in Scotland: vision and priorities*, https://beta.gov.scot/publications/justice-scotland-vision-priorities/
97 *Scottish Crime and Justice Survey*, http://www.gov.scot/Topics/Statistics/Browse/Crime-Justice/crime-and-justice-survey

127. Nevertheless, these findings coupled with a decline in the number of SCJS violent crime incidents said to have taken place in and around pubs and bars may suggest that alcohol is decreasing in prominence as a factor in violent crime overall – although it remains a factor in a sizeable proportion of incidents.

128. The 2016/17 SCJS also found that the risk of being a victim of violent crime was higher for adults living in the 15% most deprived areas in Scotland, compared to those living in the rest of Scotland, a consistent finding in recent years.

Connecting health and justice outcomes

129. Violence prevention is an important part of making Scotland healthier and tackling inequalities. For national and local policy makers and practitioners, integration across Health and Justice approaches and systems is crucial to reducing violence, reducing crime and reducing reoffending. We have comprehensive strategies and initiatives to reduce and prevent violence, including alcohol-related violence. However, we must also recognise that the underlying causes of health inequalities, and of crime including violence, are often socio-economic. It is therefore paramount that we use all levers at our disposal to tackle social injustice across our communities.

Getting It Right for Every Child

130. As previously mentioned, prevention is at the core of our approach to *Getting It Right For Every Child* (GIRFEC)[98]. GIRFEC focuses on improving outcomes and supporting the wellbeing of our children and young people, by offering the right help at the right time from the right people. This includes preventing higher-risk alcohol use and a preventative approach to offending involving children and young people.

Our Youth Justice Strategy

131. The youth justice strategy *Preventing Offending: Getting it Right for Children and Young People*[99] provides a strong focus on advancing the whole system approach and improving life chances, and helps puts GIRFEC into practice. Alcohol and substance use interventions are a common feature of Early Effective Intervention and diversion programmes, and improving health and wellbeing is a key priority under the life chances theme. Targeted support is also being provided through the Children, Young People and Families Early Intervention Fund, which funds Scottish Families Affected by Alcohol and Drugs[100], an organisation which supports those affected by higher-risk alcohol use or problematic drug use of a family member.

98 *Op cit.*, http://www.gov.scot/Topics/People/Young-People/gettingitright
99 *Preventing Offending: getting it right for children and young people*, http://www.gov.scot/Publications/2015/06/2244
100 *Op cit.*, http://www.sfad.org.uk

Scottish Violence Reduction Unit

132. We are continuing to invest in the Scottish Violence Reduction Unit (SVRU)[101], which promotes a public health approach to violence prevention. The SVRU works directly with communities to foster cohesion and reduce violence by helping them make the changes that they want, to empower them to make decisions and take responsibility for their environment and community.

Mentors in Violence Prevention

133. We are continuing to fund the delivery of *Mentors in Violence Prevention* (MVP) programme[102] across schools in Scotland. This is a peer education programme that gives young people the chance to explore and challenge the attitudes, beliefs and cultural norms that underpin gender-based violence, bullying and other forms of violence. It addresses a range of behaviours including name-calling, sexting, controlling behaviour and harassment. It includes issues around alcohol and consent and uses a 'bystander' approach where individuals are not looked on as potential victims or perpetrators but as empowered and active bystanders with the ability to support and challenge their peers in a safe way.

Medics Against Violence

134. We support the work of *Medics Against Violence* (MAV)[103], which includes a number of senior clinicians working with the VRU in schools to raise awareness amongst young people about the consequences of violence from a medical perspective. Linked to the *Curriculum for Excellence*, alcohol forms a prominent part of the MAV input, and young people are helped to understand the effects of alcohol on their ability to assess risk, to anticipate trouble and to make sensible decisions.

Navigator

135. We have also invested in the *Navigator*[104] programme, a violence interruption intervention which is based in four Emergency Departments (Glasgow Royal Infirmary, Queen Elizabeth University Hospital Glasgow, Edinburgh Royal Infirmary and University Hospital Crosshouse, Kilmarnock) where intervention and support is tailored to the needs of the patients who present at emergency departments who have been affected by violence. This programme aims to reduce violent offending and resulting injuries, increase support for victims of violent crimes and reach patients who would ordinarily not engage with statutory services. Many of the patients *Navigator* encounters have issues with alcohol, and often the way to help those individuals

101 *Violence reduction unit*, http://www.actiononviolence.org.uk

102 *Education Scotland Mentors in Violence Prevention (MVP) – An Overview*, https://education.gov.scot/improvement/practice-exemplars/Mentors%20for%20Violence%20Prevention%20(MVP)%20-%20An%20overview

103 *Medics against violence*, http://medicsagainstviolence.co.uk

104 *Violence Reduction Unit & Medics Against Violence & NHS Health Scotland: Navigator*, http://actiononviolence.org/projects/navigator

avoid further violent encounters is to help them address their alcohol-related harms.

