

AlcoholNZ article

Title

Settings for alcohol help interventions – A Scottish perspective

At a glance

- This article was published in print form in HPA's January 2015 *AlcoholNZ* magazine (available on alcohol.org.nz/alcoholnz).
- Dr Peter Rice, an addiction psychiatrist based in Scotland, is the author. He draws on his expertise, experience and knowledge of the evidence to discuss:
 - the settings where alcohol interventions take place
 - whole-population and high-risk approaches and characteristics, and what works
 - where to find useful international information, research and training materials.

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Settings for alcohol help interventions

A Scottish perspective

The following article has been prepared by
Dr Peter Rice, an addictions psychiatrist
based in Scotland.

Dr Rice has recently visited New Zealand and was a keynote speaker at the 2014 Cutting Edge national addictions conference in Dunedin and participated in a series of meetings around New Zealand. He has worked for many years in a National Health Service (NHS) Alcohol Problems Service and is the chair of Scottish Health Action on Alcohol Problems (SHAAP). SHAAP was set up in 2006 by the Scottish Medical Royal Colleges. It 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.

Setting the scene

Alcohol is everywhere. The World Health Organization (WHO)-sponsored publication which best summarises approaches to reducing alcohol harm is called Alcohol: No Ordinary Commodity (Babor et al., 2010). This is a title that is cleverly chosen to encourage us to consider why communities throughout history have regulated alcohol through controls on number and places where alcohol can be sold, who it can be sold to, who is allowed to sell it, how it is promoted, the price and other considerations.

Yet despite this acceptance that alcohol needs to be regulated, it is ubiquitous. It certainly is in the UK, and on my visit to New Zealand from Scotland in September 2014 the landscape looked very familiar, in more ways than one.

To pick out some of the UK data, Work in Wales found that 10 to 11-year-old children are more familiar with alcohol brands than confectionery brands (Alcohol Concern Cymru, 2012). TV viewers of English Premier League football see two alcohol promotions per minute (Graham & Adams, 2014) and Scottish Public Health departments tell us that 80% of the population of Edinburgh lives within 400 metres of an alcohol retail outlet and there is enough pub provision in Dundee for two-thirds of the city's population to go to the pub at the same time (Dundee City Alcohol and Drug Partnership, 2014).

Where do or should interventions take place?

In our services, people with alcohol problems are readily found in Police stations, courts, family centres, GP clinics and pretty much every department of a hospital. All this will be familiar to readers of this journal. Looking for alcohol problems in our public services is like looking for hay in a haystack.

So if our guiding principle is that our response should take place wherever the problem is identified, the opportunities are many and varied. Being able to meet all the identified need would be nirvana, but real life is that we have to choose priorities and be open about the implications of those choices.

We could aim for the most visible problems – city centre public disorder on a Saturday night, homeless street drinkers and youngsters in the park. This tends to be popular in the short term with the general population, perhaps because it doesn't threaten their own behaviour. But many of the heavy drinkers in these settings may not be worried about their drinking, and/or want to do anything about it. The problem is defined by other people, not the individuals themselves.

We could be guided by the effect on others and link alcohol interventions into family and children's services. Again, this tends to be popular, but these services reach limited numbers within the population.

We could choose our settings on the basis of where the need is, which may be different from the public or media demand. In Scotland, this approach led me to become involved in raising awareness of alcohol hospital admissions in older people, which were rising more rapidly than in younger age groups (and still are). This was not a popular move. I was accused of being a young whippersnapper (I'm neither of those things) depriving the retiree of the well-earned right of a reviving wee bevy, a routine which did no harm to anybody, albeit one which was ending up in the wards of the local hospital.

Which approach – at-risk, whole-population or both?

So there are choices to be made and the settings for alcohol interventions are part of that choice. One of the reasons for the interest in the Scottish approach to reducing alcohol harm is that, encouraged by the alcohol harm reduction sector, the Scottish Government made what was, for governments, an unusual choice. This is best described in the 2008 consultation paper *Changing Scotland's Relationship with Alcohol*.

Previous interventions have tended to target particular groups, such as those with alcohol dependency or young people, and over-relied on the promotion of general health information and education campaigns. The World Health Organization (WHO) has stated that alcohol interventions targeted at vulnerable populations can prevent alcohol-related harm, but that policies targeted at the population as a whole can have a protective effect on vulnerable populations and reduce the overall level of alcohol problems. Action on a wider scale, both population-based and targeted to particular groups, is now required (Scottish Government, 2008).

The statement above was an explicit sign that the Scottish Government was working to a whole-population approach rather than an exclusively 'problem minority' view. There was no reassuring message, of the type to be found in many Government policy statements, that most of us can carry on as we were and that this was a problem in the personal life choices of an irresponsible minority and the many should not be punished for the sins of the few. The fact that the Alcohol Harm Reduction Strategy for England (work out the acronym for yourself) (UK Cabinet Office, Prime Minister's Strategy Unit, 2004) had taken the latter approach was probably an encouragement to do something different.

