

Dying for a drink



Circumstances of, and contributory factors to, alcohol deaths in Scotland: results of a rapid literature review and qualitative research study

SHAAP



SCOTTISH HEALTH ACTION ON ALCOHOL PROBLEMS
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Glossary and abbreviations

AAD – Alcohol-Attributable Deaths - deaths caused wholly or partially by alcohol consumption

AAL – Acute Addiction Liaison

ABI – Alcohol Brief Intervention – An ABI in Scotland is a short evidence-based, structured, non-confrontational conversation about alcohol consumption

ADP – Alcohol and Drugs Partnership – A multi-agency group which is responsible for the strategic planning of drug and alcohol service provision in areas of Scotland

ARD – Alcohol-related Deaths – The old National Statistics definition includes a narrower range of conditions than Alcohol Attributable Deaths (see Appendix 2)

AUDIT - Alcohol Use Disorders Identification Test, primarily designed to screen for levels of alcohol dependency or high-risk use. The test has 10 questions, responses to each question are scored between 0 and 4 and sum to give a score of alcohol use from 0 to 40. This can then be interpreted in line with World Health Organisation (WHO) guidelines¹.

CAT – Community Addiction Team

Dependent drinker – International Classification of Disease code F10.2 describes alcohol dependence syndrome as a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state. WHO guidelines¹ indicate that an individual with a score of 20 or more on the AUDIT questionnaire warrants further investigation for possible alcohol dependence.

GP – General Practitioner

Harmful drinker – International Classification of Disease code F10.1 describes harmful alcohol use as a pattern of alcohol use that is causing physical or mental damage to health. WHO guidelines¹ indicate that individuals who score between 16 and 19 on the AUDIT questionnaire have a high level of alcohol problems (harmful drinking behaviour) for which counselling is recommended. The Scottish Health Survey¹⁴ categorises men drinking over 50 units of alcohol per week and women drinking over 35 units per week as harmful drinkers.

Hazardous drinker - According to WHO guidelines¹ individuals who score between 8 and 15 on the AUDIT questionnaire have a medium level of alcohol problems (hazardous drinking behaviour) with increased risk of developing alcohol-related health or social problems. The Scottish Health Survey categorises men drinking 21-

50 units per week and women drinking 14-35 units per week as hazardous drinkers¹⁴.

HEAT - Health improvement, Efficiency, Access and Treatment as in HEAT Targets set by the NHS in Scotland to improve performance

ICD10 – International Statistical Classification of Diseases and Related Health Problems, 10th Revision

MESAS – Monitoring and Evaluating Scotland’s Alcohol Strategy – a programme of work led by NHS Health Scotland aimed at monitoring and evaluating the Scottish Government’s alcohol strategy

MUP – Minimum Unit Price or Pricing

NHS – National Health Service

NRS – National Records of Scotland

ONS – Office for National Statistics

PAF – Population-attributable fraction: an indirect quantification of morbidity and mortality due to a specified risk factor. This is the proportion of total cases that occurred as a result of exposure to the risk factor. PSUR – Prevalence Service Utilisation Ratio – A measure of how many of those in need are accessing a service

ScotPHO – Scottish Public Health Observatory

SHeS - Scottish Health Survey

SHAAP – Scottish Health Action on Alcohol Problems

SIMD – Scottish Index of Multiple Deprivation – a measure of relative deprivation of an area

WCS – West Central Scotland

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More than anything in terms of carrying out this work, we have appreciated the inputs from external professionals and of individuals and families, enabling us to combine epidemiological evidence with the telling of ordinary people's stories. By doing so, we hope that the lived experiences of real people will be better understood and that stigma will be reduced.

Our recommendations, based on this work, are intended to influence the provision of services to support recovery for individuals, families and communities, and to help prevent the tragic loss of lives due to alcohol.

Thank you.



