Inquiring into Multi-layered, Preventative Partnership Working

A Changing Relationship with Alcohol Case Study

Co-produced by Aberdeenshire Community Planning Partnership and What Works Scotland

Case study

March 2018

This case study is an accompanying document to the collaborative research report *Inquiring into Multi-layered, Preventative Partnership Working.*

References within this case study to the "research report" are in respect of this.

Read and download the report on the What Works Scotland website at: whatworksscotland.ac.uk/publications/inquiring-into-multi-layered-preventative-partnership

Introduction

This case study explores the early development or scoping of a Local Outcome Improvement Plan (LOIP) priority relating to alcohol and the reduction of harm relating to alcohol-use within Aberdeenshire Community Planning Partnership (CPP).

This priority continues to be led by Aberdeenshire Alcohol and Drug Partnership (ADP). The study describes an early scoping discussion, facilitated by What Works Scotland, drawing on an evidence-base produced by the ADP. This has supported discussions across the CPP partners on whole population approaches and in considering potential areas of action for inclusion in the LOIP Priority action plan.

Key elements are

1. Local Outcome Improvement Plan: alcohol use as a priority

> *"The costs to Scotland and its public services of negative outcomes such as excessive alcohol consumption, drug addiction, violence and criminality are substantial. Addressing the 'failure demand' that results from focusing on consequences rather than causes, and approaches which alienate or disempower service users, has a high cost for society and high costs for public services."* (Christie Commission, 2011: 54)

Aberdeenshire Alcohol and Drug Partnership (ADP) has been working on complex approaches to strategy, service delivery and partnership working over the last eight years; responding to top-down Scottish Government National Outcomes and building bottom-up through ongoing local discussion, e.g. community forums. The ADP puts emphasis on prevention and early intervention; public protection and harm reduction; treatment and recovery; and community engagement. It promotes an asset-based approach – starting with strengths not problems – so people can re-build their lives and recover from problems.[1]

When discussions began in earnest within Aberdeenshire CPP's Board and Executive Group[2] in autumn 2015 on LOIP priorities (Local Outcomes Improvement Plan), the ADP was able to contribute through its growing evidence base (see section 2). Discussions across Executive and Board enabled informed dialogue on potential priorities.[3] Reducing levels of alcohol consumption was seen to be clearly relevant (Aberdeenshire CPP, June 2016), given**:**

- **Extent of current problem in Aberdeenshire:** 43% drink above sensible limits – not falling; 10,400 dependent drinkers – only 14% engaged with specialist services; 37 alcohol directly-related deaths (2015).
- **Wider social consequences:** for example, the link between ageing and increasing drinking because of social isolation, life transitions, and dementia and frailty.
- **Impacts on people and services:** the cost of alcohol related hospital admissions for NHS Grampian is estimated to be over £7million per annum, which rises to £17million if partially-attributed alcohol deaths are included (see section 2).
- **Health inequalities:** people on lower incomes are more likely to experience alcohol-related harm, e.g. hospitalised and death, than higher earners despite average levels of drinking being lower in deprived communities – known as 'the harm paradox'.

Discussions within the Board and Executive saw the potential for the CPP to work to change the culture around alcohol consumption, for instance, through: the role of licensing boards; lobbying central government; education (adults) and increasing professional understanding. Scoping work (autumn 2016) was initiated and led by the ADP's Lead Officer, Wayne Gault.

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[1] More re. services and initiatives Aberdeenshire ADP supports see: http://aberdeenshireadp.org.uk/
[2] See structures of Aberdeenshire CPP at: http://www.ouraberdeenshire.org.uk/about-us/our-structure/
[3] Evidence-bases for potential LOIP priorities were developed via Local Strategic Assessments; partner plans and Community Plans, horizon scanning. Criteria used to prioritise included: extent of evidence-base; links to prevention and inequalities; relevance to partners; and 'adding value' e.g. pooled resources, clear outcomes.

