

FOUR NATIONS

HOW EVIDENCE-BASED ARE ALCOHOL POLICIES AND PROGRAMMES ACROSS THE UK?

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The views and any errors in the report remain the authors' own. The report does not necessarily reflect the views of the Alliance for Useful Evidence, The Alcohol Health Alliance or its constituent partners.

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Nesta...



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HIGHLIGHTS

POLICY FRAMING

- There are substantial differences between the UK, England, Northern Ireland, Scotland and Wales in the way in which alcohol problems and policy are framed and the extent to which alcohol is considered across policy areas including health, crime, education etc. These differences appear to reflect the level of activity within each country, with alcohol framed as a minority issue affecting only a small group of the heaviest drinkers at the UK level, while the more active devolved administrations tend to view or portray alcohol problems as a whole population issue.

USE AND COMMUNICATION OF EVIDENCE IN POLICY

- There is wide variation in the way in which evidence is used by each administration to justify the implementation or non-implementation of alcohol policies. There are also a number of notable instances of policies being rejected due to 'insufficient evidence' with little indication of what level of evidence would be considered to be 'sufficient'.
- Robust evaluations of implemented policies are not routinely conducted across the 4 nations and there is little use of pilot studies prior to widespread policy implementation. This failure to contribute to the existing effectiveness evidence is likely to be a major barrier to policy transfer as it does not allow a clear picture to be gathered of the success (or otherwise) of innovative policy approaches.
- It would appear that political ideologies, perhaps about personal responsibility and the role of government in society, rather than evidence, may be more important in dictating policy. This is not problematic in principle, but such ideologies may lead to policies that do not address the problems that they are proposed or claimed to solve.

CURRENT IMPLEMENTATION OF AND SUPPORT FOR EVIDENCE-BASED POLICIES

- Overall, Scotland has the strongest approach to evidence-based alcohol policy and the greatest alignment with the recommendations of Health First, an independent, model evidence-based alcohol strategy for the UK. The main gap relates to control of marketing, over which the Scottish Government currently has very limited powers.
- Both Wales and Northern Ireland are strong in some areas (not necessarily the same ones) and weaker in others, although they are more restricted than Scotland in terms of the policy areas over which they have legislative autonomy. Both nations appear to be progressively adopting evidence-based positions, and have called on Westminster to devolve more powers to them – it is important that they act on their stated policy intentions if they are successful in gaining such powers.
- The UK/England government in Westminster comes out worst on almost all alcohol policy measures, having the weakest policies, with inconsistent use of evidence, and an evaluation strategy with obvious conflicts of interest (e.g. letting the alcohol industry evaluate the success of their own actions). The same government also has highest level of engagement with the alcohol industry.

- Across all 4 administrations there is a level of industry involvement in policy design and implementation which exceeds their role as producers and distributors of alcohol, and some evidence supporting the thesis that such involvement is likely to undermine public health and promote weak or ineffective policies.

ACCESSIBILITY OF INFORMATION

- Current policies or positions are hard to find across all jurisdictions, with no central database of current alcohol policies either for the UK or any of the 4 nations independently. This should be developed. There is also little or no clarity when policies or statements of position have subsequently been withdrawn or superseded and uncertainty over what remains in place when administrations change.
- There is often poor information in Westminster policies and programmes to tell the reader to which jurisdictions they relate.

1. INTRODUCTION

The consumption of alcohol is an established part of life in the UK. The alcohol industry contributes to the economy through employment and exports. While many people choose not to drink, the majority of adults accept and enjoy alcohol at least occasionally. This consumption comes with a price: the more frequent the drinking, and the greater the quantity on each occasion, the greater risk of harm to the individual. Such risks include a higher chance of cancer, liver and heart disease and mental health problems, and for a minority, consumption leads to dependence. For families, higher levels of alcohol consumption can lead to or exacerbate relationship problems, domestic violence, and negatively impact on parenting. As a society, we lose further through alcohol-related absenteeism and lost productivity; as well as crime and disorder and public nuisance.

In the UK, responsibility for alcohol policy is divided between the UK Government and the devolved administrations in Scotland, Wales and Northern Ireland with some powers reserved to the UK parliament and some under devolved control. Some obvious differences in approach have emerged in recent years, most notably with Scotland passing legislation to implement a minimum price per unit of alcohol, while the UK Government announced and then reversed its support for a similar policy in England and Wales. Since then the Welsh and Northern Irish administrations have announced support for this policy. As policies diverge or are replicated across different nations/administrations, the question arises of what evidence (if any) is underpinning these differing decisions.

This report outlines a comparison of alcohol policies and programmes across the four jurisdictions of the UK, and the UK as a whole, with each other and with evidence-based interventions. In doing so, we wanted to answer two questions:

- 1. How is evidence used in proposing alcohol policies and programmes, and their evaluation, across the UK?**
- 2. How evidence-based are the actions and interventions proposed in alcohol policies and programmes across the UK?**

The first question is answered in Section 2, and later sections consider the second question in detail.

WHAT IS EVIDENCE-BASED ALCOHOL POLICY?

In alcohol policy, it can be argued that there is an abundance of evidence pointing to the approaches most likely to reduce harm, and that there are as yet few studies of the effectiveness of specific interventions in a UK context. Both are true. The World Health Organisation review 'Alcohol: No Ordinary Commodity', authored by leading experts in the field, is considered the definitive review of evidence on effective public policy on alcohol worldwide. In it, the scientific evidence points clearly to action in relation to the five broad areas: **regulatory action on pricing, marketing and availability of alcohol, early intervention and treatment; and approaches to reduce drink driving, safer drinking environments and treatment**, and finds that information and education-based approaches are ineffective on their own.

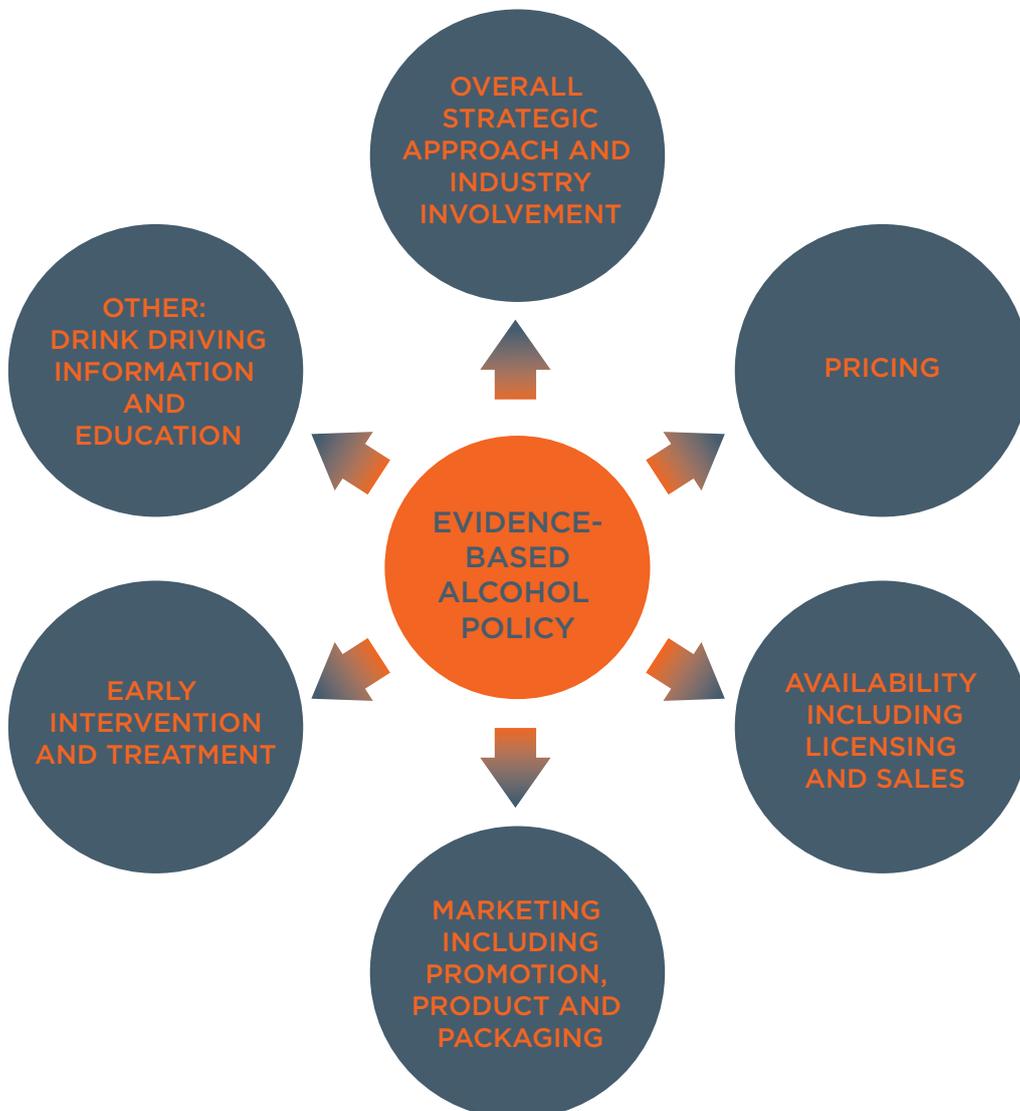
In addition to specific interventions, 'No Ordinary Commodity' emphasises the need to focus on reducing alcohol consumption across the entire population rather than to target efforts towards particular minority groups: a public health or **'whole population approach'**. Furthermore, it points to experience suggesting that working in partnership with the alcohol industry is likely to lead to ineffective or compromised policies.

