NHS Health Scotland

Monitoring and Evaluating Scotland's Alcohol Strategy

Final Annual Report

March 2016

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The MESAS project team all provide intellectual thinking to the MESAS project and review of this report. In addition, their contribution to this report is as follows:
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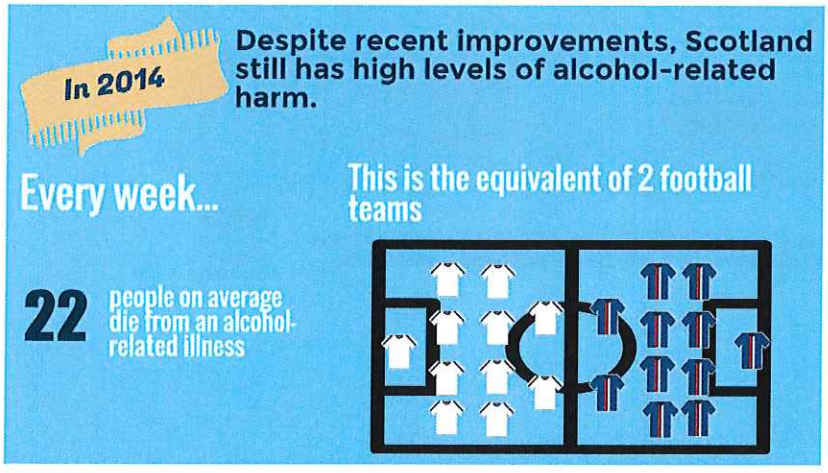
This report was signed off by Dr Andrew Fraser (NHS Health Scotland), and Dr Colin Fischbacher (NHS National Services Scotland)

Monitoring and Evaluating Scotland's Alcohol Strategy March 2016 - Executive summary

After a period of rapidly increasing rates of alcohol-related harm in Scotland and with alcohol-related harm in Scotland at historically high levels, a comprehensive strategic approach to alcohol was put in place from 2008/2009. The strategy was evidence-based and contained the main components advocated by the World Health Organisation (WHO). It aimed to reduce alcohol consumption and related harm through a wide range of interventions implemented through new policy and legislation. This evaluation was put in place to assess the success or otherwise of the strategy.

- Monitoring trends in alcohol consumption shows that population consumption of alcohol has declined in recent years, although that decline may now be flattening. A downward trend in self-reported consumption appears to be driven by declining consumption and increased abstention in young adults, and decreased consumption amongst the heaviest drinkers, especially men.

- The most reliable and robust indicators of alcohol related harm are alcohol related-related mortality and hospitalisation rates. In general, both of these have been declining in recent years. The decline in the alcohol-related mortality rate started from peaks in 2003 for men and in 2006 for women. Rates have not declined since 2012 for either gender. Alcohol-related hospitalisations began to decline from 2008/09 for both genders. The increase and subsequent decline in alcohol-related mortality and hospitalisations was driven in particular by men and those living in the most deprived areas.



- Within the context of declining overall crime, there was little evidence of a consistent trend across the indicators of alcohol related crime.

- Adverse consequences, from their own alcohol consumption, reported by 13 and 15 year olds have been declining, and are now at the lowest recorded level. Hospitalisation rates for those aged under 15 years have also declined by approximately 80% since their peak in 1995/96.

This evaluation studied the implementation and intermediate outcomes of selected components of the strategy:

- The Licensing Act has changed licensing practice. There was compliance with regulations concerning promotions in the on-trade and display of alcohol in the off-trade. Licensing standards officers, staff training and test purchasing were well received. The overprovision assessments and public health objective had influenced statements of policy, but were proving difficult to operationalise. Limitations of licensing data meant it was not possible to determine if such policy-based changes are influencing either licensing decisions or alcohol availability.

- There was evidence that the performance target, national co-ordination and increased investment for a programme of alcohol brief interventions (ABIs) successfully scaled up delivery from 2008. ABIs have since been embedded into routine NHS practice in Scotland, particularly in primary care, and the performance target was exceeded. It was estimated that ABIs have been delivered to 43% of harmful and hazardous drinkers over the seven years of the programme. There were insufficient data collected within the ABI programme with which to assess the characteristics of those reached, uptake or impact on alcohol consumption.