2. Scoping the Priority – identifying the evidence base

Wayne Gault (ADP Lead) developed a *LOIP Alcohol Priority Discussion Paper*[4] establishing in-depth understanding of the evidence and of possible strategies for further deliberation:

> ***"International evidence emphasises the importance of a systems approach and clearly shows that increasing price, reducing availability and restricting marketing are amongst the most effective and cost effective policy measures to reduce alcohol consumption and harm in a population … the 'three best buys' of alcohol policy.[5] Conversely, framing alcohol problems as the sole responsibility of individuals arising from the prolific marketing of an addictive carcinogenic product appears unjust."***

The Paper sets out key learning and principles for discussion across the whole CPP including:

- Commitment to whole population approaches (see 3.3 in the research report) and the need for developing public support and mandate for such approaches.[6]
- 'Willingness to implement' in a society that values freedoms: important discussions to take forward – and potential for blocks via business interests and fears of politicians.
- 'Universalism' – is a public mandate possible for a whole population approach?
- Communicating levels of risk: for professionals and the public as there is no entirely safe level of regular consumption – UK Chief Medical Officer Guidance, 2016.[7]
- Cultural change: some 'Mediterranean countries' have seen shifts to lower levels of consumption and so lower impacts on health and wellbeing – change is possible.[8]
- Geographical inequalities: areas with highest density of off-sales premises have 150% more hospitalisations per head of population – tend to be deprived communities[9]
- Health inequalities: Scotland-wide in 2014, levels of alcohol-related mortality in the 10% most deprived areas were eight times higher than in the 10% least deprived.[10]

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[4] View initial LOIP Priority Alcohol Discussion Paper at: http://aberdeenshireadp.org.uk/wp-content/uploads/2015/08/5d-LOIP-Alcohol-Priority.pdf

[5] Research points to 'system-wide' interventions such as pricing, regulating availability and limiting marketing as particularly effective in reducing harm from alcohol-use: (1) World Health Organization and World Economic Forum (2011) From Burden to "Best Buys"; (2) Babor T et al. (2010) *Alcohol: no ordinary commodity*.

[6] The Scottish Government is currently working on a 'refresh' of the 2009 national alcohol framework for action, *Changing Scotland's Relationship with Alcohol*; the latter adopts a whole population approach view: http://www.gov.scot/Resource/Doc/262905/0078610.pdf

[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf

[8] For instance, while UK average recorded consumption (15+years) per person has risen slightly since 1970 from to 2010 (10l); Italy in the same period has fallen dramatically from approx. 20l to 6.5l. In the UK (2010) 11.1% of this same population recorded 'alcohol dependence and harmful use'; in Italy, this was 1.0%. (Source, WHO 2014, view: http://www.who.int/substance_abuse/publications/global_alcohol_report/en/

[9] https://cresh.org.uk/webmap/about-creshs-map-of-neighbourhood-alcohol-and-tobacco-environments-in-scotland/

[10] See: Beeston C et al. (2016) Monitoring and Evaluating Scotland's Alcohol Strategy. Final Report (p24) at: http://www.healthscotland.scot/media/1100/mesas-final-annual-report_5780_mar-2016.pdf

- Targets: a target of reducing alcohol consumption in Aberdeenshire by 10% over ten years could potentially deliver a 20% reduction in deaths and hospital admissions after 20 years – but data on levels of alcohol consumption is difficult to obtain.
- Campaigns and education: tend to focus on individual change and have not been found to be effective in generating population wide change (see 3.2 in the research report).

Examples of plausible interventions outlined in the Discussion Paper:

- Reducing availability of alcohol through work with the three Licensing Boards
- Increasing the price of alcohol via indirect interventions e.g. health and safety levy
- Working for an alcohol-free childhood e.g. limiting local marketing; supporting parents – whole life interventions
- Bans of alcohol on CPP partner premises: to support public alcohol-free spaces
- Increased engagement with services: assertive outreach work with adults, children and young people; one initial addictions contact point; increased service capacity
- Increase screening/early intervention e.g. health assessments, brief interventions
- Bring alcohol into all policy discussions e.g. economic and social development
- Effective enforcement: reliably reduces levels of alcohol-related harms; clear expectations of enforcement re. drink driving; health and safety at work; sales to intoxicated people; drunkenness in public e.g. fixed penalties or treatment.
- Community engagement: to build deliberation on the need for culture change.
- Public education: hard-to-reach groups; older people; deprived communities; professionals.
- Partnership with private sector: e.g. seeking voluntary agreements with alcohol retailers to provide sales data – to support measurement against targets.