Eric Carlin

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1 Introduction

1.1 Background

Alcohol-related deaths are higher in Scotland than in England and Wales² where death rates are high by international standards³. Although there has been a downward trend in deaths since the mid-2000s this may now have levelled off⁴. As well as the number of deaths, alcohol causes or exacerbates many health conditions and has implications for families of drinkers, the justice system and society in general³. The cost of alcohol misuse in 2007 was estimated to be £2.25 billion⁵. In 2009, the Scottish Government issued a new alcohol strategy, 'Framework for Action', which set out policies to reduce both alcohol consumption and the associated harms⁶. The impact of the 2009 strategy has now been evaluated⁷ and work is underway to refresh the strategy. Scottish Health Action on Alcohol Problems (SHAAP) was commissioned by the Scottish Government in December 2017 to lead work to enhance understanding of the circumstances of and contributory factors to alcohol-related deaths (ARD) to inform recommendations for evidence-based services that will support prevention, early intervention, treatment and recovery from alcohol-related problems. This document reports the results of that exercise.

1.2 Purpose, scope and methods

A rapid desktop review of relevant statistical sources and literature suggested by an expert advisory group was undertaken, followed by a brief qualitative research exercise. The principal aim of the rapid desktop review was to synthesise selected existing sources of evidence on ARD. The qualitative research involved hearing from fifty people, namely five people currently drinking excessively, fourteen in recovery, eleven family members, of which five had lost someone through their alcohol use, and twenty professionals, all experts in this field.

The synthesis from the desktop review is presented in Sections 2-4 of this report. Section 2 sets out the statistics on alcohol deaths in Scotland. Section 3 gives a brief overview of Scottish Government strategy and its impact and an outline of the services available to support people with alcohol problems in Scotland. Section 4 summarises audit work undertaken into services provided in Glasgow. The results of the qualitative research exercise are presented in Sections 5-7. Summary of key findings and limitations of this study form Sections 8 and 9, and Recommendations are made in Section 10. The composition of the expert group and the scope of the project are attached as Appendix 1 to this report. Appendix 2 comprises definitions of alcohol-related death (old definition) and deaths attributable to alcohol consumption, and Appendix 3 contains results of three audits relating to alcohol-related deaths in Glasgow. Appendix 4 summarises key findings from a secondary review published by SHAAP in 2017 about contributory factors to mortality of heavy drinkers in Edinburgh and Glasgow.

2 Statistics on alcohol deaths in Scotland

2.1 Key points from this section:

- *Alcohol-related deaths (ARDs) have formed the basis for alcohol death statistics issued by National Records of Scotland from 2006 to 2018 and are the main statistic used in this section of the report^{4 43}.*
- *The two main causes of alcohol-related deaths in 2017 were alcohol-related liver disease (738 deaths, 60%) and mental and behavioural disorders caused by alcohol (321 deaths, 22%). Total ARDs in 2017 were 1,235^{4 9 42 43}.*
- *Alcohol-related deaths peaked in the mid-2000s and have been reducing since, although recently the decline has stalled^{4 42 43}.*
- *Men are approximately twice as likely to have an alcohol-related death as women and this has remained broadly constant over time^{4 42 43}.*
- *The largest number of ARDs occurred in the 55-64 age group for both men and women over the period 1981-2017^{42 43}.*
- *There is a clear social gradient in ARDs in Scotland with those living in the most deprived areas just over six times more likely to suffer an ARD in 2017 than those living in the least deprived areas, although this gradient has reduced since 2002.*
- *Alcohol-attributable deaths (AADs) include an appropriate proportion of a further 30 causes of death which are partially caused by alcohol⁸. Using this wider definition, there were an estimated 3,705 deaths attributable to alcohol in Scotland in 2015⁸.*
- *The main causes of AADs for people under 35 are intentional self-harm, road/pedestrian accidents and poisoning^{4 8}.*
- *The main causes of AADs for people over 35 are alcohol-related liver disease, mental and behavioural disorders and neoplasms of the breast and oesophagus⁸.*

The definition of alcohol-related deaths (ARD) used in this report is the one used for reporting by National Records of Scotland (NRS) statistics between 2006 and 2018 (the 'old National Statistics definition')⁴. These figures include only deaths regarded as being most directly due to alcohol consumption. It includes all deaths from chronic liver disease and cirrhosis (excluding biliary cirrhosis) even when alcohol is not specifically mentioned on the death certificate, and deaths due to poisoning with alcohol (accidental, intentional or undetermined). The definition does not include road accidents, falls, fires, suicides or violence involving people who had been drinking or medical conditions considered partly attributable to alcohol.

