## Briefing Paper Findings Series 42: Appendix 1

# Alcohol-related harm in Glasgow: a national, city and neighbourhood perspective

### A summary of policy and practice discussions held in October 2013

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A group of professionals working in public health, policy, practice and research came together to discuss the implications of the findings in this briefing paper for policy and practice, focusing particularly on local implications for Glasgow. The following account summarises the facilitated discussions during a two-hour workshop and a number of one-to-one meetings.

Discussions focused on:

- How can these research findings be used?
- What else does this relate to and what are the connections?
- How does this report move us forward?
- What are the implications for current and future policy?

Below is a summary of the areas for action emerging from these discussions.

Scotland is taking some bold steps towards tackling the high levels of alcohol harm in the country, although more work needs to be done.

**Challenges of interpretation**

With the many different ways to describe consumption of alcohol and alcohol harms across the various different populations it is often difficult to determine the important alcohol-related trends in Glasgow. For example, within weeks the media had reported on the alcohol-related mortality trends in deprived cities[1,13] and also on alcohol problems in elderly populations[14].

*Is there potential to develop better relationships between public health intelligence and services?*

*Can we improve our IT and reporting systems to better inform service planning? (e.g. the new Drug and Alcohol Information System (DAISY))*

*How can health professionals be supported to work with the challenges that come from dealing with complex issues and complex data?*

**Relationship between consumption and harm**

The wide inequalities in alcohol-related deaths across area deprivation clearly support a continued effort to tackle the overprovision of licensed premises within some areas of Glasgow. Although Scotland has *protecting and improving public health* as one of the five licensing objectives[a], taking advantage of the inclusion of public health as an explicit objective has been difficult and less effective than many would have liked.

*Is there more that can be done to ensure that public health and licensing speak the same language?*

*How can we strengthen the role of the community in the licensing process for local applications? For example, maximising community representatives on the Local Licensing Forum?*

**Taking advantage of existing structures**

Alcohol is firmly positioned as a priority in the city, and as such there are existing structures that can be used to advance work in the alcohol field:

- The Alcohol and Drug Partnerships (ADPs)[b] work to engage wider partners in the alcohol agenda. The six sub-committees (prevention and education; drug death prevention & monitoring; children & young people; city centre alcohol action; recovery; and communities & service user engagement) can be useful in translating the national frameworks to the local level.
- Glasgow Community Planning Partnership's Single Outcome Agreement[15] (2013) includes alcohol as one of its three priorities.
- The three Sector Partnerships[c] have a role in taking the city-wide priorities to the sector level.
- The 21 Area Partnerships (working at the multimember ward level) have a role in translating the sector priorities to a more local level, which includes community engagement.
- The new Priority Planning Process works to progress information sharing at the multimember ward level.

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[a] As set out in the Licensing (Scotland) Act 2005.

[b] The Framework for Action, a key feature of Scotland's alcohol strategy, mandated the establishment of Alcohol and Drug Partnerships (ADPs) in each local authority. The Partnerships should include all include key stakeholders from police, health, the voluntary sector, the community, housing, education, and so on.

[c] For more information about the Sector Partnerships, Area partnerships or Priority Planning Process please contact Michael Robinson of the Glasgow City ADP (Michael.Robinson@glasgow.gov.uk).

**Alcohol as an entry point into inequalities**
Many of us have seen significant progress made with the inequalities agenda in Glasgow and this should be celebrated; services are increasingly recognising the need for tailoring services to client groups. That said, the inequalities agenda can appear to be all-encompassing and overwhelming.

Given the high levels of alcohol-related harm in communities with high levels of deprivation, action around the alcohol agenda can be a useful entry point into discussions and actions aimed at reducing health inequalities.

**Innovation**
Most actions need time to develop, allowing lessons to be learnt and embedded. At the same time local settings need to be able to respond to their local needs and priorities.

*How can we effectively balance the need to have consistency in action with the need for individual settings to have local flexibility?*

**Implications for prevention**
The city-wide picture suggests a welcome downward trend in alcohol deaths, which is consistent with a downward trend in alcohol sales. The increased deaths in younger females highlighted in this report and the enduring inequalities across levels of deprivation, however, show that not all of the population is benefiting from these downward trends. Efforts at the preventative end need to take into account these trends.

*Where can we further support local conversations around trends in alcohol harm? Examples where this is happening include the Ripple Effect[16], GRAND week[17].*

**Working across boundaries**
Clients with alcohol issues cross a number of services – including addictions, homelessness, mental health, social work – and as such, working across boundaries is essential. Some progress has been made with integrated working in some settings but we recognise but there is potential for further progress.

*Where are we working in an integrated way? What can we learn from this?*

*Where is there potential to improve our working practices?*

*Where can we provide leadership for integrated working?*

**Working across settings**

The alcohol harm reduction agenda needs to be owned by not just health but a broad range of settings including education, regeneration, social care and so on. The following are insights on working towards this agenda within the education setting.

- Is the **inverse care law**[d] operating in the area of joint working? In areas of less deprivation it can be easier to pursue joint working because of less pressure on capacity.
- We need to think of the **whole system** – for example, in young people, reduction of alcohol consumption does not necessarily equate to reduction in harm because of the issue of replacement behaviours.
- Existing **funding and commissioning structures** pose challenges for developing a shared ownership of the alcohol harm reduction agenda across settings. For example, when one organisation's priority is pulled towards working to a very specific funder's objective it's more difficult to be responsive to calls for joint working with their counterparts in health.
- Similarly, **greater synergy between targets** across settings would support more effective joint working – if education is working towards their alcohol-related target, it is more difficult to divert resources to work with health colleagues to achieve a different alcohol reduction target.

*How can we improve dialogue between practitioners and academics? How can we improve dialogue across different settings?*

*In these times of limited resources and capacity how can we protect time for learning, sharing and reflection? How can we keep it relevant for practice?*

[d] **The Inverse care law** states that the availability of good health or social care (or working practices needed to ensure good healthcare provision) tends to vary inversely with the need of the population served.

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