The conclusions of 'No Ordinary Commodity' are strong and are based on a comprehensive review of evidence regarding the most likely effective approaches. However, it recognises that there are gaps in the representations of the evidence-base are likely to be unreliable where made by those countries in which some policies have been studied. Policy-making is not determined solely by evidence but rather on how it is used by all interested parties, including government, industry, non-governmental organisations, academic, health and other professionals, the media, and the general public. In this context, **interpretations of an incomplete evidence-base** are likely to be particularly unreliable where made by those with vested interests, such as the alcohol industry. The gaps in the literature also point to the need for policy interventions to be rigorously evaluated in order to contribute to national and international knowledge of what works best (or does not work) to reduce alcohol-related harms.

In the arena in which policy decisions are considered and debated, **research evidence** can contribute to and influence the nature and outcome of arguments, but to do so it must be **policy-relevant and clearly communicated**. While 'No Ordinary Commodity' is a comprehensive review of the evidence, it is a lengthy document, and does not present direct or UK-specific policy recommendations. With this in mind, an independent group of UK experts prepared 'Health First', a UK alcohol strategy, applying the findings of 'No Ordinary Commodity' to a UK context, and outlining 30 clear policy recommendations in the same broad areas outlined above. 'Health First' was compiled under the auspices of the Alcohol Health Alliance UK (www.ahauk.org), and is supported by over 70 organisations including Royal Colleges, NHS bodies, third sector bodies and universities. As such it represents a **broad consensus drawing on the scientific literature, and independent of the alcohol industry, on both evidence-based alcohol policy and how such policies should be established and managed by government**.

2. HOW THIS REPORT WAS COMPILED

The 'Health First' alcohol strategy outlines 30 evidence-based policy recommendations. The first four relate to an overall approach to developing policy, and the rest fall into five categories that align with the evidence in No Ordinary Commodity (above): Pricing, Availability (including licensing and sales), Marketing (including promotion, product and packaging), Early Intervention and Treatment, and Other (including drink driving, information and education). The first four are considered in Section 2 below, along with an additional recommendation on the appropriate use of evidence which we added. The five remaining categories form the following sections in this report.



HOW DID WE FIND THE POLICY INFORMATION?

We searched for information on all 30 recommendations, focusing separately on England, Northern Ireland, Scotland, Wales and the UK as a whole, primarily using government websites, legislation.gov.uk (which holds the text of laws and regulations passed by government or the devolved administrations), and google searches. We also searched within the documents found for any mention of the use of research or evidence in support of policy decisions. We contacted key individuals known to us in each region both to access and clarify policies or programmes where necessary. Finally we noted any policies or programmes found in the course of our searches that did not directly relate to the 30 recommendations in Health First.

WHAT WAS INCLUDED OR EXCLUDED?

We only included information on policies or programmes that had some kind of official published sanction by the government or devolved administration in each area, and where we could find information that was in the public domain. We therefore excluded policies issued by bodies such as Royal Colleges, or local alcohol initiatives, unless they were explicitly endorsed and advanced for wider implementation by a government (or Executive in the case of Northern Ireland), a quasi-governmental organisation (e.g. Public Health England), or a devolved administration. We also excluded information that was only known to us through contacts, but for which we could not find a publicly available supporting document.

READING THIS REPORT

For the recommendations in each policy category, we have presented a summary of the position of each nation as a grid at the start of the relevant section. These grids show how supportive each nation is of the particular policy in terms of the following categories:

The colour of the box indicates the level of support i.e.

-  **Green:** Full support
-  **Amber:** Partial support
-  **Red:** Stated or apparent lack of support or action contrary to recommendation
-  **Grey:** No position

The contents of the box indicate the extent to which a recommendation has been implemented, or whether it is within the powers of the devolved administration.

✓✓ = Fully implemented

✓ = Partially implemented including if legislation passed but no evidence of implementation;

C = Out to consultation

NP = Not within current powers of the devolved administration

NI = No information found during our search.

A box will be left blank if the policy has not been implemented, or if this policy recommendation is not relevant in this area.

The section then also summarises interesting or key differences between the nations or UK policy or programme.

3. OVERALL ALCOHOL STRATEGIES AND APPROACHES TO EVIDENCE

APPROACH TO EVIDENCE	UK	England	Wales	Northern Ireland	Scotland
National alcohol policies and programmes should refer to available scientific evidence in defining alcohol-related harms, and proposing or implementing specific policies to address them. They should also seek to contribute to the evidence base where gaps exist.			✓	✓	✓✓
HEALTH FIRST RECOMMENDATIONS ON STRATEGY					
Public health and community safety should be prioritised in all public policy-making re. alcohol			✓	✓✓	✓✓
Drinks companies should contribute only as producers, distributors and marketers (not involved in policy formation or health promotion)					
Local authorities should develop comprehensive alcohol strategies that prioritise public health and community safety.		✓	✓	✓	✓✓
UK Government and devolved administrations should develop appropriate policy targets for each nation and region of the UK			✓	✓	✓✓

APPROACHES TO EVIDENCE IN NATIONAL ALCOHOL STRATEGIES

Wales has a National Substance Misuse Strategy called 'Working Together to Reduce Harm', which covers the period 2008-2018, but this has to some extent been superseded by a Welsh Government 2014 white paper consulting on proposals for a public health bill.

Northern Ireland also has a combined alcohol and drug strategy, the **New Strategic Direction for Alcohol and Drugs** - Phase 2 which covers the period 2011 to 2016

Based on an earlier consultation document from 2008, Scotland launched a national 'framework for action' entitled 'Changing Scotland's Relationship with Alcohol' in 2009, which is currently being updated.

NATIONAL ALCOHOL STRATEGIES

England: *The Government's Alcohol Strategy, 2012.* Published under previous administration, no current strategy.

Wales: *Working Together to Reduce Harm National Substance Misuse Strategy 2008-2018.*

Scotland: *Changing Scotland's Relationship with Alcohol: A Framework for Action, 2009.*

Northern Ireland: *New Strategic Direction for Alcohol and Drugs Phase 2, 2011-2016.*

The 2010-2015 UK coalition government published 'The Government's Alcohol Strategy' in 2012 which included aspects that applied in some cases to England, or England and Wales or to the UK as a whole. The status of the 2012 strategy is unclear under the new Conservative government as its website has been edited after the 2015 general election to flag up that it was published under the previous Government.

Each of the four original alcohol strategies makes multiple references to evidence to support certain policy positions. All cite statistical evidence relating to levels of alcohol consumption and alcohol-related problems including crime, health and economic costs.

The original Welsh strategy includes 'supporting evidence-based decision making' as a key aim, but makes little reference to evidence on alcohol policy in the body of the strategy. Recent legislation in Wales requires all local authorities to have a set of 'well-being objectives' and to publish annual progress reports towards these objectives. The 2013-2015 Substance Misuse Delivery Plan in Wales outlines policy actions, along with details on how performance on each action will be measured, in relation to 12 overall outcomes.

The Northern Ireland strategy includes 'Evaluation, evidence and good practice' as one of a list of values and principles 'on which this document is based'. This is defined as 'A commitment to taking action informed by evidence about what the problems are 'what works' and by information on cost-effectiveness.' In addition, one of the five pillars of the Northern Ireland strategy is 'monitoring, evaluation and research' which outlines a clear commitment to evidence-based activities and programmes, and to innovation (see box).

The Northern Ireland strategy is structured around short term, and combined medium/long-term outcomes which it states will be measured; and 'the overall success or otherwise of achieving the long-term aim will be measured' using key indicators. Having said this, 'public concern' rather than any scientific evidence of effectiveness or even of such public concern, is cited in support of a ban on certain drinks promotions (see page 20).

The Scottish alcohol strategy states that it is based on 'knowledge of evidence-based interventions', and specifically commits to evaluating a number of pilot initiatives on alcohol brief interventions (see page 28). Stating that 'we recognise the importance of a robust evidence base', the national framework established the MESAS initiative 'Monitoring and Evaluating Scotland's Alcohol Strategy' (see box). Their legislation on Minimum Unit Pricing also includes a 'sunset' clause in which it will be reviewed five years after implementation.

The Conservative/Liberal Democrat coalition government commissioned a number of independent systematic reviews of alcohol policy evidence, which

MONITORING, EVALUATION AND RESEARCH IN THE NORTHERN IRELAND STRATEGY

'It will be essential that the resources available to deliver the [strategy] be properly targeted at activities and programmes that have been shown by previous research and evaluation to be effective. This does not devalue the need for innovation. Arrangements for evaluation will be an integral part of all current and future services funded as part of the [strategy].

It is recognised that it is of vital importance at both regional and local levels to monitor and evaluate processes, outputs and outcomes in order to inform the overall implementation of the [strategy] and ultimately measure its success.

Where appropriate, existing systems and surveys will help to set baselines and monitor progress and changes, however it may be necessary to develop new monitoring systems or build on existing ones to provide additional information required. In addition, well-designed and targeted research projects can address gaps in knowledge and seek to explore specific topics and issues in detail.'

are referenced in the 2012 alcohol strategy. This seems positive on the face of it, but the strategy cites strong and consistent evidence in favour of minimum unit pricing - a policy which was subsequently shelved (see page 19) after a public consultation and reportedly intense lobbying by the alcohol industry.

The (then minority) Scottish Government also put their draft alcohol strategy out to consultation in 2008. The final version the following year dropped some of the more controversial policies such as a proposal for separate check-outs for alcohol in supermarkets and an increase in the legal purchase age in off-licences to 21 years old, although these interventions are broadly in line with the international consensus on the evidence base.