The report also draws on a recent study published by the Scottish Public Health Observatory (ScotPHO) which calculated deaths 'attributable' to alcohol consumption⁸. Under this wider definition an appropriate proportion of deaths from 30 chronic and acute conditions is included. Appendix 2 includes more detail about these definitions.

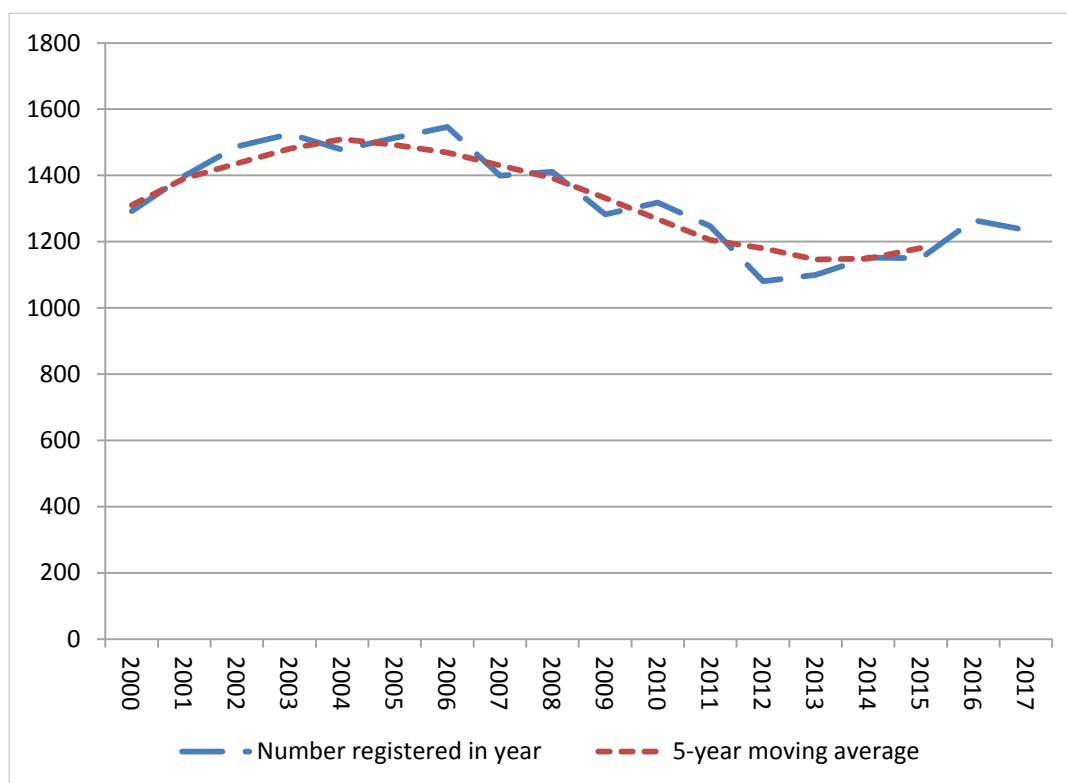
Appendix 4 also summarises key findings from a [secondary review](#) published by SHAAP in 2017 about contributory factors to mortality of heavy drinkers in Edinburgh and Glasgow.

2.2 Alcohol-related deaths - Scotland

2.2.1 Alcohol-related deaths – overall trend (all data^{42 43})

Alcohol-related deaths (old definition) peaked in the mid-2000s at around 1,500 per year. Since then the trend has been generally downwards with deaths in 2012 down to 1,080. Three of the last four years to 2016, however, have seen increases such that the five-year moving annual average rose for the first time for about ten years, and has risen again in 2017. 1,235 alcohol-related deaths were registered in Scotland in 2017, 30 fewer than the previous year. This is almost double the corresponding figure for 1991. Figure 1 illustrates the number of deaths registered as well as the five-year moving average for the period 2000 to 2016.

Figure 1: Alcohol-related deaths in Scotland (old definition): 2000-2017⁴



2.2.2 Alcohol-related deaths – by sex and age group

Men are more than twice as likely to die than women from alcohol-related causes; a ratio that has remained relatively constant over time (see Figure 2). Trends over time by age group and by sex are shown in Figures 3 and 4. The 55-64 years age group had the highest rate for ARDs in both men and women over the period 1981-2017.