Find out more about the monitoring and evaluation of Scotland's alcohol strategy programme here: **healthscotland.com/mesas**

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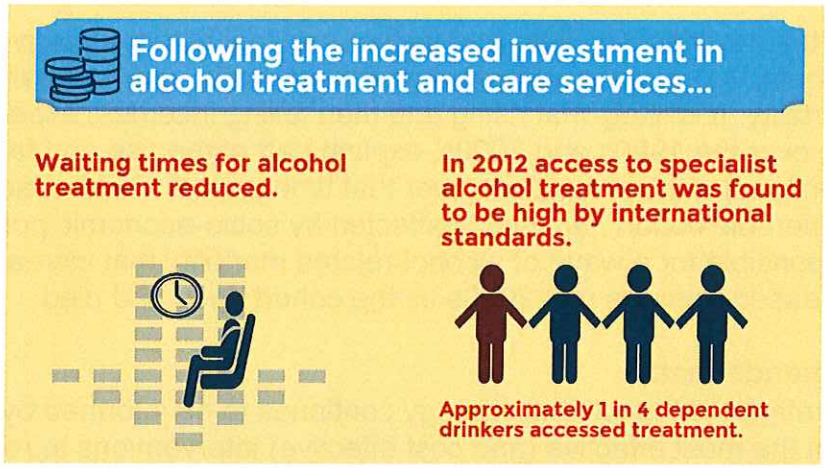
- There was a tripling of investment in specialist treatment and care services. Staff perceived the increased investment, reformed planning arrangements and guidelines, to ensure quality and consistency in alcohol treatment and care services, from 2008 had improved the availability and quality of services in Scotland. Waiting times for specialist services reduced. In 2012 the ratio of prevalence of alcohol dependence to service users (the PSUR) estimated that 1 in 4 individuals in need had accessed a specialist service. This is a high level of service access by international standards. However, it is sensitive to changes in the estimate of prevalence of alcohol dependency (and the definition of need) and, given the limitations of the estimate used, is likely to be an overestimate. It was not possible to estimate the PSUR before the increase in investment, or to compare with service access in England or England & Wales.



- The Alcohol Act, which included the ban on multi-buy discounts, was introduced in October 2011 and was associated with a modest reduction in alcohol sales in the off-trade, driven by a reduction in off-trade wine sales. This does not appear to have had a measurable, short-term impact on deaths or hospitalisations entirely caused by alcohol. Its effect on wider alcohol attributable conditions was not examined.

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- Evidence of knowledge and attitude change was mixed. There was evidence that there had been no consistent change in knowledge about units or attitudes to drunkenness or the social role of drinking. However, there was evidence that harm caused by alcohol in Scotland was increasingly recognised. There was a lack of evidence on whether or not the media discourse, or the de-normalisation of alcohol implicit in many of the interventions had changed attitudes not measured in the study.

- Minimum Unit Pricing (MUP) is subject to a legal challenge and has not yet been implemented. Other than the removal of the financial incentive to buy more alcohol than intended through the ban on multi-buy promotions any change to the affordability of alcohol was due to factors external to the strategy.

Given the timing of the declines it is clear that factors external to the strategy are likely to have contributed to changes in alcohol-related mortality and hospitalisation, especially male mortality. It is likely that rising and then falling incomes, especially for the poorest groups, over the 1990s and 2000s, explain part of the rise and fall in alcohol consumption and harms in Scotland over that time period. There is some evidence that a 'vulnerable cohort', adversely affected by socio-economic policies in the 1980s, was responsible for a wave of alcohol-related mortality that increased in the 1990s and decreased from the mid-2000s as the cohort aged and died.

