Scottish Health Action on Alcohol Problems (SHAAP) response to the Government of Malta consultation on Malta's National Alcohol Policy

November 2016

Scottish Health Action on Alcohol Problems (SHAAP) welcomes the opportunity to comment on Malta's National Alcohol Policy. SHAAP provides the authoritative medical and clinical voice on the need to reduce the impact of alcohol related harm on the health and wellbeing of people in Scotland and the evidence-based approaches to achieve this.

SHAAP was set up in 2006 by the Scottish Medical Royal Colleges through their Scottish Intercollegiate Group (SIGA). SHAAP is governed by a Steering Group made up of members of the Royal Colleges and Faculties in Scotland.

SHAAP works in partnership with a range of organisations in Scotland and beyond. Key partners include Alcohol Focus Scotland, the British Medical Association (BMA), the Scottish Alcohol Research Network (SARN), the Alcohol Health Alliance, the Institute of Alcohol Studies, Eurocare and the European Public Health Alliance (EPHA).

Background to alcohol and alcohol policy in Scotland

Scotland continues to have a troublesome relationship with alcohol. Latest figures show that 10.8 litres of pure alcohol was sold per adult in Scotland (in 2015). This is equivalent to 20.8 units per adult per week, or 41 bottles of vodka, 116 bottles of wine, or 476 pints of beer per adult[1]. Levels of alcohol consumption in Scotland are more than 25% higher than in Malta (7.9 litres per adult) and also exceeds the European average of 9.4 litres.

Alcohol-related deaths are also a significant issue in Scotland. On average, 22 Scots die every week because of alcohol. Further, this is also associated with significant levels of alcohol-related morbidity in Scotland. In 2015/16, there were almost 35,000 alcohol-related hospital admissions in Scotland[2], at significant cost to the country. Indeed, it is estimated that alcohol misuse costs £3.6 billion per year, equivalent to £900 for every adult in the county. Excessive alcohol consumption is also associated with a range of other costs including costs to society, the family, communities, and the health of the individual.

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[1] NHS Health Scotland Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) (2015) Alcohol consumption and price in Scotland 2015 http://www.healthscotland.com/uploads/documents/27345-00.%20Alcohol%20consumption%20and%20price%20in%20Scotland%202015%20-%20May2016.pdf

[2] Information Services Division (ISD) (2016) Alcohol-related hospital admissions 2015/16 https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2016-10-25/2016-10-25-ARHS-Report.pdf

In 2009, the Scottish Government introduced a comprehensive Alcohol Strategy for Scotland – Changing Scotland's Relationship with Alcohol: A Framework for Action[3]. Key elements of the strategy include:

- A ban on price promotions of alcohol in off-licensed premises;
- The introduction of minimum retail pricing for alcohol to prevent loss-leading and below-cost selling of alcohol;
- Establishing a youth commission to explore the issues faced by young people in relation to problem alcohol use;
- Giving licensing boards the power to raise the minimum age for off-sales purchases within their area;
- Support for the delivery and evaluation of brief interventions to reduce harmful alcohol use.

A number of key pieces of legislation have been introduced to support these elements. The Strategy is currently being refreshed, with the refreshed strategy due to be published before the end of the year.

We believe that the Framework and Strategy of the Scottish Government offers a good benchmark for other governments when introducing and/or amending their alcohol strategies, and encourage the Government of Malta to adopt, while adapting to suit local circumstances, some of the measures outlined above to reduce levels of population consumption and alcohol-related harm.

Policy Actions to Address Underage Drinking

We welcome the actions outlined in this section. There is a large body of evidence which shows that the more young people are exposed to alcohol at a young age, the greater the likelihood they will drink and increases amount they will drink and the frequency of their drinking[4].

Actions 1-3

In Scotland, there is a scheme called the Test Purchasing Scheme, which is operated by the national police, Police Scotland, and is designed to prevent alcohol being sold to minors (those under the age of 18). Operating a test purchasing scheme could contribute towards reducing the number of outlets where children and young people are able to purchase alcohol. Education and engagement with alcohol retailers in this regard is important to address the knowledge gap that many of them have[5]. At a meeting SHAAP held with Police Scotland in October last year to discuss test purchasing, they stressed that education of the license holder (of an outlet or premise) is key to the success of test purchasing. When an outlet or premise fails a test purchase, it is usually widely publicised in media and the local area, and thus has a much wider impact. This should also be accompanied by stronger enforcement of ID checks.