The Paper concludes by pointing out that the evidence base argues for system-wide and preventative up-stream approaches, which seek to change the political, social and economic factors (determinants) that create health inequalities. Yet, 'we' often end up taking forward a raft of downstream and individual activities that can't create culture change and engage with health inequalities:

> ***"If we are to successfully address the LOIP priority, we need to figure out how to make progress on the upstream systematic determinants so that low alcohol consumption becomes the norm and drunkenness becomes socially unacceptable. … It seems inevitable that that would include tackling the political dimension head on by gaining a clear public mandate for change. Given the integral part alcohol plays in many of our lives, this LOIP priority requires all CPP partners to act with foresight and courage."***

3. Engaging with CPP partners – early dialogue and deliberations

The ADP worked with What Works Scotland on an initial participatory workshop on this LOIP priority involving key partners (see below) and with support from the Lloyd TSB Foundation.

Mapping current partnership working between alcohol-related services

Meaningful consultation and evidence generation with children and young people – *learning from national partner, the Lloyds TSB Foundation for Scotland* (now the *Corra Foundation*).

Specialist input from the Foundation's *Partnership Drugs Initiative* deepened the dialogue…

Key reports:

1. Reversing the Trend*:* a report with young people by the Foundation and Evaluation Scotland on preventative work with young people[11]
2. Everyone has a story: overview*:* both illustrates effective consultation work with young people re. alcohol-use and evidences their experiences through stories[12]
3. Thinking Differently Partnership Fund and Projects: seeks to reduce alcohol-related harm and empower young people, families and communities through building skills and knowledge[13]

Key discussions across the CPP partners generated via these reports:

Issues for children and young people:

- increased risks of under-age drinking in remote areas where there is little to do …
- working with parents and families to understand how parent alcohol-use can impact.

What supports meaningful consultation and communication with children and young people:

- the right language, appropriate use of website and social media, right places to bring people together to talk are all important factors;
- young people need to say 'what changes and why' are making sense to them … it's important to both listen and then act on such consultation … 'you said, we did'
- … also, to be aware of the dangers of 'boomerang effect' – here interest in alcohol-use is unintentionally stimulated through such communications and education work.

Other areas to consider for further action:

- the potential for young people's evidence to be presented to Licensing Boards.*
- supporting young people in vulnerable situations – e.g. increased risk of sexual assault.
- engaging across partnerships to seek integrated, joint action and shared challenge.