Figure 2: Alcohol-related deaths by sex in Scotland 1981-2017⁴

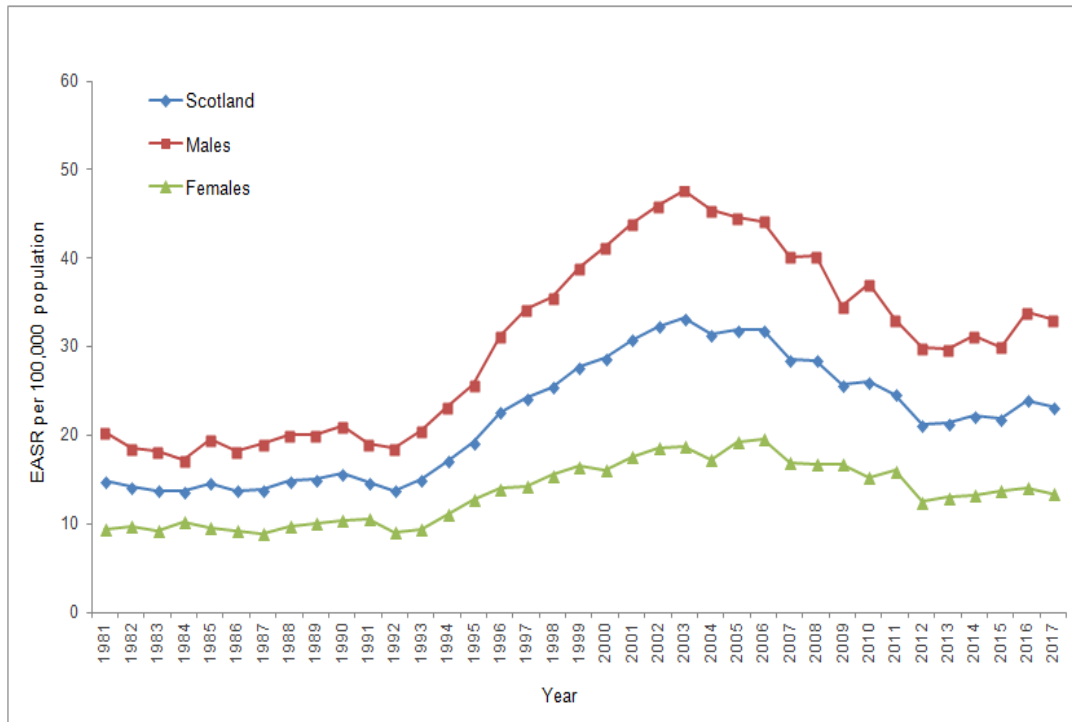


Figure 3: Alcohol-related