Submissions to public consultation on policy merit cautious treatment, in that they may vary enormously in relation to the extent to which they reflect scientific evidence. In the Scottish public consultation on minimum unit pricing, the alcohol industry was reported by an independent study to have 'misrepresented strong evidence and promoted weak evidence as well as making unsubstantiated claims about the adverse effects of unfavoured policy proposals'. The researchers also cited examples where 'advocacy of policies favoured by industry was not supported by the presentation of evidence'. This example illustrates the unsystematic nature of the consultation process and the likelihood that 'evidence' submitted will be biased by those with various vested interests in the policy. Perhaps with this in mind, the Northern Ireland Executive declined to take forward the liberalisation of alcohol licensing laws in line with England, despite calls for it in a 2014 consultation exercise.

MONITORING AND EVALUATING SCOTLAND'S ALCOHOL STRATEGY

The Scottish Government tasked NHS Health Scotland with the responsibility of evaluating Scotland's alcohol strategy (including Minimum Unit Pricing (MUP), if implemented) through the Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) programme of work. The key evaluation questions outlined for the whole MESAS programme of work are:

- How and to what extent has implementing the package of measures (taken together and/or individually) contained in the Scottish alcohol strategy contributed to reducing alcohol-related harms?
- Are some (people and businesses) affected (positively and negatively) more than others?
- How might the strategy be implemented differently to improve effectiveness?

A 'Theory of Change' approach has been adopted to address the evaluation questions presented above. The Theory of Change assumes that alcohol related harms will reduce if alcohol consumption goes down. Further information on the Theory of Change and the evaluation plan is available in the first annual MESAS (baseline) report.

The evaluation comprises of a portfolio of seven studies on licensing, alcohol brief interventions, impact of investment in treatment, changes in knowledge and attitudes, price and consumption, economic impact, and alcohol-related harm. The studies started at the beginning of 2010 and will run through to 2015, with the monitoring of routine data continuing beyond.

PRIORITISING PUBLIC HEALTH AND COMMUNITY SAFETY.

“Public health and community safety should be prioritised in all public policy-making re. alcohol”

The first key recommendation of Health First emphasises the importance of public health as well as community safety in alcohol policy-making. This means consideration of the impact of alcohol at a population level, rather than solely in relation to individuals or minority groups. The ‘Health First’ strategy cites ‘unequivocal’ research evidence that population measures to reduce alcohol affordability and availability are the most effective at reducing alcohol consumption and alcohol-related harm. It notes that ‘we will not reduce the harm from alcohol in the UK unless we significantly reduce the total volume of alcohol that the population consumes’. This is in line with the evidence presented in ‘No Ordinary Commodity’ and is known as a ‘whole population approach’.

The 2008 Scottish Government strategy was the first in the UK to clearly outline a whole population approach to tackling alcohol problems, explicitly rejecting the industry’s suggestion of a targeted approach focusing on specific groups in society. Listing alcohol-related accidents, crime, family break-up, cancer and liver disease, it states that ‘alcohol misuse is no longer a marginal problem’, as justification for taking an approach that is ‘targeted at everyone’. Scotland subsequently passed legislation on the licensing of premises that sell alcohol (restricting availability) and to introduce a minimum price per unit of alcohol (known as ‘minimum unit pricing’ or ‘MUP’ (reducing affordability).

The Northern Ireland strategy (Phase 2, 2011-2016) identifies alcohol and drug misuse as ‘significant public health and social issues’. For alcohol in particular, it is noted that this represents an explicit change from Phase 1 of the strategy which focused on ‘binge-drinking’. Phase 2 takes ‘a population approach to address alcohol misuse and is seeking to reduce overall consumption’ focusing on ‘health and community harms including antisocial behaviour and serious violent crime’.

The original Welsh strategy (2008-2018), did not emphasise public health, but rather described a ‘substantial minority’ of drinkers ‘who ‘blight the streets of our towns and cities through alcohol related crime and disorder and damage their own long term health in the process’. However the more recent Welsh Government white paper on public health described the ‘harmful use of alcohol’ as ‘widespread’, and noted the desire in Wales for powers over licensing to be devolved to enable greater control of the availability of alcohol. It also expressed support for minimum unit pricing as ‘proportionate and preventative action to protect public health’. The white paper also introduced the idea of ‘health in all policies’ which led to 2015 legislation requiring all public bodies to do what they can to work towards ‘a healthier Wales’.

The ‘Government’s Alcohol Strategy’ devised by the 2010-2015 UK coalition government, focused on ‘binge drinking’, crime and disorder and the actions of a minority rather than public health. It announced plans to introduce MUP which were subsequently abandoned. This ‘U-turn’ was considered unsurprising by some, who noted that the rest of the document was not supportive of the kind of public health approach that underpins arguments for MUP. The 2015 election manifesto of the Conservative party has few mentions of alcohol, which focus solely on minority issues such as ‘dependence’ and ‘alcoholism’. Alcohol is mentioned as a ‘driver of crime’ and there is not a single mention of alcohol as a health issue.

INDUSTRY INVOLVEMENT

“Drinks companies should contribute only as producers, distributors and marketers (not involved in policy formation or health promotion)”

The ‘Health First’ strategy states that ‘the [alcohol] industry’s conflict of interest is too great to allow it to take on a meaningful role in reducing the harm from alcohol’. This is based on growing body of research that suggests that co-operation with that alcohol industry on policy is likely to lead to less effective or ineffective policies being favoured over more effective ones. In particular, the alcohol industry focus on information and education approaches including funding school education initiatives and the UK Drinkaware website; in some cases such information and education campaigns may even have detrimental effects, and at best they distract from more effective policies.

The former UK (coalition) Government established the ‘Public Health Responsibility Deal’ (RD), which is officially supported by the Welsh Government and on which Northern Ireland and Scotland also have observer status for alcohol. It is currently unclear whether the RD will continue to exist under the new Conservative UK Government. The RD includes an industry pledge (A6) to maintain funding for Drinkaware, which aims to ‘reduce alcohol-related harm by helping people make better choices about their drinking’. Other RD pledges that are inconsistent with the Health First recommendation focus on school education (A9), self-regulation of advertising and marketing (A6), and partnership with local health organisations through community alcohol partnerships (A7).

Ironically, although the Scottish Government has been taken to court by the alcohol industry (acting through the Scotch Whisky Association) over its plans to introduce Minimum Unit Pricing, it also co-operates with the industry through its own ‘Scottish Government Alcohol Industry Partnership’. This is inconsistent with the ‘Health First’ recommendation as it is described as a ‘consultative forum on policy’ as well as covering issues such as health promotion through collaboration on ‘alcohol awareness week’, and the development of a ‘co-regulatory approach to promotional activities’. It is difficult to assess to what extent the partnership, which is much lower profile than the responsibility deal, reflects

THE PUBLIC HEALTH RESPONSIBILITY DEAL

Launched in March 2011, the Responsibility Deal aimed to ‘Tap into the potential for businesses and other organisations to improve public health and help to tackle health inequalities through their influence over food, physical activity, alcohol and health in the workplace’ through a ‘core commitment’ to ‘Foster a culture of responsible drinking, which will help people to drink within guidelines’. The cornerstone of the RD was a series of voluntary pledges which companies and industry bodies could sign up to. Evaluations of the two key pledges (to improve the labelling of alcohol products and to remove 1 billion units of alcohol through greater availability of low-strength drinks) have been published; both were commissioned by and/or had some degree of design input from the alcohol industry. Both evaluations concluded that the pledges had been met, however these claims have been questioned by subsequent research which criticised both the methods and data used. Independent research published in early 2015 concluded that the pledges did not reflect best evidence on effective strategies to reduce alcohol-related harm, and in many cases reflected actions which were already being undertaken irrespective of the existence of the RD.

These findings support the conclusions of international and national experts that partnership with the alcohol industry is likely to lead to less effective or ineffective policies being favoured over more effective options.

a genuine belief in working with the industry on policy, or exists to deflect potential criticism if the Government appeared to be anti-industry.

The Northern Ireland Executive does not refer to the UK Public Health Responsibility Deal in their alcohol strategy except in relation to the pledges on product labelling, where they note that they ‘will monitor progress on this target closely and give consideration to taking a more robust regulatory approach if this commitment is not met’. However, the Executive does involve the alcohol industry in the policy-making process, in contradiction to the recommendations of Health First, through representatives of the alcohol industry sitting on the Alcohol Advisory Group and the New Strategic Directions for Alcohol and Drugs steering group, who oversee policy development and the delivery of Northern Ireland’s alcohol strategy.

LOCAL AUTHORITY STRATEGIES

“Local authorities should develop comprehensive alcohol strategies that prioritise public health and community safety”

In Scotland, each local area is mandated by the national alcohol framework to have a strategic, multi-agency partnership made up of representatives from the NHS, police, local authority and third sector organisations. These ‘Alcohol and Drug Partnerships’ are required to submit local strategies to deliver improvements in 7 core (nationally mandated, see below) and additional locally established outcomes, and they are responsible for decisions to achieve these. Nationally identified core indicators exist for each of the core outcomes. There is no equivalent to this system in England or Wales. Community safety is one of the core outcomes. Although the outcomes do not explicitly mention public health, one core indicator is the percentage of individuals drinking above daily or weekly recommended limits. This is in line with a whole population (public health) approach.