Braveheart Industries

136. The SVRU is also supporting abstinence based employment via *Street and Arrow*, part of Braveheart Industries, a social enterprise[105]. This model employs and mentors a number of people who have significant offending histories, providing them with support, training and opportunities to positively re-engage with society. Crucial to the delivery of the programme is the abstinence-based ethos, as many of the clients' offending histories are intrinsically linked to alcohol.

Safer environments and promoting best practice

137. We have worked with our partners to encourage safer drinking environments in the night time economy. This includes the continued delivery and development of *Best Bar None*[106] initiatives, which have been operating in Scotland since 2005, and are designed to raise the standards of licensed premises and address alcohol-related crime, anti-social behaviour and violence in the night time economy, with premises now participating in 58 towns and cities across Scotland. Currently over 400 premises have been accredited in Scotland within locally co-ordinated schemes, and most recently Edinburgh Airport joined the list of venues with accredited status.

138. *Best Bar None* follows the five high level objectives set out in the Licensing (Scotland) Act 2005: the prevention of crime and disorder; securing public safety; the prevention of public nuisance; protecting and improving public health; and the protection of children from harm. In so doing, *Best Bar None* supports a number of initiatives including '*Ask Angela*' and '*Keep Safe – I am me*' as well as messaging to encourage safe responsible drinking and wider safety.

139. Police Scotland and SVRU also regularly deliver awareness inputs to staff from the licensed trade (which also extends to security staff and taxi marshals) using the 'Bystander Approach'[107] as a creative prevention tool designed to raise awareness, challenge attitudes and open dialogue in relation to sexual violence and vulnerability. Their '*Who are you*' film focuses on the night time economy and is utilised as part of these training inputs to identify vulnerability and provide staff with the tools to prevent incidents.

Developments in technology

140. Police Scotland has invested in technology to support a preventative approach which has been developed in collaboration with partners participating in the Violence Prevention Strategy Group. In 2016, 'Innkeeper', a new National IT solution for Liquor and Civic Licensing, was introduced to be used in conjunction with a Business Intelligence Toolkit, which

105 *Violence Reduction Unit: Street & Arrow*, http://www.actiononviolence.org.uk/projects/braveheart-industries

106 *Scottish Business Resilience Centre: Best Bar None*, https://www.sbrcentre.co.uk/about-us/our-focus/best-bar-none-scotland

107 https://www.mvpstrat.com/the-bystander-approach/

is a series of products used by all local policing divisions in Scotland since April 2015.

141. These products use management information data to identify crime and incident trends in small geographical areas to allow resources to be deployed early to the right places at the right times for preventative purposes. The products are being continuously improved with new iterations being added, for example a new 'Licensing Admin' tool has been designed to specifically capture all activity at or near licensed premises, both on and off-sales, to identify issues directly related to premises and to enhance the information on Innkeeper to facilitate appropriate engagement with members of the licensed trade.

Road safety

142. We have also acted to reduce alcohol-related harm on Scotland's roads after the Scotland Act 2012 provided the Scottish Parliament with the power to set the drink drive limit in Scotland. New legislation to reduce the drink driving limit came into effect on 5 December 2014. The drink driving limit of 80mg of alcohol per 100ml of blood was lowered to 50mg of alcohol per 100 ml of blood, with equivalent changes to the limits for alcohol in breath and urine[108]. This brings Scotland into line with the majority of other European countries.

143. The *Road Safety Framework* to 2020[109] sets out our commitment to work with road safety partners to ensure that there is a steady reduction in injuries and deaths on Scotland's roads. There is clear evidence, cited in the 2010 North Report on drink and drug driving[110], that a lower drink drive limit will save lives on our roads. The reduced limit appears to be having an impact on public attitudes towards drink driving acceptability. A 2015 Yougov poll[111] found that some 82% of Scots believe that drinking any alcohol before driving is unacceptable.

ACTION 20: we will continue to work with partners to reduce alcohol-related violence and crime, through a combination of enforcing legislation, prevention work and early intervention activity.