deaths by age in Scotland 1981-2017 – men⁴

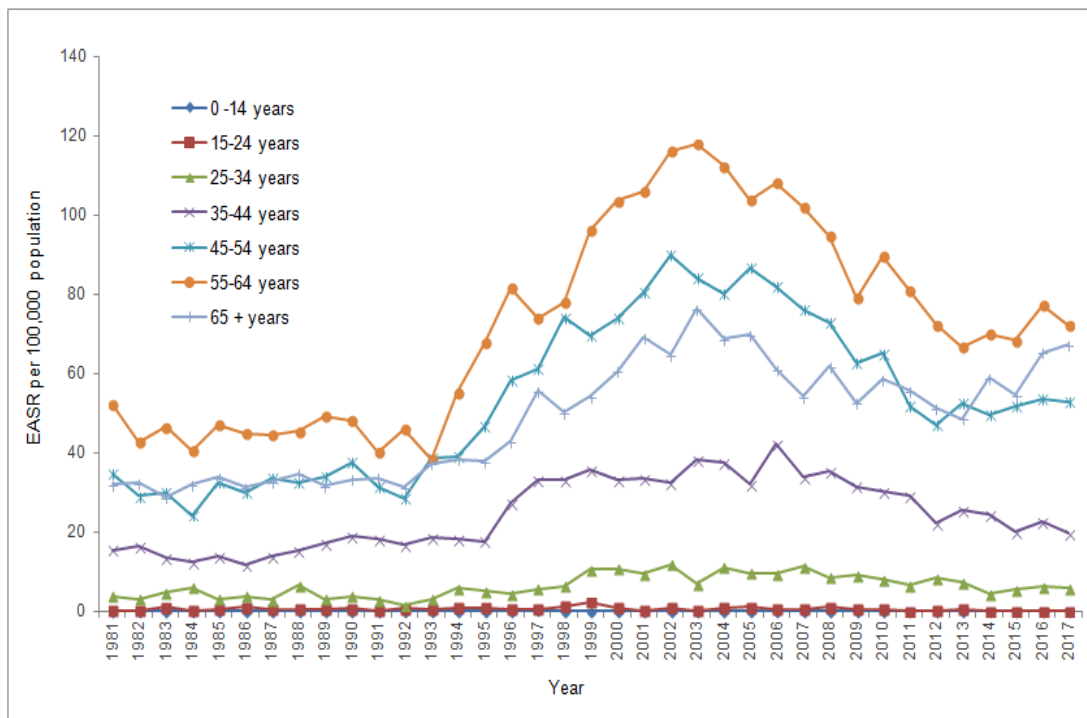
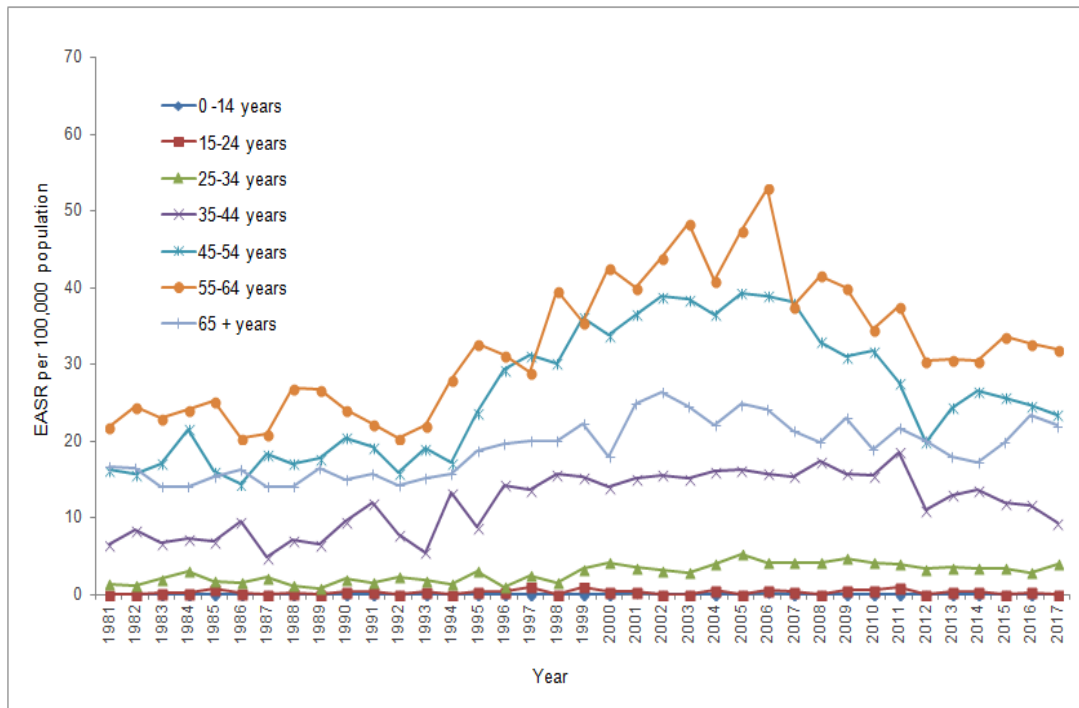