This recommendation is in general less relevant to Northern Ireland, where local authorities do not have fully devolved control over health, education, social services or alcohol licensing. However, Northern Ireland has a number of local Drug and Alcohol Co-ordination Teams, and has consulted on a commissioning framework for ‘prevention, early interventions, treatment and rehabilitation’, which includes outcome-based ‘commissioning priorities’ at local and regional level. [The consultation is complete and a July 2013 document states that ‘the priorities will be redrafted’, however a final version of the framework could not be found].

Recent legislation (2015) in Wales requires all local authorities to have a set of ‘well-being objectives’ and to publish annual progress reports towards these objectives. These build on existing structures, particularly local service boards, however it is too early to judge the extent to which these arrangements will address alcohol. New legislation proposes that local authorities be empowered to enforce minimum unit prices for alcohol in Wales. Public Health Wales is also active in supporting local areas in Wales to address alcohol misuse, though authorities are not required to report on specific alcohol-related outcomes, as in Scotland.

Local authorities in England must have a ‘Health and Wellbeing Board’ which is responsible for developing a Joint Health and Wellbeing Strategy. These arrangements do not necessarily include alcohol. In addition, there is a range of supportive activity underway by Public Health England to share information around initiatives to tackle alcohol-related harm between local authorities, encourage self-assessment, and to

support them in implementing various alcohol interventions. This work is welcome and valuable, and similar work is underway through the national health-improvement agencies in the other nations of the UK, but it relies on the voluntary engagement of local authorities and seems therefore less likely to be effective in driving consistent evidence-based practice across all authorities, particularly in local authorities which have not prioritised alcohol as an issue.

Another aspect of local authority strategy is that alcohol licensing authorities in Scotland, England and Wales are required to publish statements of licensing policy on a regular basis (every 5 years in England and Wales; every 3 years in Scotland). There is no equivalent system for licensing policy in Northern Ireland, where licensing decisions are made by county courts.

POLICY TARGETS

“UK Government and devolved administrations should develop appropriate policy targets for each nation and region of the UK”

The Scottish Government manages its performance as a government by publicly monitoring 50 indicators in relation to sixteen national outcomes that together articulate their overall purpose. ‘Reducing alcohol-related hospital admissions’ (the number of general acute inpatient and day case discharges per 100,000 of population with a diagnosis which is wholly-attributable to alcohol, e.g. alcohol poisoning or alcoholic liver disease) is one of the 50 national indicators which are used to monitor overall Government performance. Outcomes and indicators for local authorities and Alcohol and Drug Partnerships (see above) are tied into this overall national framework.

Separate from the national performance management framework, two recent national targets for the NHS in Scotland relate to alcohol policy: one on waiting times for alcohol treatment, and the second mandating delivery of alcohol brief interventions. Both continue to be monitored by the Scottish government as performance standards on which local NHS boards must report annually. Furthermore, a ‘theory of change’ model has been created by NHS Health Scotland for the Scottish alcohol strategy with logic models outlining short, medium and long term actions, factors affecting outcomes, and anticipated outcomes. This model has been used to plan evaluation of impact of actions taken under the national strategy.

The 2013-2015 Substance Misuse Delivery Plan in Wales outlines policy actions, along with details on how performance on each action will be measured, in relation to 12 overall outcomes. As noted above, recent legislation also requires all local authorities to establish and assess progress on a set of ‘well-being objectives’, which may include alcohol.

In addition to the commissioning framework noted in the previous section, the Northern Ireland Phase 2 strategy on alcohol and drugs is structured around ‘Short Term Outcomes/Outputs’ and ‘Medium Term/Long Term Outcomes’. Update reports in 2013 and 2014 outlined progress in relation to the short term outcomes/outputs.

No targets or outcomes were set for the coalition government alcohol strategy: the Responsibility Deal includes a series of pledges, many of which are difficult to monitor and/or are not subject to any formal evaluation. See above for more information on Responsibility Deal; see Section 5 below for information on pledges in relation to product labelling.

CONCLUSIONS

Scotland and Northern Ireland have current strategic frameworks that best reflect the current evidence base in relation to alcohol policy. Recent outputs from the Welsh Government indicate a shift in official policy towards a whole population approach, in line with evidence, however it is unclear exactly how the requirements of recent legislation will be implemented. All four nations are involving the alcohol industry in ways that contravene the Health First recommendations. Across the board, the UK Government approach, which also includes English strategy, fails to meet evidence-based recommendations.

Scotland appears to have the best system for evaluating the impact of interventions generating new evidence through its MESAS team, and for monitoring progress at both local and national level through a comprehensive and integrated outcomes-based approach. Northern Ireland has stated a clear commitment to the former, and regularly reports on progress in relation to outcomes/outputs in its strategy. A new system may emerge in Wales following recent legislation and there is no equivalent in England.

4. PRICING

HEALTH FIRST STRATEGY RECOMMENDATIONS ON PRICING	UK	England	Wales	Northern Ireland	Scotland
Taxes should be used to raise the real price of alcohol products such that their affordability decreases over time			NP	NP	NP
Tax on alcohol products should be proportionate to the volume of alcohol they contain, and the tax rate should increase with product strength.	✓NP	✓NP	NP	NP	NP
A minimum price of at least 50p per unit of alcohol should be introduced with a mechanism to regularly review and revise this price.			NP/C	C	✓
All bulk-buy discounting of alcohol including 'happy hours' should be prohibited.		✓	NP	✓	✓✓

The evidence suggests that pricing and discounts are used by alcohol producers and retailers to sell more alcohol and that the simplest way to reduce the demand for, and consumption of alcohol, is to increase its price. Governments can influence the price of alcohol by adjusting taxation levels, though retailers do not always pass on the cost of full tax rises to consumers. The Health First strategy notes that very cheap alcohol plays the biggest part in driving alcohol-related harm, by enabling heavier drinkers to maintain their consumption by switching to cheaper products, and by making alcohol accessible to young people with limited budgets.

TAXATION

Levels of taxation of alcohol products for the whole of the UK are set by the UK Government, and the devolved administrations do not have power over taxation. In 2013, the then coalition government abolished a policy introduced by the previous government, 'the duty escalator' whereby the duty rate on all alcoholic drinks would increase annually by 2 per cent above the rate of inflation (thus reducing affordability). Taxation was cut in 2014 (on beer) and in 2015 (on beer, spirits and most cider). There are currently different rates of duty for beer, cider and wine depending on what strength category they fall into, and in the case of wine/cider whether the product is still or sparkling.

There are restrictions under EU law that do not permit directly proportionate taxation by strength for certain products (wine and cider), as currently exists for beer and spirits which are taxed at varying rates per litre of pure alcohol contained in the product. The Welsh government has expressed its support for 'linking levels of taxation more closely to strength, in particular to bring cider in line with beer of equivalent alcoholic strength'. In addition, a recent House of Lords Select Committee report on EU Alcohol Strategy recommended that these restrictions be removed.

MINIMUM (UNIT) PRICING (MUP)

“A minimum price of at least 50p per unit of alcohol should be introduced for all alcohol sales together with a mechanism to regularly review and revise this price.”

The price of the cheapest alcohol can be raised by setting a minimum price for every unit of alcohol contained in all alcoholic drinks. Recent evidence from Canada, where a similar system has been in place for some years shows this to be an effective measure at reducing alcohol-related harm, a finding which is mirrored by recent modelling studies in all 4 UK nations. This research shows that a minimum price in the UK would save thousands of lives, and lead to substantial reductions in alcohol-related crime and workplace absenteeism, with the greatest impact on the heaviest drinkers, while moderate drinkers would remain largely unaffected by the policy.

The Scottish Government legislated to introduce MUP in 2012, the legality of the policy was challenged by the alcohol industry and is currently under consideration by the European Court of Justice. The price per unit announced was 50 pence.

The UK Government announced plans to introduce MUP in 2012, however reversed this decision following consultation (see box). The response to the consultation stated that the policy was ‘not rejected’ but ‘merely delayed until we have conclusive evidence that it will be effective’. The coalition government subsequently introduced a ban on selling alcohol at below the total amount of duty and value-added tax (VAT) on the product (often referred to as a ‘ban on below-cost selling’), however a recent study found that this is likely to have very little impact on population alcohol consumption and associated harms (approximately 50 times smaller than the estimated impact of a 50p MUP).

Subsequent to the Scottish legislation, both Northern Ireland and Wales announced their support for minimum unit pricing in principle. Consideration was given by the Welsh Government as to whether it currently has sufficient powers to implement the policy. The Public Health (Minimum Price for Alcohol) (Wales) Bill was published in July 2015, proposing a 50p MUP to be introduced under new powers for Welsh Ministers. The bill proposes to empower local authorities to enforce the minimum price including powers of entry for authorised officers, an offence of obstructing an authorised officer and the power to issue fixed penalty notices. A consultation on the bill is currently underway and will run until December 2015.

(FORMER) UK GOVERNMENT USE OF EVIDENCE ON PRICING

UK Government 2012 Alcohol Strategy: ‘There is strong and consistent evidence that an increase in the price of alcohol reduces the demand for alcohol which in turn can lead to a reduction in harm, including for those who regularly drink heavily and young drinkers under 18. We can no longer afford to ignore this.’

UK Government 2013 Response to related Consultation: ‘[The consultation] has not provided evidence that conclusively demonstrates that Minimum Unit Pricing (MUP) will actually do what it is meant to: reduce problem drinking without penalising all those who drink responsibly. In the absence of that empirical evidence, we have decided that it would be a mistake to implement MUP at this stage.’