The report recommends that:

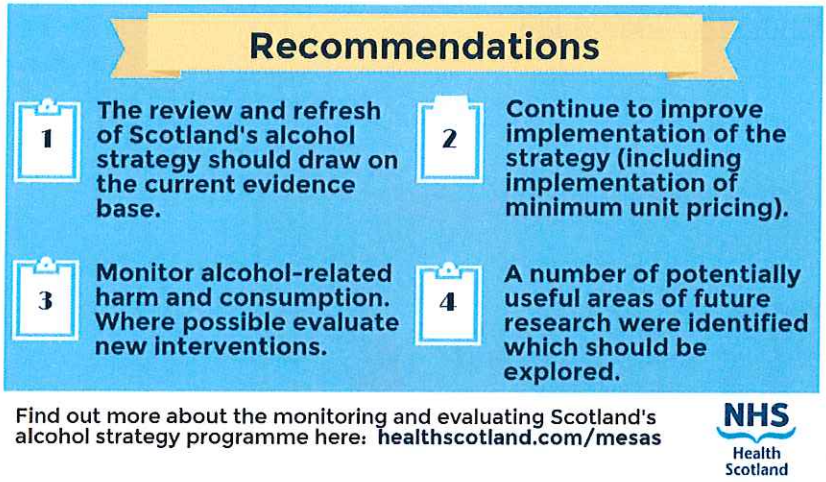
- The current refresh of the alcohol strategy continues to be informed by the evidence that the most effective (and cost effective) interventions to reduce alcohol consumption and related harm involve action to reduce alcohol price, availability and exposure to marketing. Consideration should be given as to how alcohol consumption and related harm can be addressed within the context of the wider socioeconomic determinants of health.

- Effort is made to improve implementation of existing components of the strategy, particularly those with the potential to reduce the availability of alcohol and to incorporate the learning on implementation facilitators when developing new interventions. Notably, the lack of implementation of MUP due to on-going legal challenge has constrained the impact of the strategy. There is a need to improve the completeness and consistency of local data collection so that how an intervention is being implemented, by whom, reaching whom and with what immediate impact is better understood. Such data are crucial for informing and assessing whether interventions are likely to be having the desired and equitable impact locally and to drive improvement. Allowing sufficient lead time to establish systems to support delivery, including data collection systems is vital.

- Monitoring of key trends in alcohol price, affordability, sales and alcohol related mortality and morbidity continues to ensure any consistent increase in alcohol affordability, consumption or related harm is spotted early. Where possible and feasible, new interventions should be planned to enable robust evaluation before integration into policy. Better collection, collation,

accessibility and use of national and local data on delivery could improve implementation.

- There are recommendations for future research. These include: 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..



Conclusion

Alcohol-related harm in Scotland has declined in recent years. There was evidence that the evidence-based interventions studied were implemented, although there were difficulties operationalising some aspects. There was evidence of impact on several of the intermediate outcomes, although lack of data and/or data limitations meant impact was not assessable for others.

Two factors external to the strategy were considered to have made a contribution to the mortality trends: falling disposable income (and hence alcohol affordability) for people living in the most deprived areas, and a vulnerable cohort responsible for a wave of alcohol-related mortality, that increased in the 1990s and decreased from the mid-2000s as the cohort aged and died.

It was impossible to quantify precisely the impact of these external factors, nor determine the relative contribution of the external factors and the strategy to the declines. The declines in both mortality rates and hospitalisation rates have been much steeper in Scotland than England/England & Wales and, given the evidence base, the strategy may be contributing to these improvements.

Despite these recent improvements, rates of alcohol-related mortality and morbidity in Scotland continues to be higher than in the 1980s and higher than England & Wales. Inequalities in alcohol-related harm persist, with those living in the most deprived areas, especially men, having the highest rates. There is, therefore, a

continued need for action to further reduce alcohol-related harm in Scotland and to address these health inequalities. Minimum unit pricing has not been implemented and this is likely to have constrained the strategy's contribution to declining alcohol consumption and related harm. There is some evidence that the downward trends in both alcohol consumption (sales) and alcohol-related mortality may have stalled, with no decreases in 2013 and 2014. To say whether this marks the start of a longer-term change in trend requires continued monitoring.

The full annual report of the Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) can be accessed at http://www.healthscotland.com/uploads/documents/26884-MESAS__Final%20annual%20report.pdf