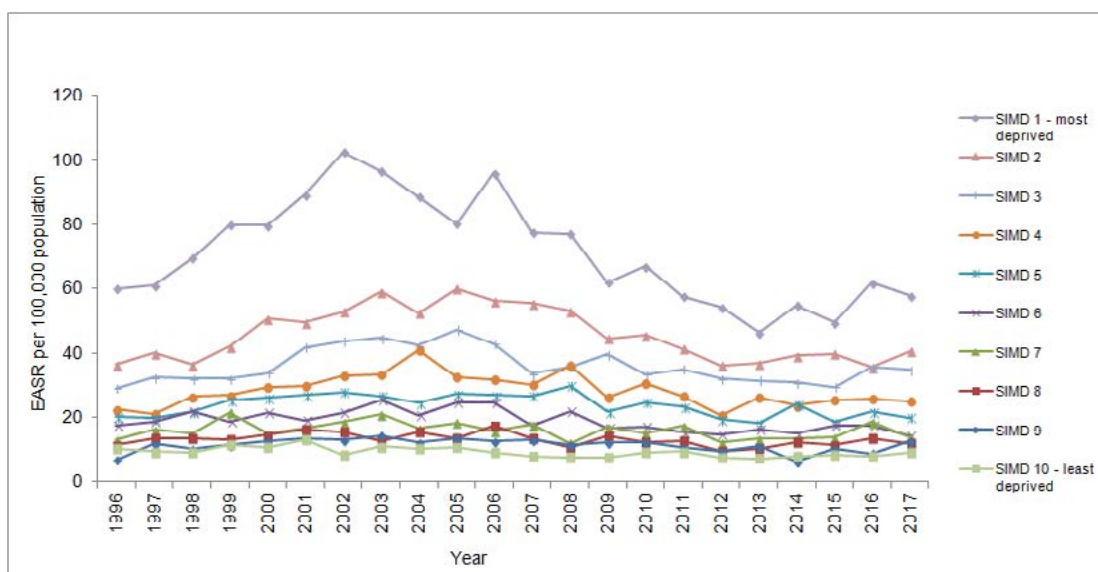
Figure 4: Alcohol-related deaths by age in Scotland 1981-2017 – women⁴



2.2.3 Alcohol-related deaths by deprivation

In 2017, alcohol-related death rates were just over six times higher in the 10% most deprived areas in Scotland than in the 10% least deprived areas, compared with just over 12 times higher in 2002 (when rates in the most deprived areas peaked). The change is mostly down to a fall in rates in the 10% most deprived areas. This is illustrated in Figure 5.

Figure 5: Inequalities in alcohol-related death rates in Scotland, 1996-2017 by Scottish Index of Multiple Deprivation (SIMD) decile⁷



2.3 Causes of alcohol deaths

2.3.1 Causes of alcohol-related deaths

The main causes of alcohol-related deaths have remained consistent over the period 2000-2017⁹. Alcohol-related liver disease was the primary cause and accounted for 60% of all ARDs in 2017 (738 out of 1,235 deaths). The second largest cause of death was mental and behavioural problems which accounted for 22% of all ARDs in 2017 (277 out of 1,235 deaths).

2.3.2 Causes of alcohol-attributable deaths

Using the wider definition of alcohol-attributable deaths referred to in Section 2.1 there were an estimated 3,705 deaths attributable to alcohol in Scotland in 2015⁸. This compares with 1,150 alcohol-related deaths using the definition used between 2006 and 2018 by NRS. This figure is so much higher because it includes a proportion of deaths from conditions where alcohol has been shown to be a contributory factor to the death. Using this definition Tod et al⁸ showed their estimates of the top three causes of death for each sex in each age group. Causes and rates of alcohol-attributable death vary with age. For both men and women under the age of 35, alcohol-attributable deaths are most likely to occur from intentional self-harm, road/pedestrian traffic accidents and poisoning. For women the numbers of deaths are much lower (23 compared to 89 for men) and include epilepsy and alcohol-related liver disease. For ages 35-64 alcohol-related liver disease is estimated to cause most alcohol-attributable deaths for both men and women with poisoning, mental and behavioural disorders and neoplasms of the breast and oesophagus also major causes of alcohol-attributable deaths.

Table 1 (taken from Tod et al. Table 5⁸) summarises the top three causes of alcohol-attributable deaths in Scotland in 2015 by age group and sex.

Table 1: Top three causes of alcohol-attributable deaths by age and sex in Scotland 2015, as a percentage of all deaths in each age group (data taken from Tod et al.⁸).