108 *The Road Traffic Act 1988 (Prescribed Limit) (Scotland) Regulations 2014*, http://www.legislation.gov.uk/ssi/2014/328/contents/made

109 *Scotland's Road Safety Framework Purpose*, http://www.gov.scot/Publications/2009/06/05140447/1

110 *Report of the Review of Drink and Drug Driving Law*, http://webarchive.nationalarchives.gov.uk/20100921035225/http:/northreview.independent.gov.uk/docs/NorthReview-Report.pdf

111 https://beta.gov.scot/news/82-of-people-believe-that-drink-driving-is-unacceptable

Annex A

Summary of the UK Chief Medical Officers' lower-risk drinking guidelines

Impacts of alcohol

1. The impacts that alcohol can have are now well known. The health harms from regular drinking of alcohol can develop over many years. This occurs either from the repeated risk of acute harms (e.g. alcohol-related accidents) or from long-term diseases caused by alcohol, which may take ten to twenty years to develop. These illnesses include various cancers, strokes, heart disease, liver disease, and damage to the brain and nervous system.

2. Alcohol-related harm can take different forms and has the potential to affect us all. Alcohol can be a factor in both physical and mental conditions. We can be affected, either directly or indirectly, by alcohol through anti-social behaviour and violence.

3. And alcohol can impact on those around the drinker too, especially children. This can take the form of violence, accidents, child neglect, partner abuse, relationship problems, harassment, noise and criminal damage, and can happen in public spaces as well as in the home.

4. The latest evidence suggests that the net benefits to the heart from small amounts of alcohol are less than previously thought. Further, they are only applicable to a small group of the population (women over the age of 55, for whom the maximum benefit is gained when drinking around 5 units a week, with some beneficial effect up to around 14 units a week).

5. These developments are reflected in the recently updated lower risk drinking guidelines issued by the UK CMOs[112], which confirmed that risk increases in line with consumption.

The CMOs' lower-risk drinking guidelines are summarised below.

Summary of the new guidelines

6. The UK CMOs have agreed three main recommendations:
   - a weekly guideline on regular drinking
   - advice on single episodes of drinking
   - a guideline on pregnancy and drinking

For regular drinking, there is a weekly drinking guideline:

This applies to adults who drink regularly or frequently, i.e. most weeks.

7. The CMOs' guideline for both men and women is that:
   - to keep health risks from alcohol to a low level it is safest not to drink more than 14 units a week on a regular basis;
   - if you regularly drink as much as 14 units per week, it is best to spread your drinking evenly over 3 or more days. If you have one or two heavy drinking episodes a week, you increase your

112 *UK Chief Medical Officers' Low Risk Drinking Guidelines,* https://www.gov.scot/Resource/0050/00504757.pdf

risks of death from long term illnesses and from accidents and injuries;

- the risk of developing a range of health problems (including strokes as well as cancers of the mouth, throat and breast) increases the more you drink on a regular basis; and
- if you wish to cut down the amount you drink, a good way to help achieve this is to have several drink-free days each week.

For 'single occasion' drinking episodes:

This applies for drinking on any single occasion (not regular drinking, which is covered by the weekly guideline)

8. The CMOs' advice for men and women who wish to keep their short term health risks from single occasion drinking episodes to a low level is to reduce them by:
   - limiting the total amount of alcohol you drink on any single occasion;
   - drinking more slowly, drinking with food, and alternating with water; and
   - planning ahead to avoid problems e.g. by making sure you can get home safely or that you have people you trust with you.
9. The sorts of things that are more likely to happen if you don't understand and judge correctly the risks of drinking too much on a single occasion can include:
   - accidents resulting in injury (causing death in some cases)
   - misjudging risky situations, and
   - losing self-control (e.g. engaging in unprotected sex).
10. Some groups of people are likely to be affected by alcohol and should be more careful of their level of drinking on any one occasion for example those at risk of falls, those on medication which may interact with alcohol or where it may exacerbate pre-existing physical or mental health problems.
11. If you are a regular weekly drinker and you wish to keep both your short and long-term health risks from drinking low, this single episode drinking advice is also relevant for you.

On pregnancy and drinking:

12. The CMOs' guideline is that:
    - if you are pregnant or think you could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum.
    - drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk.
13. The risk of harm to the baby is likely to be low if you have drunk only small amounts of alcohol before you knew you were pregnant or during pregnancy. If you find out you are pregnant after you have drunk alcohol during early pregnancy, you should avoid further drinking. You should be aware that it is unlikely in most cases that the baby has been affected. If you are worried about alcohol use during pregnancy do talk to your doctor or midwife.

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