Police Scotland also identified proxy purchasing by adults as a source of alcohol for minors. Those who commit the offence of proxy purchase are liable to a £90 Penalty Notice for Disorder (PND). Retailers are encouraged to display notices warning against proxy purchase and are encouraged to inform police and/or Trading Standards of any instances of adults who may be buying alcohol on behalf of young people[6]. Extension and expansion of ID verification practices in off-trade premises

[3] Scottish Government (2009) Changing Scotland's Relationship with Alcohol: A Framework for Action http://www.gov.scot/Resource/Doc/262905/0078610.pdf
[4] Alcohol Concern et al (2014) Children's recognition of alcohol marketing http://www.alcohol-focus-scotland.org.uk/media/62890/Children_s_Recognition_of_Alcohol_Marketing_Briefing.pdf
[5] Scottish Centre for Social Research (2007) Evaluation of Test Purchasing Pilot for sales of alcohol to under 18s – Interim Report http://www.gov.scot/Resource/Doc/166491/0045369.pdf
[6] http://www.communityalcoholpartnerships.co.uk/what-we-do/enforcement

for example, such as verifying the age of all present when alcohol is purchased, could contribute to a reduction in proxy purchasing. Such practice would be both effective and cost-effective. Achieving progress will thus require a combined approach of public information, server training, effective policing and price controls.

Action 4
We are pleased to note the inclusion of proposals to segregate alcohol products within licensed retail outlets. In Scotland, the Alcohol Act (2011) introduced legislation which restricted the display of alcohol products to a certain specified section of the retail outlet, and also banned multi-buy promotions such as buy one get one free. Since the introduction of the Act, off-trade sales have fallen by 2.6%, primarily driven by a 4% reduction in wine sales. This is equivalent to 4.5 million fewer bottles of wine sold in the year following implementation[7]. We would like to see this extended to further segregate alcohol displays within stores. The proposal could be further supported by the introduction of alcohol-only check outs, another measure we have called for to be introduced into Scotland[8]. Such practices would help to help de-normalise the practice of purchasing alcohol and help it be viewed as not an ordinary commodity.

Action 7
We would urge caution when involving the alcohol industry in the development of education campaigns. Producers and industry bodies should not have any direct involvement in the production of health information or education materials for use in schools or youth settings by minors. The idea of Corporate Social Responsibility (CSR) by alcohol producers and other industry actors is largely for image building and minimising reputational damage, and rarely reflects a genuine interest in preventing and/or reducing alcohol-related harm[9].

Policy actions to address harmful alcohol use in the general population

We welcome the proposals outlined in this section.

To address harmful alcohol use in the general population, whole population measures which address the price, availability and marketing of alcohol are crucial. Action to address the World Health Organisation's three 'Best Buys'[10] of price, availability and marketing have the greatest impact on improving the health and wellbeing of the whole population.

Action 10
Price is a key driver of consumption and we welcome the recommendation to monitor and control its impact on the harm caused by alcohol. There is a significant and well-evidenced relationship between the price of alcohol and levels of consumption.

A key measure for reducing the harm caused by alcohol is controlling the price of alcohol via minimum unit pricing (MUP). MUP is particularly effective at protecting those most at risk by reducing the amount of alcohol drunk by harmful drinkers who buy most of the cheap high strength

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[7] NHS Health Scotland Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) (2016) Final Annual Report, March 2016 http://www.healthscotland.com/uploads/documents/26884-MESAS__Final%20annual%20report.pdf

[8] SHAAP (2016) SHAAP's Top Twenty: A Manifesto for Action on Alcohol http://www.shaap.org.uk/images/shaap-top-20.pdf

[9] SHAAP (2013) The (Ir)responsibility Deal?: Public Health and Big Business http://www.shaap.org.uk/images/UserFiles/File/SHAAP%20Irresponsibility%20Deal%20AmendedMay13.pdf

[10] http://www.who.int/nmh/publications/who_bestbuys_to_prevent_ncds.pdf

alcohol. MUP targets cheap, strong alcohol sold in supermarkets and off- licences that is favoured by heavy drinkers who suffer the most harm[11]. It sets a floor price below which alcohol cannot be sold.

In Scotland, alcohol misuse costs £3.6 billion per year, equivalent to £900 for every adult in the country. Scottish Government analysis found that a 50 pence minimum unit price would save over 300 lives per year and significantly reduce alcohol-related costs to the NHS. This substantial health impact would be supplemented by a wide range of other social benefits including a reduction in crime and disorder, fewer alcohol-related employment absences and reduced unemployment among harmful drinkers. By year 10 of the policy, the current estimated value of harm reduction is £924 million[12]. Evidence from Canada further highlights the effectiveness of MUP. In British Columbia, a 10% increase in the average minimum price of all alcohol products was associated with an estimated 32% fall in deaths wholly attributable to alcohol and a 9% drop in acute alcohol-related hospital admissions. This price increase also led to a more than 8% reduction in consumption[13]. Minimum unit pricing could contribute to significant cost savings over the next decade in Malta, as well as reducing alcohol-related mortality.