Minimum unit pricing is also under consideration in the Republic of Ireland and several other EU countries, where there has been a sustained advocacy effort and publicity around MUP, at least in part due to the ongoing European Court of Justice case. The importance of the industry-led legal challenge in raising awareness of MUP, and therefore driving 'policy transfer' is unknown. However it is also possible that the litigation will put other countries off implementing evidence-based policies that are opposed by industry, particularly if the ultimate costs to the Scottish Government are high.

BULK-BUY DISCOUNTING

“All bulk-buy discounting of alcohol including ‘happy hours’ should be prohibited.”

Bulk-buy discounts are those special offers which make it cheaper to buy more alcohol such as 'buy one get one free' and 'three for two' (known as 'multi-buy discounts'), or unlimited alcohol for a specific price or entry fee, or special prices for a limited time (e.g. 'happy hours'). These kinds of promotions provide an incentive for people to drink more and/or faster than they had intended and they are banned in Scotland across all retailers, including 'on-licence' premises such as pubs and restaurants and 'off licences' such as supermarkets and shops.

In Northern Ireland, drinks promotions supplying unlimited amounts of alcohol for a fixed charge (or entry charge) are prohibited in on-licence premises only. A similar ban applies in England and Wales. The UK coalition government rejected a ban on 'multi-buy' discounts in off-licences after consultation on the alcohol strategy in 2013. The Welsh Government does not currently have powers over alcohol licensing to enable them to prohibit such promotions but has made a general call for UK-wide action.

CONCLUSIONS

Scotland, Wales and Northern Ireland have stated their support for minimum unit pricing for alcohol, and Scotland has legislated for it. The previous UK Government reversed a decision to introduce MUP, and has reduced duty on alcohol, both policies which directly contravene evidence-based policy recommendations.

5. MARKETING: PROMOTION, PRODUCT AND PACKAGING

HEALTH FIRST STRATEGY RECOMMENDATIONS ON MARKETING	UK	England	Wales	Northern Ireland	Scotland
The sale of alcohol products that appeal more to children and young people than to adults should be prohibited.	✓	✓	NP	NP	NP
An independent body should be established to regulate alcohol promotion, including product and packaging design in the interests of public health and community safety.			NP	NP	NP
All alcohol advertising and sponsorship should be prohibited (and in the short term restricted to factual information, in newspapers and adult press).			NP	NP	NP
Alcohol producers should be required to declare their marketing expenditure and the level of exposure of young people to their campaigns.			NP	NP	NP
Guidelines for the portrayal of alcohol in television and film should be developed and promoted.			NP	NP	NP
One third of alcohol product labels should be given over to an evidence-based health warning specified by an independent regulatory authority.	✓	✓	✓	✓	✓
Every alcohol product label should describe, in legible type, the product's nutritional, calorie and alcohol content.	✓	✓	✓	✓	✓

There is robust research evidence, outlined in both Health First and No Ordinary Commodity, that exposure to alcohol advertising and promotion has a strong relationship with alcohol consumption, particularly in young people. Robust and independent regulation of marketing is therefore a key aspect of any evidence-based strategy to reduce alcohol-related harm in young people. The evidence for the effectiveness of regulation of product labelling is less equivocal, but there is a strong argument that the public have a right to understand the contents of and risks associated with all products that they consume.

PROMOTION AND ADVERTISING

Regulation of alcohol promotions and advertising are dealt with at the UK-level. In the main these are governed by a series of codes of conduct compiled by the Portman Group, an organisation established and funded by leading alcohol producers to 'promote responsible drinking'. Separate codes of conduct exist for Alcohol Marketing, Sponsorship, and Advertising and Broadcasting. The content of the codes is set out by the Portman Group and breaches of the code, determined by an independent complaints panel, may be met with notifications that retailers should no longer stock offending products, or ultimately, expulsion of the producer from the Portman Group.

The exception to this self-regulatory system is broadcast advertising (TV and radio), for which the Portman Group's code is enforced independently by the Advertising Standards Authority, who also enforce their own codes covering general advertising (not specific to alcohol). This combination of self-regulation and 'co-regulation' goes against the recommendation in Health First that in the longer term all alcohol advertising and sponsorship should be banned and an independent body set up to regulate marketing and promotion. The UK coalition government's 2012 alcohol strategy acknowledges that 'there is known to be a link between advertising and people's alcohol consumption, particularly those under the age of 18', however it dismisses the idea of a ban on advertising, stating 'we have not seen evidence demonstrating that a ban is a proportionate response'. In contrast, whilst they have no independent powers to regulate alcohol marketing, both the Welsh Government and Northern Irish Executive have called for the UK Government to strengthen or mandate the industry's codes of conduct. The Scottish Government has called for UK action to protect children, including a ban on television advertising before the 9pm watershed, and a co-regulatory approach to online and possibly billboard advertising.

Within these limitations, the current codes of conduct state that 'a drink, its packaging or promotion should not have a particular appeal to under-18s', in line with the recommendations of Health First. There is no mention, either in the codes or in the alcohol strategy of any requirement for the industry to disclose either their marketing expenditure or the exposure of young people to their advertising campaigns, or of guidelines covering the portrayal of alcohol in broadcast media other than in advertisements (i.e. in TV programmes or films).

PRODUCT LABELLING

“One third of product labels should be given over to an evidence-based health warning specified by an independent regulatory authority.”

“Every alcohol product label should describe, in legible type, the product's nutritional, calorie and alcohol content.”

Under UK law all alcoholic drinks stronger than 1.2 per cent alcohol by volume (ABV) must be labelled with an indication of their strength. This is the only legal requirement on labelling, however a previous voluntary labelling scheme was revised jointly by the Portman Group and the UK Department of Health in 2010/11. The revised scheme states that all pre-packaged alcoholic products should be labelled with the alcohol content of the container in units, a warning about drinking whilst pregnant and a reference to the Chief Medical Officer's drinking

NO UK CONSENSUS ON LABELLING?

In February 2010 the Department of Health, together with the devolved administrations in Scotland, Wales and Northern Ireland, launched a consultation on the labelling of alcoholic drinks. This sought opinion on whether the existing voluntary labelling code should remain, be strengthened, or be replaced by a mandatory, legislated, alternative.

The published response to this consultation makes it clear that the Scottish, Welsh and Northern Irish administrations all supported mandatory legislation, but Westminster did not. All parties agreed that given that 'there was not a consensus amongst the UK administrations in favour of legislation' and that 'there are clear advantages for both consumers and the industry from a UK-wide approach', they would accept an offer from the Portman Group to strengthen the existing voluntary code and increase compliance to 80 per cent. This target became one of the key pledges in the UK Government's 'Public Health Responsibility Deal'.

guidelines. In addition, best practice guidelines recommend that this information should be grouped together, easily visible and clearly legible. This scheme is self-regulated by the Portman Group.

A key pledge in the Responsibility Deal was that 80 per cent of products on shelves in the UK would be compliant with this scheme by the end of 2013 and an evaluation of this pledge, commissioned by the Portman Group, was published in late 2014. This concluded that the pledge had narrowly failed to achieve its target, with 79.3 per cent of products on the shelf complying with the scheme. The Portman Group have represented this as a major success, although it should be noted that only 57.1 per cent of products met the best practice guidelines and that these still fall well short of the Health First recommendation that a third of labels be given over to an evidence-based health warning devised by an independent regulatory authority. In contrast, a recent independent study found that pregnancy warning labels on wine bottles are significantly smaller than those on other drink types, which is of particular concern, given that women are more likely to drink wine than men.

The Scottish Government has devolved power over alcohol labelling (as do Wales and Northern Ireland) and it remains to be seen if they will act to legislate on labelling following this apparent failure of self-regulation, as the Scottish First Minister previously mooted.

Health First also recommends that all alcoholic products be clearly labelled with nutritional and calorie content. Alcoholic drinks over 1.2 per cent are exempt from the EU legislation which requires this to be displayed on all food and soft drinks. A recent vote in the European Parliament supported the inclusion of calorific content on alcoholic drinks labels, although this vote was not binding and it is unclear whether any further action will be taken. Some drinks producers, including Diageo, have committed in principle to including nutritional and calorie content on product labels, although no timescale or specific proposal has been given for this to be implemented.

WHAT'S NEXT FOR LABELLING?

"This consultation makes it clear that, if the drinks industry does not act responsibly, the government will not hesitate to take action."

Nicola Sturgeon, then Scottish Health Secretary, 2010.

CONCLUSIONS

The current predominantly self-regulatory approach to the marketing of alcohol in the UK falls well short of the recommendations of Health First. Whilst there is some positive action with regards to advertising to young people and product labelling, significant changes would have to be made in order to align with current evidence-based policy recommendations. This is well illustrated by the UK Government's position on a total ban on advertising: acknowledging it as effective whilst dismissing it as not proportionate. The status quo on alcohol labelling is in line with the view of the former UK Coalition Government – seeking to work together with the industry through self-regulation – despite the fact that the stated preferences of all three devolved administrations was a stronger legislative approach, more in line with the evidence.

6. AVAILABILITY: LICENSING AND SALES

HEALTH FIRST STRATEGY RECOMMENDATIONS ON AVAILABILITY	UK	England	Wales	Northern Ireland	Scotland
Licensing authorities should be empowered to control availability of alcohol		✓	✓NP	✓✓	✓
Public health should be a licensing objective		NI	NP		✓✓
Alcohol sales in off-trade should be restricted to designated times...			NP	✓✓	✓✓
...areas of the shop			NP		✓✓
Active enforcement of ban on sales to drunk people		✓	✓	✓	✓
Local authorities should create alcohol-free public spaces		NI	NI	NI	✓
A cheaper soft drink option should always be available where alcohol is sold		✓	✓NP	NI	✓

There is strong evidence from studies across a range of countries, including the UK, that increases in the availability of alcohol, through increased hours or days of sale, or a higher density of alcohol outlets in a given area, are associated with increased consumption and alcohol-related problems. Therefore the most evidence-based recommendations here are the first three in the table above.