Age	Condition (men)	Number of deaths in age group	% of deaths in age group	Condition (women)	Number of deaths in age group	% of deaths in age group
16-24	Intentional self-harm	12	7.7%	Intentional self-harm	2	3.6%
	Road/pedestrian accidents	9	5.8%	Road/pedestrian accidents	2	3.6%
	Poisoning	7	4.5%	Poisoning and epilepsy	1	1.8%
25-34	Poisoning	26	6.6%	Poisoning	7	3.6%
	Intentional self-harm	20	5.1%	Alcoholic liver disease	7	3.6%
	Road/pedestrian accidents	13	3.3%	Intentional self-harm	4	2.1%
35-44	Alcoholic liver disease	36	4.9%	Alcoholic liver disease	26	6.0%
	Poisoning	35	4.8%	Poisoning	13	3.0%
	Intentional self-harm	23	3.1%	Mental and behavioural disorders	11	2.5%
45-54	Alcoholic liver disease	113	6.9%	Alcoholic liver disease	74	6.5%
	Mental and behavioural disorders	65	4.0%	Neoplasm of breast	21	1.8%
	Neoplasm of oesophagus and poisoning	23	1.4%	Mental and behavioural disorders	19	1.7%
55-64	Alcoholic liver disease	139	4.4%	Alcoholic liver disease	76	3.6%
	Neoplasm of oesophagus	66	2.1%	Mental and behavioural disorders	23	1.1%
	Mental and behavioural disorders	57	1.8%	Neoplasm of breast	23	1.1%
65-74	Neoplasm of oesophagus	102	1.6%	Alcoholic liver disease	45	1.0%
	Alcoholic liver disease	92	1.5%	Neoplasm of breast	27	0.6%
	Mental and behavioural disorders	61	1.0%	Neoplasm of oesophagus	25	0.5%

3 Alcohol harms, strategy and treatment

3.1 Key points from this section

- *Health harms from alcohol at a population level are primarily driven by overall consumption and pattern of drinking.*
- *There are also links and interactions between drivers of mental health, alcohol and drug problems.*
- *Patterns of consumption and harm vary between different populations and are associated with levels of socio-economic deprivation.*
- *Policies focussing on increasing price, reducing availability and marketing are most likely to be effective in reducing overall population consumption and harms.*

3.2 Mechanisms of harm

Alcohol is a psychoactive substance that may cause harm to health both immediately and in the long term. Immediate harm can be caused through intoxication leading to the impairment of physical co-ordination, consciousness and cognition and can affect perception and behaviour. Long-term use can damage organs and tissues and have social impacts. Alcohol dependence increases the risk of both immediate and long-term damage to health³.

The level of health harms suffered at a population level is driven by the level of alcohol consumption, patterns of consumption, and, to a lesser extent, the quality of alcohol³. Alcohol consumption may impact upon the incidence and/or the course of disorders and their outcomes. In some disorders alcohol is only a component in causation. In many instances there is a clear dose/response relationship with harms correlated with the volume of alcohol consumed. Pattern of consumption appears to be an important driver of harms with drinking while eating being associated with lower risks of harm and heavy episodic drinking (HED) being associated with higher risk. HED is associated with increased risk of acute injuries and accidents, poisoning and violence and may be detrimental even when average consumption is low.

The level of harm may be affected by both societal and individual vulnerabilities. Societal factors that may impact the level of harms suffered include the level of development of health systems, cultural factors such as the stigma attached to alcohol-related health conditions, drinking contexts and arrangements for regulation, production and distribution of alcohol. Individual factors include age, gender, familial factors and socio-economic status.³ Age is of importance; the brain is particularly vulnerable in adolescence and into the early twenties. Older people may be physiologically less able to deal with the amounts of alcohol drunk at a younger age. Women suffer more harm from the same amount of alcohol due to increased body fat levels and lower weights, although as men generally consume more alcohol they suffer greater levels of harm overall. Familial factors impact harms through genetic and environmental factors. Socio-economic factors impact harms in multiple ways. It has been hypothesised that a lack of resources may prevent some people from

avoiding the adverse consequences of alcohol consumption through, for example, limiting access to health care or preventing them from drinking in safer environments. Other mechanisms which have been suggested are that people from poorer socio-economic environments may have less extensive support networks, that they may have the presence of multiple risk factors for disease and that they may indulge in more 'all or nothing' drinking behaviour.³

3.2.1 Mental health

Alcohol can be a primary cause of cognitive impairment and a contributory factor along with traumatic brain injury, cerebrovascular disease and neurodegenerative disease such as Alzheimer's disease. There is also a substantial service gap particularly for younger people (under 65) with cognitive impairment¹⁰.