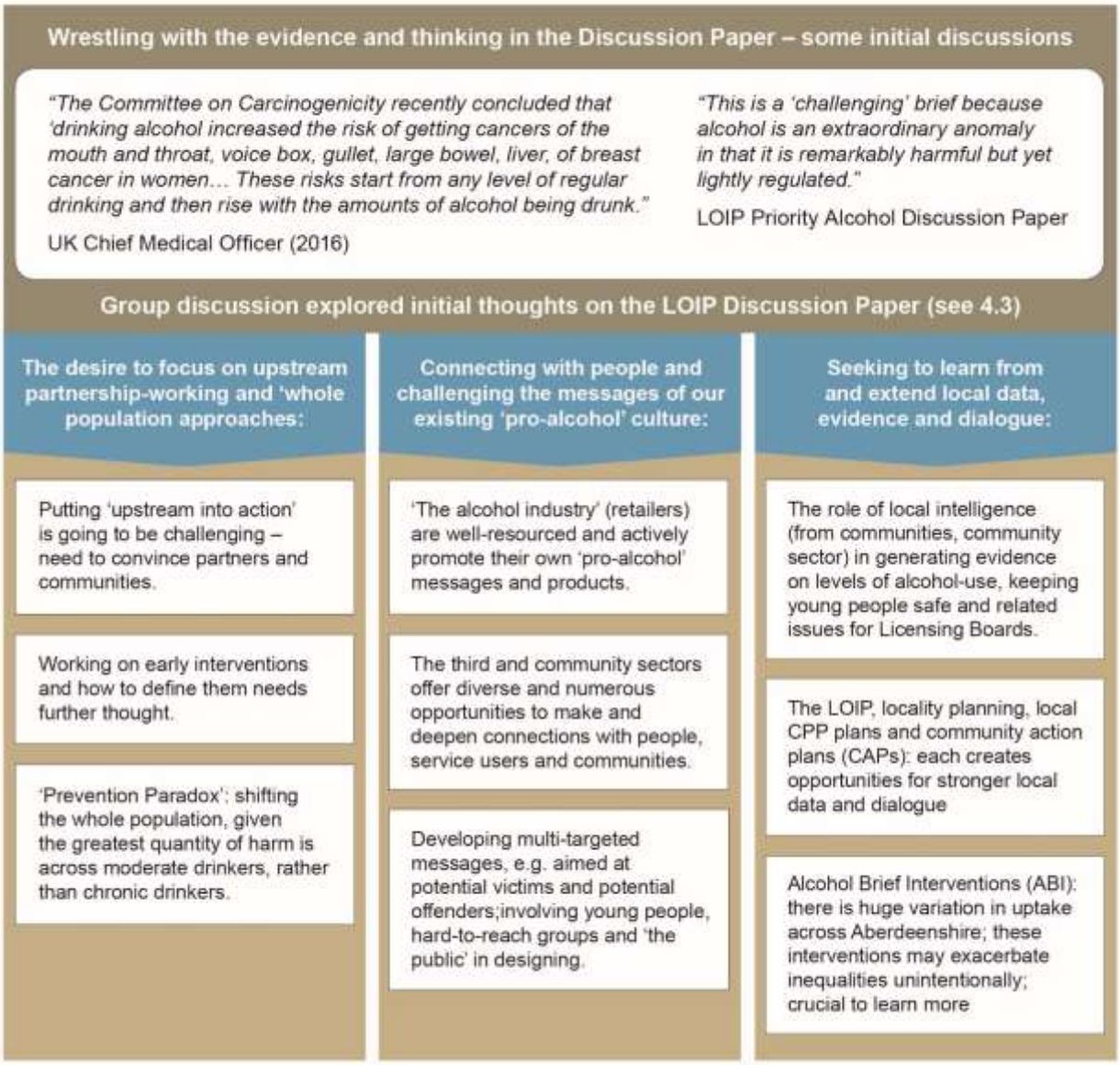
*See, for instance, the Imagining Project where the Children's Parliament works with children to imagine Aberdeen as a city where all children are healthy, happy, safe and doing their best.[14]

[11] https://www.corra.scot/wp-content/uploads/2015/10/Reversing-the-trend-Key-Messagess-Summary.pdf
[12] https://www.corra.scot/wp-content/uploads/2015/10/Everyone-Has-a-Story-Overview-Report.pdf
[13] http://www.therobertsontrust.org.uk/innovation-and-learning/alcohol-misuse/young-people-and-families/thinking-differently-partnership-fund
[14] https://blogs.glowscotland.org.uk/glowblogs/imaginingaberdeen/2016/05/10/the-imagineer-issue-1/

Talking with key partners: issues, opportunities and challenges raised

Wrestling with the thinking in the Discussion Paper: initial deliberations

This is a 'challenging' brief because alcohol is an extraordinary anomaly in that it is remarkably harmful but yet lightly regulated. [15]



[15] See, for instance, the UK Chief Medical Officer's Report 2016: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/545937/UK_CMOs__report.pdf

4. Using the LOIP to generate discussion of 'wicked issues'

The ADP is seeking to use an *adaptive leadership approach* to develop this LOIP priority, and creating the space for partners to consider their existing approaches and what might be blocking progress towards a shared approach – drawing from Heifetz, Grashow and Linsky (2009).[16] A learning culture, rather than a blaming culture, is crucial; supporting partners to suspend current views, consider fresh perspectives and see hidden issues and problems – in a supportive space.

Since the early scoping discussions in section 3 above, the LOIP Alcohol Scoping Group has met monthly, engaging further partners e.g. Community Learning and Development; Community Safety; Local Community Planning Groups; Scottish Fire and Rescue Service … and sought input from the Chamber of Commerce and the Alcohol Standards Licensing Officers too.

Key areas of discussion and development on this LOIP priority and action plan include:

How to frame this priority: given the sensitivity of the issue it has been re-framed from 'reducing alcohol consumption' to 'changing Aberdeenshire's relationship with alcohol' – with a longer-term aim of culture change over 10-20 years – and as two objectives:

- Normalising low-risk alcohol choices and challenging high-risk drinking cultural norms via education and promotion of gentle changes to achieve healthier relationships with alcohol.
- Reducing the number of high-risk drinkers by focusing on the needs of the individual and the nature of their environment.