The Scottish Government passed legislation in 2012 called The Alcohol (Minimum Pricing) (Scotland) Act which set out plans for the introduction of a 50p minimum price per unit. MUP has not yet been introduced due to a legal challenge fronted by the Scottish Whisky Association. In October of this year, the Scottish Court of Session ruled that MUP is legal and dismissed the industry challenge to the policy. We hope that the policy will now be implemented as soon as possible and call on the Scottish Government to implement[14]. It is worth noting that the Scottish MUP legislation includes a sunset clause. If, after 6 years there is evidence that MUP is having unintended consequences, the legislation can be repealed.

We believe that the introduction of a minimum unit price for alcohol in Malta would be highly significant and would make a substantial contribution to reducing levels of alcohol consumption and its associated harms.

Actions 11-16

Scotland has introduced a comprehensive suite of alcohol policies which have successfully contributed to reducing alcohol-related harms and levels of consumption.

The Licensing Act (2005) introduced mandatory server training for all staff to increase server liability, and measures to reduce underage selling, particularly test purchasing, as outlined earlier[15]. In October 2011, the Licensing Act was amended to introduce a new mandatory condition that all premises must have an age verification policy in relation to the sale of alcohol. The regulation introduced the 'Challenge 25' scheme whereby retailers are required to ask for identification if they believe the person trying to purchase alcohol is under 25[16]. Although the legal purchase age for alcohol in Scotland is 18, the Challenge 25 policy is designed to ensure that age verification becomes widespread and to minimise the number of people who slip though the net.

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[11] http://www.shaap.org.uk/minimum-pricing-for-alcohol.html

[12] Scottish Government (2014) Scottish Government's position on Minimum Unit Pricing of alcohol

[13] Scottish Government (2014) Scottish Government's position on Minimum Unit Pricing of alcohol

[14] http://www.shaap.org.uk/news/scottish-court-finds-mup-legal-shaap-press-release.html

[15] NHS Health Scotland Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) (2016) Final Annual Report, March 2016 http://www.healthscotland.com/uploads/documents/26884-MESAS__Final%20annual%20report.pdf

[16] http://www.challenge25.org/

Scotland was the first country in the world to introduce and operate a national programme of Alcohol Brief Interventions (ABIs). The ABIs are delivered in priority settings of primary care, A&E, and antenatal care, as well as being expanded into a range of wider settings, such as criminal justice and social work. The programme as a whole was designed to increase the reach and quality of ABIs delivered to hazardous and harmful drinkers, to provide support to those who could benefit, and increase detection and referral of dependent drinkers. Between 2008/09 and 2014/15, an estimated 569,792 ABIs were delivered in Scotland. This is 149% of the target set. Since its implementation, it is estimated that the programme has reached 43% of harmful and hazardous drinkers[17]. In 2015/16 specifically, 97,245 ABIs were delivered, exceeding the target by 59% and over 80% of these were delivered in priority settings[18]. The ABI programme is making an important contribution to reducing levels of alcohol related harm in Scotland.

We believe the above measures could make an important contribution to addressing harmful use in the general population in Malta, as well as effectively targeting those most at risk.

Actions to reduce negative effects of drink driving

Scotland lowered its drink driving limit from 80mg/100ml to 50mg/100ml in December 2014, following a period of consultation. In the nine months immediately following the reduction, drink driving offences fell by 12.5%. This is equivalent to a fall in the number of offences from 4,208 to 3,682[19]. Better education and enforcement are also critical parts of the solution. The introduction of the lower limit in Scotland was accompanied by both of these.

Previous evidence supports these outcomes. Evidence suggests that the risk of dying in a road traffic collision is twice as high with a blood alcohol concentration (BAC) of between 50 and 80mg/100ml than between 20 and 50mg/100ml[20], with drinking by drivers with BAC levels of between 50mg/100ml and 80mg/100ml a significant but largely hidden cause of accidents. According to research by the Institute of Alcohol Studies (IAS) conducted in England and Wales, reducing the drink drive limit to 50mg/10ml would save 64 lives per year. Further, a modelling study carried out by the Parliamentary Advisory Council for Transport Safety (PACTS) found that lowering the drink driving limit can also be expected to have an effect on a broad range of drivers[21]. It can influence those with BAC already below 50mg/100ml, who want to ensure they remain firmly within the limit; those with BAC between 50mg and 80mg/100ml who wish to comply with the new limit; and those with BAC somewhat above the current limit of 80mg/100ml but who are intending to comply with both the existing and new proposed limit. The effect of any regulation to lower the drink driving threshold can therefore be expected to be wide ranging and comprehensive.