LICENSING LEGISLATION

In the UK, licensing powers are devolved to Scotland and Northern Ireland but not to Wales, therefore legislation introduced by the UK Government applies to both England and Wales. This does not prevent the Welsh Government expressing views that are contrary to current UK Government policy on licensing for England and Wales.

A useful example is that the Welsh substance misuse strategy calls for UK actions including a ban on the sale of alcohol at petrol stations, separate areas for alcohol sales in supermarkets and a public health objective for alcohol licensing. Such policies cannot currently be implemented independently in Wales. Interestingly, while Scotland and Northern Ireland have the power to introduce separate check-outs for alcohol, both consulted on the policy and decided against taking it forward. This ought to instil caution in interpreting the Welsh position as evidence that the policy would definitely be implemented should the relevant powers be devolved.

The Licensing Act 2003 (England and Wales) liberalised the supply of alcohol, enabling premises to obtain 24 hour licences. It also introduced objectives for licensing for the first time (see box). Guidance was later issued (2012) which was intended to allow local authorities to restrict sales of alcohol between midnight and 6am if this would contribute to the licensing objectives. This has never been implemented despite extensive effort: most notably in Blackpool where there was vociferous opposition from the licensed trade. The current Government has no stated plans to reverse 24 hour licensing.

Scotland introduced a new Licensing Act in 2005, also including the same four objectives for licensing, but adding a fifth, that of 'protecting and improving public health'. Mandatory licensing conditions introduced in 2007 under the Act restricted alcohol sales to a single publicly accessible area of the shop and prevented items other than soft drinks being displayed alongside alcohol products. The Act also introduced for the first time, a duty on licensing authorities to assess whether any given area in their remit is currently overprovided with licensed premises of any given type. This is intended to enable local authorities to refuse to grant additional licences where they deem an area to be overprovided, however no legal definition of overprovision is outlined. Evidence suggests that there has been considerable variation in the effort made by local areas in Scotland to use overprovision policies to refuse to grant new premises licences. The success (or otherwise) of the provision, and the accompanying public health objective cannot yet be fully judged and no substantial evaluations are underway.

Subsequent to the Scottish Act, additional guidance was issued for England and Wales to enable local authorities to apply for 'Cumulative Impact Policies' (CIPs) where there is 'potential impact on the promotion of the licensing objectives of a significant number of licensed premises concentrated in one area'. Both overprovision and cumulative impact policies may be applied to on or off-trade premises, but neither can be used to revoke an existing licence. Despite the lack of a public health objective, some areas in England report similar progress to those in Scotland in their attempts to influence licensing decisions in ways that promote public health. In both cases, decisions made by local authorities have been subject to legal challenge by wealthy vested interests (including supermarket and pub chains). It is therefore doubtful whether either licensing Act truly empowers local authorities to control the availability of alcohol in their area.

In Northern Ireland, licensing legislation is the responsibility of the Department for Social Development, which is then implemented by local county courts. Only a limited number of licences are available for pubs and off-licences; any new pub or off-licence wanting to sell alcohol must wait until an existing one surrenders its licence (known as the surrender principle). Licences are granted and administered by the courts, not elected local authorities; the courts have no guidance to assist in the practical application of the law. A new licence is granted by the County Court and will only be granted on the surrender principle, and only if the court is satisfied that the existing number of licensed premises is not already adequate (the need principle). The transfer of a licence is a matter for the magistrates courts.

LICENSING OBJECTIVES (ENGLAND AND WALES, 2003):

1. Prevention of crime and disorder
2. [Securing] Public safety
3. Prevention of public nuisance
4. Protection of children from harm

LICENSING OBJECTIVES (SCOTLAND, 2005): AS ABOVE PLUS

5. Protecting and improving public health.

PROPOSED LICENSING OBJECTIVES (NORTHERN IRELAND, 2009 PROPOSALS)

1. Promotion of public health.
2. Promotion of public safety.
3. Prevention of crime and disorder.
4. Prevention of public nuisance.
5. Protection of children from harm.
6. Fair treatment of all stakeholders

Proposals dating from 2009 in Northern Ireland suggest the introduction of six licensing objectives (see box above) and the transfer of licensing powers from the courts to local Government. The proposals make multiple references to the Scottish legislation, suggesting a degree of policy transfer. The Minister has announced a range of legislative changes to be introduced following a consultation in 2012, including advertising restrictions in supermarkets and off-licenses and limited late-night opening, although these are yet to be enacted. The administration has also previously rejected calls for 24 hour licensing that were made in the public consultation on the proposals.

ENFORCING BANS ON SALES TO DRUNK PEOPLE

“Active enforcement of ban on sales to drunk people”

In all four jurisdictions it is illegal to knowingly sell alcohol to someone who is already drunk, but there is no national action in relation to enforcement. The 2013 UK Government response to their alcohol strategy consultation, simply notes that ‘the Government want to ensure that local authorities make best use of’ their ‘tools and powers’.

ALCOHOL-FREE AREAS AND OPTIONS

“Local authorities should create alcohol-free public spaces.”

“A cheaper soft drink option should always be available where alcohol is sold.”

Only in Scotland were we able to find provision for local authorities (subject to confirmation by the Scottish Ministers) to create byelaws to ban drinking in designated public places (under a 1973 Act). The evidential basis for this recommendation may be weak, with the international review No Ordinary Commodity suggesting that such bans may simply displace drinking especially by young people.

In Scotland and in England and Wales, drinking/tap water must be available free of charge at licensed premises. Scottish legislation also provides that ‘other non-alcoholic drinks must be available for sale at a reasonable price’. In Wales, the substance misuse strategy calls for UK action ‘to ensure the availability and better promotion of...low priced soft drinks’.

CONCLUSIONS

Despite provisions across the UK to enable local control of the availability of alcohol, current legislation does not allow for reductions in the numbers of premises by revoking existing licences in the interests of public health.

It could be argued that the strongest current policy on licensing exists in Northern Ireland where no increase in licenced premises is possible – a new premise can only open if it acquires a licence from another venue anywhere in Northern Ireland. The situation in Scotland is largely consistent with the recommendations of Health First although it is clear that the public health objective does not necessarily ensure that local authorities can control availability, even as it continues to be challenging to exert any control over sales of alcohol online or via home delivery from supermarkets.

7. EARLY INTERVENTION, TREATMENT, RECOVERY

HEALTH FIRST STRATEGY RECOMMENDATIONS ON TREATMENT	UK	England	Wales	Northern Ireland	Scotland
All health and social care professionals should be trained to routinely provide early identification and brief alcohol advice to their clients.		✓	✓	✓	✓
People requiring intensive interventions should be routinely referred to specialist treatment services.		✓	✓	✓	✓
Greater investment is needed in specialist treatment services			NI	✓	✓✓
All acute hospitals should have specialist alcohol care teams to reduce readmissions			NI	✓	✓

Early identification of people drinking at levels that are risky or harmful for their health by health professionals, and the provision of brief and, where necessary, more intensive interventions are strategies supported by a solid evidence base and are cost effective.

ALCOHOL BRIEF INTERVENTIONS

There is consistent evidence from multiple studies to support the efficacy of early identification of people with alcohol problems by primary care professionals (GPs and nurses), when followed by a short conversation or small number of sessions of advice or counselling for those who are drinking more than is recommended. Little is known about the optimal content or duration of alcohol brief interventions to ensure effectiveness however, and although the Health First recommendation focuses on training, it is clear that in many cases training is insufficient to ensure routine delivery of these interventions.

Scotland has led the way in prioritising the delivery of these so called ‘alcohol brief interventions’ having established a national training programme and set an NHS target for their delivery in 2008 which has consistently been exceeded. Local Alcohol and Drug Partnerships must report the numbers of brief interventions they deliver in different settings and the target is still set annually and monitored by the Scottish Government. Despite a clear commitment to the evaluation of the national strategy, no research was commissioned to evaluate the quality or effectiveness of the interventions being reported to Government under the target, although two process evaluations are available.

The Welsh Substance Misuse Delivery Plan includes specific commitments to expand delivery of training on alcohol brief interventions in primary and hospital care. Since April 2015, GPs in England are contractually required to identify newly registered adult patients who are drinking at increased or higher risk levels. If fully implemented this

would result in the delivery of millions of alcohol brief interventions annually, however it does not appear that there is currently any mechanism in place to monitor compliance. An 'alcohol risk assessment' has also been introduced as part of the NHS health check for adults aged 40-75, which should in principle lead to a brief intervention being delivered to any patients identified as being at risk as a result of their drinking, although again there is no monitoring system in place to ensure that this is happening in practice. Local authority public health departments may also commission additional delivery of 'identification and brief advice' or IBA (as alcohol brief interventions are more commonly known in England). However in 2015, cuts to the public health grant for local authorities were mooted, which would potentially reduce the funding available to do this.

The Northern Ireland alcohol strategy recommends that 'Health professionals, particularly within primary care and A&E [be] trained and encouraged to undertake brief alcohol advice/intervention programmes across Northern Ireland', and 'Prevention and Early Identification' is identified as one of the 5 pillars which underpin the entire strategy. This is supported by a 'Regional Enhanced Service' launched in August 2010 which provides financial incentives to subscribing primary care practices for delivering alcohol brief interventions.