Developing an action plan to include: the following key themes – and initially 50 possible actions – to provide a framework: safer and healthier choices; availability of alcohol/licensing; alcohol-free childhood; cultural norms; engagement with treatment services; improving data and sharing enforcing laws; lobbying; communications; and community involvement.

Emerging issues and questions that are generating further discussions across the CPP:

- How does alcohol impact on health inequalities and healthy life expectancy?
- How to avoid silo approaches to alcohol – it's one of a range of risk factors.
- Is there agreement on taking a whole population approach across the CPP?
- The need for effective, ethical ways of working with and screening high-risk groups.
- How to support change that doesn't extend inequality between places?
- Balance of actions across 'primary, secondary and tertiary prevention' (see 3.2 in the research report).
- Locality Plans – what fits best … natural communities, electoral wards, 'hotspots'.

Community engagement and consultation (citizens' panel) on the draft LOIP Action Plan will follow – in particular regarding the openness of the public to be challenged on this sensitive issue.

[16] For a brief introduction to Adaptive Leadership see Giordano (2013; pages 8-9) published by the Kings Fund: https://www.kingsfund.org.uk/sites/files/kf/Leadership_challenge_for_general_practice.pdf

5. WWS commentary: creating spaces for longer-term discussions

It is too early to draw conclusions of substance in relation to this LOIP Priority scoping process, but certain key questions relevant to all CPPs are being illustrated.

5.1 Developing effective multi-layered collaborative partnership working

In seeking an adaptive leadership approach (Heifitz et al., 2009), the ADP and CPP can be understood as working towards multi-layered *dialogue* across diverse CPP partners and in a supportive, facilitated space. Views and perspectives can be broadened and both rational and emotional capacities engaged (Escobar, 2011)[17]. The LOIP can then offer a safe space for tackling wicked issues (see 2.4 in the research report). Whether this can be seen as fully *deliberative* yet – as in seeking to evaluate alternatives and work for consensus-based decision-making following *substantial exchange of reasons* (Escobar, 2011) – is beyond the evidence available here. Yet, there is clearly ambition for such deliberation and an opportunity for significant learning as to what happens when you try it.

5.2 Deepening understanding of 'prevention' and preventing inequalities

The *LOIP Alcohol Priority Discussion Paper* (see section 2) provides an impressive in-depth discussion of the evidence base; one that resonates with the NHS Health Scotland's (Craig 2014) focus on whole population health approaches (3.2, 3.6 in the research report). For instance, the availability of alcohol; targeting services to more vulnerable groups, e.g. deprived communities, in the context of universal provision; and early years working and concern for the impact on children and their health of current culture. It is too early to say to what extent the emerging action plan will prioritise whole population health approaches over individual behavior change. Yet, this LOIP is offering opportunities to building understanding and share learning on *how* to deliberate with sometimes skeptical partners on this and other issues – including recognising how shared work re. alcohol use can relate to other factors generating health inequalities, and so avoiding silo approaches. For instance, Fitzgerald et al. (2017)[18] in considering how public health practitioners can advocate for whole population approaches point to the longer-term relational work needed. One participant also suggested the value of specialist resource for 'critical assessment' to support preventative LOIP development across all CPPs – 'prevention proofing' perhaps.

5.3 Seeking committed and creative approaches to preventing inequalities

One key area of potential innovation highlighted above (sections 2 and 3) is the concern to build a public mandate for work in relation to alcohol use. And further, the potential of the community sector (community organisations) to engage with communities in exploring culture change, for instance: in supporting local dialogue and deliberation e.g. as Community Action Plans; and, in providing local activity and services – including through trading activity – that support alternatives to a 'pro-alcohol culture' e.g. transport, community social activity and 'recovery housing'. There is scope for such work with the community sector to be part of wider health inequalities strategies and work on the LOIP.

[17] Escobar (2011) report at: http://www.beltanenetwork.org/DialogueTheory2012.pdf
[18] Fitzgerald et al. (2017) article at: http://www.mdpi.com/1660-4601/14/3/221