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[17] NHS Health Scotland Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) (2016) Final Annual Report, March 2016 http://www.healthscotland.com/uploads/documents/26884-MESAS__Final%20annual%20report.pdf

[18] NHS Scotland Information Services Division (ISD) (2016) Alcohol Brief Interventions 2015/16 https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2016-06-14/2016-06-14-ABI2015-16-Summary.pdf

[19] http://news.scotland.gov.uk/News/82-of-people-believe-that-drink-driving-is-unacceptable-1ffc.aspx

[20] Centre for Public Health Excellence NICE (2010) Review of effectiveness of laws limiting blood alcohol concentration levels to reduce alcohol-related road injuries and deaths, Final Report, March 2010 http://www.ias.org.uk/uploads/pdf/Drink%20driving%20docs/BloodAlcoholContentEffectivenessReview.pdf

[21] Allsop (2015) Saving Lives by Lowering the Legal Drink-Drive Limit, Parliamentary Advisory Council on Transport Safety (PACTS) http://www.racfoundation.org/assets/rac_foundation/content/downloadables/saving_lives_by_lowering_legal_drink-drive_limit_Allsop_December_2015.pdf

Lowering the drink driving limit changes public perceptions of the issue, helps to reinvigorate messages that it is unacceptable, and can lead to actual behaviour change.

Evidence from Scotland in the twelve months following the introduction of the lower limit shows that 82% of people believe drink driving is unacceptable. Only five per cent would now opt to drive home after a night out where they had been drinking, and 67% would no longer consider driving the morning after[22]. Under a limit of 80mg/100ml, the average person could consume a pint and a half of beer and half a glass of wine, for example, and expect to pass a breathalyser test. Now, under the 50mg/100ml limit, this has been cut to a single pint of beer or glass of wine. This example is for illustrative purposes only. Given that people metabolise alcohol at varying rates, it is almost impossible to advise people on what they can and cannot drink before getting behind the wheel. According to the Scottish statistics, most people now chose not to drink at all if they are driving. This is a significant behavioural change.

The lowering of the limit in Scotland was also accompanied by a high-profile publicity campaign warning drivers of the risk from even one drink. As seen in other policies around alcohol, education campaigns/programmes to increase knowledge and shift attitudes are known to have limited impact on individual behaviour, but are important in terms of ensuring people have the information necessary to make informed choices about risk[23]. Such campaigns also help to challenge the normalisation of alcohol in society. Legislation and education/public-awareness campaigns should therefore not be viewed in isolation but rather as mutually reinforcing for influencing behaviour change.

In our response[24] to the Scottish Government's Consultation of 2012 on reducing the drink driving limit in Scotland, we outlined a range of options that could be considered in order to tackle drink driving, and we believe some of these options may be relevant to the Maltese context. These include:

- Making it clear that even the smallest amounts of alcohol will impair function to drive. Giving some more specific examples of how your ability to drive safely is compromised might be helpful as would reviewing relevant medical evidence.
- Supporting a campaign to discourage drinking at any level whilst driving – given that people metabolise alcohol at varying rates, it is almost impossible to advise people on what they can and cannot drink before driving. We note there are a small number of EU countries with a zero limit for drink-driving.
- Targeting specific groups of drivers. Evidence suggests that younger drivers are more greatly affected by alcohol than older drivers, with the peak age for drink driving being 27.
- Primary prevention and education activities, especially for young people.
- Comprehensive access to treatment and support services for people with alcohol problems, and support for families affected by alcohol misuse, including drink-driving.
- Zero-tolerance for novice drivers, drivers of commercial vehicles and drivers of motorbikes.
- Graduated licensing should be introduced, restricting the circumstances in which novice drivers can drive.

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[22] http://news.scotland.gov.uk/News/82-of-people-believe-that-drink-driving-is-unacceptable-1ffc.aspx

[23] NHS Health Scotland (2016) Monitoring and Evaluating Scotland's Alcohol Strategy (MESAS) Final Annual Report, March 2016, page 41
http://www.healthscotland.com/uploads/documents/26884-MESAS Final%20annual%20report.pdf

[24] http://www.gov.scot/Resource/0041/00416770.pdf

We are encouraged to note the legislation outlines measures for new roadside breath testing powers, including random and selective breath testing, which SHAAP recommended in our response to the Scottish Government's consultation in 2012.

We believe, as has been shown in Scotland, that a new, lower drink-driving limit in Malta would be extremely beneficial and contribute to a significant reduction in alcohol-related road deaths and injuries, and this can be achieved in a relatively short period of time. Further, the introduction of the same lower drink driving limit of 50mg/100ml in Malta would produce similar changes in public attitudes that will lead to subsequent behaviour change. Crucially, such action must be accompanied by widespread, high-profile public information campaigns to ensure consistent reinforcement of the message. A message that there is no safe level of alcohol consumption in relation to driving should be promoted.

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