The evidence base is considerably less strong for the delivery of alcohol brief interventions by social care professionals as recommended here. Scotland allows 20 per cent of the ABI target to be delivered outside of health settings, and the English and Welsh strategies are supportive of wider delivery despite this gap in evidence, perhaps in part due to the recommendation by the National Institute for Health and Care Excellence. The Northern Irish Alcohol and Drugs Commissioning Framework also highlights criminal justice settings as a 'priority area' for brief intervention delivery. While the Scottish strategy included a commitment to piloting alcohol brief interventions in newer settings, and conducted some valuable work in criminal justice settings, such pilots have not as yet included robust research designs such as randomised controlled trials. A similar situation exists in Northern Ireland, which has committed to piloting brief interventions in other settings. In England, three large trials of alcohol brief interventions were commissioned by the Department of Health (see box), but these failed to find evidence of impact on alcohol consumption, contrary to a common misunderstanding that they were supportive of the impact of minimal interventions.

THE SIPS STUDIES

In England, the Department of Health commissioned three large trials of alcohol brief interventions (in primary care, criminal justice and A&E settings) known as 'SIPS': none of the trials found evidence for the effectiveness of the interventions in reducing alcohol consumption over and above the control arm of the trials, in which participants received an information leaflet. Particularly in primary care, these findings were incorrectly interpreted by many as establishing the effectiveness of an information leaflet, rather than failing to demonstrate the effectiveness of the brief interventions. The SIPS primary care findings are contrary to the established body of evidence and point to the complexities of understanding what works in alcohol brief interventions and the subsequent need for caution in designing, trialling and implementing alcohol brief interventions.

Ironically, local authorities were encouraged in the 2012 English/UK strategy, prior to the publication of the SIPS findings, to 'examine the strong case for further local investment in IBA by primary care staff, using the evidence set out in the SIPS research'.

TREATMENT

“People requiring intensive interventions should be routinely referred to specialist treatment services”

“Greater investment is needed in specialist treatment services”

“All acute hospitals should have specialist alcohol care teams to reduce readmissions”

The Scottish Government invested record amounts in treatment services under its alcohol strategy from 2008, and has managed to increase the proportion of alcohol-dependent individuals in treatment compared with England and Wales where there has not been the same injection of resources. All areas are broadly supportive of the role of alcohol liaison nurses in hospitals. Although not specifically discussed in Health First, there are many local examples of innovation and quality in alcohol services throughout the UK.

‘Health First’ does not focus on the move in many treatment services towards a ‘recovery-oriented’ approach – that may be because there is at present little robust evidence for this approach. There is however a supportive and vocal grassroots movement committed to enabling people to move on from alcohol and other dependence, which has led to extensive service re-organisation and change in some areas. The impact this will have on alcohol-related harms is unknown.

CONCLUSIONS

All areas of the UK are supportive of the implementation of alcohol brief interventions, although gaps in the evidence-base make it difficult to be certain of how effective such interventions are, particularly outside of primary care or of the best way to achieve routine delivery.

8. OTHER: DRINK-DRIVING AND INFORMATION/EDUCATION

HEALTH FIRST STRATEGY RECOMMENDATIONS	UK	England	Wales	Northern Ireland	Scotland
The legal limit for blood alcohol concentration for drivers should be reduced to 50mg/100ml		NI	NP	✓	✓
Random breath testing of drivers should be introduced		NI	NP	NI	NP
Graduated driver licensing for young and novice drivers should be introduced		NI	NI	✓	NI
Mass media campaigns should be developed as part of broader strategies to reduce the harm from alcohol, designed and run independently of the alcohol industry.		✓	NI		✓

DRINK DRIVING

There is consistent evidence from many countries for the effectiveness of lower drink driving limits in preventing alcohol-related accidents, injuries and deaths on the roads, even more so in younger people. Effectiveness depends partly on the level and visibility of enforcement, which is also true of random breath testing. Graduated driver licensing, in which additional restrictions are placed on new drivers, is also supported by good evidence.

Health First recommends a legal limit for blood alcohol content for drivers of 50mg/100ml, which mirrors the recommendations of the World Health Organisation. Currently 89 countries around the world meet or exceed this recommendation, and the rest of the UK excluding Scotland is one of only two areas in Europe (together with Malta) with a higher limit of 80mg/100ml.

Following the transfer of the relevant powers to the Scottish Parliament, the Scottish Government legislated to reduce the legal limit from 80 to 50 mg/100ml. The Scottish Government continues to appeal to the UK Government to devolve the power to introduce random breath testing.

A similar legal change in the blood alcohol limit has been drafted in Northern Ireland, but has not yet been through the full legislative processes. The Welsh Government's strategy calls for a reduction in the limit, and for random breath testing but they do not currently have the powers to enact these policies.

We were unable to find any information on graduated driver licensing in England, Wales or Scotland, however legislation is in process in Northern Ireland to bar new drivers for carrying passengers at night for 6 months after passing the driving test.

INFORMATION AND EDUCATION APPROACHES

“Mass media campaigns should be developed as part of broader strategies to reduce the harm from alcohol, designed and run independently of the alcohol industry”

While there is no evidence for the effectiveness of mass media campaigns (and very little to support other educational interventions) in changing people's drinking behaviour, conventional public health wisdom (based on evidence relating to mass media in other health behaviours including smoking) is that they may have an important part to play in building public support for the other policy approaches that are more effective. It is important therefore that they are not seen as effective by themselves, and not designed, funded or implemented by organisations which are opposed to other measures such as the regulatory approaches described here.

All areas were involved in public campaigns such as Change4Life in England and Wales or Alcohol Awareness Week in Scotland. The latter initiative is supported by the alcohol industry which is inconsistent with this Health First recommendation. Furthermore, both the former UK Government responsibility deal and the Scottish Government's Alcohol industry partnership, endorse Drinkaware, an industry sponsored website for the public. There remains a link to Drinkaware on the Scottish Government website.

Although outside the scope of this report, we are aware of many industry-funded initiatives working in schools across the UK. Neither the UK nor devolved administrations have publicly provided guidance to schools and local authorities in relation to the evidence base on the conflicts of interest involved, and their implications.

CONCLUSIONS

Scotland has led the way in reducing the drink driving limit, however all areas except possibly Northern Ireland (see page 12) are involved with the UK Responsibility Deal which endorses an industry-funded public information website Drinkaware, out of line with Health First.

9. DISCUSSION AND RECOMMENDATIONS

This report is, as far as we are aware, the first robust effort to comprehensively describe and compare alcohol policy across the UK, against an evidence-based model strategy compiled by independent experts. The findings clearly illustrate the point that scientific evidence does not, in itself, dictate policy; that Scotland has led the way on evidence-based alcohol policy (albeit having more powers than the other devolved administrations); and that there is no single, clear, easy to access, up to date source of information on the full range of alcohol policies and programmes in each area of the UK.

EVIDENCE-INFORMED POLICY?

There are examples throughout the policy and programme documentation of evidence being cited to support policy decisions, but other examples where public support, argument or assertion is used instead. In rejecting policy options which are considered by experts to be supported by evidence, the UK Government also deploys a range of defences – notably that there is not enough evidence that they do not feel that the policy (e.g. banning alcohol advertising) is a ‘proportionate response’ – presumably meaning that they are unconvinced that the level of problem is worthy of this level of intervention in the alcohol marketplace. This suggests that policy decisions are based to a significant degree, on underlying beliefs or ideologies – core questions about the role of the state, and the autonomy of individuals over their own behaviour, in an unequal society. Politically, action on public health is seen as interventionist, more associated with left-leaning administrations, rather than the smaller government, market-led approaches favoured by the political right.

This ideology is also reflected in the way in which alcohol problems are framed in national documents, either as a ‘whole population’ issue (needing everyone to think about and reduce their consumption) or as the result of bad behaviour by an irresponsible minority (binge drinkers and the young). It would seem in this case, that the UK Government is fundamentally unconvinced that alcohol is in fact ‘No Ordinary Commodity’, which would justify market intervention; preferring the same rhetoric as the alcohol industry, focusing on individual responsibility and consumer information and choice.

The importance of ideology is lent further support by the clear conclusion that the UK Government, the most right-leaning of all the administrations, was/is the only one which is not clearly implementing or moving towards a public health approach to alcohol. The former coalition actively opposed action at a UK level (e.g. mandatory product labelling), even when it was supported by the other three areas. Ironically, this particular policy is one which is devolved to the nations, and it remains to be seen if any of the three devolved administrations will seek to go it alone.

While the use of existing evidence has been inconsistent, there have been even fewer robust examples of Government taking the lead on piloting or robustly evaluating policies and programmes in ways which improve our understanding of what works or doesn’t work. Alcohol brief interventions have been the subject of much research in primary care, but very little is known about how best to drive implementation in routine practice. Neither the Scottish Government (where a large programme of ABIs was rolled out in primary care), nor the Department of Health at Westminster (who commissioned a large randomised controlled trial of ABIs in primary care), have sought to roll out ABIs in a piloted, stepwise fashion with randomisation and data collection built into routine

practice, to generate this much needed evidence. As a result, the answers to even simple research questions are unknown. Failing to properly evaluate innovation deprives future decision-makers of valuable information about whether to continue with policy experiments, but also fails to provide the kind of learning necessary for policy transfer to other regions or countries.

Recommendation 1: There is a need for Governments to more fully embrace the value of experimentation as there are inevitably gaps in evidence about what will work, where, how and with whom, and whether there are unintended consequences.