The battle between whole-population and high-risk models had been played out for many years in the alcohol sector. The characteristics of the two approaches are outlined below.

Population approach	High-risk approach
Overall reduction of consumption	Promotes responsible alcohol use
Target is whole population	Targets segments of the population
National action	Local solutions
Regulation and legislation	Information on products and harm
Wider public interest	Personal choice and responsibility
Wide range of outcomes	Specific targets (binge drinking, drink driving)
Early interventions	Treatment for dependence
Leadership	Partnership

So where there are two teams, there are usually two different kinds of supporters. Whole-population approaches, with their emphasis on interconnections, broad trends and political leadership, are favoured by public health specialists. High-risk models focused on personal choice (“It’s not the drink, it’s the drinker who is the problem”), individually focused interventions and an avoidance of the regulation of the nanny state or wowsersism are favoured by the alcohol industry. Politically, the Left likes whole-population, the Right, the high-risk approach. In truth, most strategies such as the WHO Global Alcohol Strategy have elements of both, for good reason (Anderson, 1993).

Ideal settings for intervention

So what does all this theory mean for where we should target our intervention efforts?

If you’ve chosen to go for a strong whole-population orientation, can you find a setting which:

- has contact with big numbers of people
- is likely to find acceptance from the public as appropriate for alcohol work
- has a track record of effectiveness in doing this kind of thing and even the holy grail of a decent research base of effectiveness?

In Scotland, the settings which fitted these requirements were in the health system. The National Health Service (NHS) performed well in international comparisons. Access is easy, it’s free, staff follow guidelines and the outcomes are good.

The access and reach are important. Compare the proportion of the population consulting primary health care services with the proportion arrested each year. The number will vary from place to place, but I’d be surprised if the number seeing a GP and nurse doesn’t outnumber criminal justice services contacts 25:1.

People expect alcohol to be raised as part of health and wellbeing advice. More importantly, there is a very well-established evidence base for providing Alcohol Brief Interventions (ABI) in primary health care services (Kaner et al., 2007).

Interested readers will find much more information at the website of the International Network on Brief Interventions for Alcohol and Other Drugs, INEBRIA (www.inebria.net).

Internationally, there is a group of highly active researchers who are developing the evidence base in other settings, such as criminal justice services and emergency medicine departments. The UK SIPS project, headed by Colin Drummond from Kings College, London, is also an important project (www.sips.iop.kcl.ac.uk), looking at questions such as how brief can the intervention be, and can criminal justice services deliver ABIs effectively? The answer to the latter is a highly qualified yes.

While there is interest and enthusiasm for other settings such as community pharmacies, housing agencies and courts, clients need to be in a receptive mindset, and somewhere which deals mainly with people with serious alcohol problems and dependence will need to provide much more than a brief intervention.

So no setting rivals primary health care services for their access to the population or the proven effectiveness. This was the reason NHS Scotland established a national Alcohol Brief Intervention programme, focused on primary health care (including ante-natal care), in 2008. I had the opportunity to discuss this with groups in Whangarei, Christchurch, Invercargill, Dunedin, Wellington and Auckland. Many general medical practitioners and senior planners attended, and many of these opinion formers and clinical leaders were already well informed on Alcohol Brief Interventions. The project that Dr John McMenamin is running in Whanganui, with support from the Health Promotion Agency, is very similar to the Scottish national programme.

So there is plenty of 'bottom-up' interest and knowledge in New Zealand. In Scotland we also had the advantage of top-down leadership. Brief Interventions became a national priority for the health system. Targets were set and health authority CEOs' performance was measured against these. There was additional investment to cover the infrastructure and additional staff costs. In short, the exercise was similar to that undertaken for a health challenge like a flu epidemic or a cancer screening programme. This sent out the message that ABIs were important and needed to happen. Training materials were developed (now available at www.healthscotland.com/topics/health/alcohol/alcohol-brief-interventions-communications-and-guidance.aspx).

Alongside this, there was a range of other actions to tackle Scotland's alcohol problems (www.healthscotland.com/scotlands-health/evaluation/planning/MESAS.aspx) including the pioneering step of introducing a minimum unit price for alcohol – a measure which has the support of the Scottish Parliament and the Scottish population. However, its implementation is being delayed by organisations representing the large alcohol producers, who have dismissed the views of others, including many in the alcohol industry who support effective regulation, to pursue their own commercial gain.

Scotland and New Zealand have many historical ties and many things in common. The countries look alike; are home to many sheep and cattle; have human populations of similar size; have a complex (mostly convivial) relationship with a larger neighbour; and share a sense of humour which is hard to describe but you know it when you see it.

We have much to learn from each other. My two visits to New Zealand, in 2009 and 2014, have taught me a lot and I hope there are some useful lessons for New Zealand in Scotland's recent work on alcohol.

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