WHY DID SCOTLAND LEAD THE WAY?

The election of the Scottish National Party to power heralded the start of the shift to a whole population approach to alcohol which was subsequently adopted at least in part by Wales and Northern Ireland. Scotland has greater autonomy and powers than the other areas, and has led the way on many of the most evidence-based measures. The reasons for this have been much discussed. Five possible explanations merit mention. Firstly, a paper published in the leading medical journal 'The Lancet' in 2006 showed steep increases in deaths due to liver cirrhosis in the UK, with the steepest increases in Scotland giving it one of the highest rates in Western Europe. This paper is highly cited and graphs from it appeared in PowerPoint presentations with remarkable frequency at health conferences in Scotland from 2007 onwards. So perhaps Scotland acted first, and did more, because it had the biggest problem.

Another theory is that the new nationalist Government wanted to act on a high-profile issue on which to distinguish Scotland as a nation, and their administration, from the rest of the UK. Related to that is the idea that as the previous Labour/LibDem coalition in Scotland was lauded for being the first area in the UK to introduce a ban on smoking in public places, a policy that was subsequently introduced across all four areas, the SNP Government wanted to create a similarly ground-breaking health legacy.

A fourth potential explanation arises from studies of industry lobbying which find that the three main Westminster parties have been and continue to be targeted and influenced by long-term, extensive lobbying activity by alcohol industry public relations representatives. It is this close, intricate involvement of industry activists with the Westminster parliament, in part, that is thought to have scuppered minimum unit pricing in England. In contrast, the thinking goes, the alcohol industry did not see the SNP coming and had not established the kind of relationships to shape politicians' and civil servants' thinking over time (like 'water dripping on stone') to more industry-favourable positions.

Finally, the devolved administrations are smaller, their politicians, civil servants and ministers more accessible, and the populations they serve much smaller compared with Westminster. These factors are thought to have enabled third sector advocacy organisations, public health professionals and academics to more easily reach, inform and influence the devolved governments. Organisations such as Scottish Health Action on Alcohol Problems, which was newly established at that time by the Royal Colleges in Scotland, were particularly influential.

The truth may lie in a combination of all or some of these factors and it remains to be seen if Wales and Northern Ireland will be able to progress similarly to (or better than) Scotland in relation to evidence-based alcohol policy, should they be awarded all of the necessary powers.

WHAT NEXT?

The Scottish Government is currently taking stock of the 2008 national framework with a view to updating it. Of the top three policies considered likely to be most effective – price, availability, marketing – there has been little attention paid to date in relation to the latter. This would be the obvious way for the Scottish Government to continue to lead on evidence-based alcohol policy, providing that they can persuade Westminster to devolve the relevant powers. Their stated position of banning television advertising before the 9pm watershed seems a good starting point; as does banning alcohol-related sports sponsorship.

Recommendation 2: The Scottish Government should continue to seek the powers necessary to take legislative action in line with the evidence, in particular in relation to alcohol advertising and sponsorship. Wales and Northern Ireland should also continue to lobby in support of their already stated policy positions, and for the devolution of the necessary powers to implement them, if the UK Government is unwilling to take evidence-based action on all outstanding issues.

Across Scotland, Wales and Northern Ireland (and indeed in many European countries), policy-makers are anticipating a decision on minimum unit pricing by the European Courts of Justice. Whatever the decision, it is unlikely to be definitive, and it is unclear whether Wales or Northern Ireland will go ahead with minimum unit pricing before legal proceedings in Scotland are resolved.

Recommendation 3: The UK Government should reverse its opposition to MUP and all of the administrations should state their support for a change in EU law to allow for directly proportionate taxation by strength. In the meantime, the UK Government should reverse recent tax cuts on alcohol and reintroduce the ‘duty escalator’ in order to prevent further falls in the affordability of alcohol (see page 18).

On availability, a recent consultation on licensing in Scotland has called for more accountability on the part of licensing boards in relation to their policies and decisions. It is also recognised across the UK however that an unequal playing field exists where the alcohol industry have large resources to legally challenge licensing boards, and this creates a barrier to attempts to reduce availability. In order to reduce availability, powers beyond the ability to decline new licence applications would be needed, as well as greater control over online shopping. Some aspects of licensing legislation could be strengthened now, however more radical solutions may be needed after rigorous debate, innovation and research.

All four administrations continue to engage with the alcohol industry through partnership approaches in ways the evidence suggests may be unhelpful to public health (and very helpful to the industry). On the face of it, the Scottish Government Alcohol Industry Partnership (SGAIP) seems at least as inappropriate (in the face of the evidence) as the UK Responsibility Deal (RD). Closer analysis of the minutes of SGAIP meetings, and the lack of publicity given to it in Scotland (compared with high-profile RD events), makes us consider an alternative explanation, that it is perhaps a way for Scottish Government to be seen (by critics of their progressive alcohol control measures) to be engaging with industry. If this is the case, is it the public health equivalent of a kind of ‘corporate social responsibility’ activity that is often used by the alcohol industry to deflect criticism? If the SGAIP is truly not a substitute for the headline policies that really matter, then perhaps its existence partly enables the Scottish Government to be more radical while still keeping lines of communication open.

Similarly, the impotence of the Responsibility Deal in improving public health would not matter as much if the UK Government were controlling advertising, raising taxes and strengthening licensing law – but while it is not, it gives a veneer of something being done, even though it is almost totally ineffective. This approach may be pragmatic, but seems likely to serve the interests of industry more than those of public health.

Recommendation 4: All administrations should stop engaging with the alcohol industry except in relation to their role as producers and retailers of alcohol, in particular, avoiding any involvement of the industry in public health policy as it relates to alcohol.

A COMMENT ON ACCESSIBILITY

In this review, we limited our scope to information in the public domain, and intended to limit it to information which could be easily tracked down using search engines and the main government websites. We found that there was no single, clear, easy to access, up to date source of information on the full range of alcohol policies and programmes in each area of the UK. Even in Scotland where there was a national strategy, evaluation and outcomes framework; it was difficult to track down the most up to date position in relation to many of the Health First recommendations.

In general, the national strategies became outdated very quickly, as they are superseded by a series of subsequent activities and policy announcements. Relevant information is often split between different documents, with one covering public health policy on population drinking and another on treatment systems for individuals. Some areas published updates on action in relation to each element of the strategy, which is very helpful. Without this, it is impossible to be sure of whether a strategy document (irrespective of the date on the front) is still current policy, particularly if there has been a change of minister or administration.

The complexity is further increased by the question of who has power to do what, where. A Government may state support for a particular policy which they do not have power to implement (e.g. random breath testing for drivers in Scotland) or may propose the implementation of a policy even where it is unclear, and requires legal review to determine, whether they have the necessary powers (e.g. minimum unit pricing in Wales). Furthermore, it is often hard to determine whether a policy announcement by the UK Government applies to England only or England and other jurisdictions, in particular Wales, but sometimes also Northern Ireland and Scotland. This could be made much clearer in UK documentation. A clear example of this lack of clarity is the Public Health Responsibility Deal, whose website states that it aims to ‘improve public health in England’, yet several of the major pledges (including those on product labelling and the ‘billion unit’ pledge) relate to the whole of the UK without this being stated explicitly.

Overall however, our finding is that it is very time-consuming and relatively complex to get a full snapshot of policy and programmes in each jurisdiction, even coming from a position of considerable prior knowledge. In one case, even the relevant government department were unable to tell us the year in which a particular policy measure was introduced, as they had no record of it.

Recommendation 5: All administrations should ensure that alcohol policies and programmes are clearly outlined in one easily navigable online resource that is continuously kept up to date. This should articulate the administration’s overall strategic approach, draw together all actions, developments, plans and policy positions relating to all issues outlined in Health First.

CONCLUSION

This benchmarking of national alcohol policy against Health First shows clearly how the different administrations in the UK are framing, evidencing and implementing alcohol policies and programmes. We expect that it will be informative for the administrations in each jurisdiction and those trying to influence them towards evidence-based alcohol policy. It should be particularly timely for the UK Government, which currently does not have an alcohol strategy, and the Scottish Government, whose strategy is being updated.

Recommendation 6: This benchmarking exercise should be repeated regularly and used to monitor progress or regress in relation to effective alcohol policy over time.

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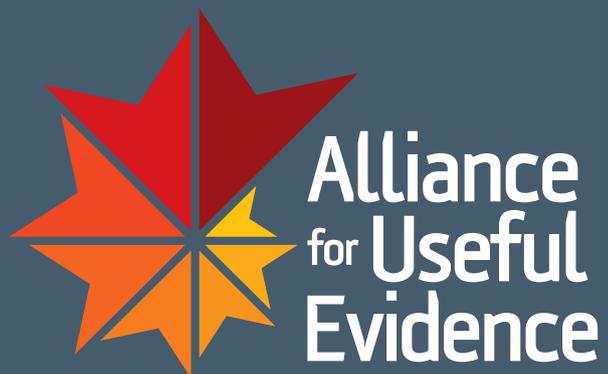
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DISCLAIMER

The authors have made every effort to identify and review the most recent published information on the alcohol policy and programmes of each administration. For the reasons discussed in the report however, it is not easy to ascertain the specific position of each administration in relation to every policy, and such positions can change rapidly. We cannot therefore guarantee the accuracy of all of the information provided, and the contents should be viewed as a 'best available snapshot' at the time that the review was conducted (July 2015). We cannot accept responsibility for any consequences that may arise from inaccuracies or misinterpretations contained herein.



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