Alcohol is often used by people with mental health problems to self-medicate and, at the same time, can exacerbate mental health problems because of its range of neuropsychiatric effects. There is a complex relationship between alcohol use, self-harm, and suicide. Alcohol dependence both increases the lifetime risk of suicide and is implicated in the act of suicide/self-harm. More than half (58%) of people known to mental health services in Scotland who died by suicide had a history of alcohol misuse¹⁰.

For people who already have mental health and alcohol and/or drug problems, it is important that they receive appropriate support to address all of these. Too often there is a gap in service provision for those with co-morbidity. The stigma experienced by those with mental health issues can also be compounded if they have substance misuse issues. There is a strong inequalities dimension to both mental health problems and to alcohol harm. For example, according to the 2015/2016 statistics on alcohol-related stays in psychiatric hospitals, those from the most deprived areas were 15 times more than those from the least deprived areas²⁷.

3.3 Drivers of alcohol harms

The following sections address population consumption, patterns of consumption and the impact of socio-economic status in relation to Scotland.

3.3.1 Population consumption

Scotland has a high level of alcohol consumption. The 2017 MESAS Monitoring Report² used alcohol retail sales data to estimate that the mean volume of pure alcohol sold in Scotland in 2016 was 10.5 litres per adult, sufficient to allow each adult to consume 20.2 units of alcohol per week². Per adult sales were 1.5 litres per capita higher than England and Wales and 93% of this excess was due to off-trade sales. Generally, the trend in recent years has been for consumption to decrease, with the exceptions of 2013 and 2015, when there were increases. In 2016, consumption dropped again.

Population consumption is affected by availability and affordability of alcohol. International evidence indicates that both acute and chronic alcohol-related health problems are linked to local alcohol outlet densities¹¹. According to Alcohol Focus Scotland (<http://www.alcohol-focus-scotland.org.uk/media/310762/alcohol-outlet-availability-and-harm-in-scotland.pdf>), which reported on the relationship between outlet availability and crime and deprivation rates, alcohol-related hospitalisations and deaths are significantly higher in neighbourhoods with higher outlet densities. They also found that crime rates were more than four times higher in neighbourhoods with the most alcohol outlets compared to the least and that there were 40% more places to buy alcohol in the most deprived neighbourhoods than in the least. Studies from a number of countries have shown off-sales outlets tend to be disproportionately concentrated in areas of socio-economic disadvantage¹¹. While political and media attention frequently focuses on binge drinking in public spaces such as city-centres (therefore on-sales outlets), off-sales outlets actually have greater potential for alcohol-related harm. Scottish heavy drinkers have repeatedly reported that, even if not intending to drink, a ubiquitous local supply makes abstinence challenging¹².

Price and income levels combine to impact upon affordability. In Scotland, the average pence per unit (ppu) of alcohol (combined on- and off-trade sales) increased slowly from 2002, reaching 84 ppu in 2014². This increase has been driven mainly by on-trade price increases and the average price of alcohol in the off-trade has remained static since 2013². Analysis of the price distribution of alcohol showed that in 2016, 51% of off-trade alcohol was sold below 50ppu. This percentage was similar in the previous three years.¹³ Alcohol affordability in the UK increased steadily between 1980 and 2007, driven mainly by increasing average disposable incomes in the population as a whole. Alcohol affordability has since fallen. This has been largely due to falling average disposable income, linked to the 2008-2013 economic downturn. Since 2011, rising incomes and a slight reduction in alcohol prices led to a small increase in affordability². From 1st May 2018, Scotland implemented Minimum Unit Pricing (MUP) which sets a minimum price of 50p per unit of alcohol, below which no alcohol may be sold.

3.3.2 Pattern of consumption

Overall population consumption derived from alcohol sales data does not reveal patterns in consumption by different genders or age groups. A recent Scottish study⁸ used an established approach to triangulate self-reported alcohol consumption estimates from the Scottish Health Survey¹⁴ with alcohol sales data to adjust alcohol consumption to more realistic levels. This study showed that for men, the highest consumption was 40.66 grams (5.08 units) per day in the 55-64 age group, followed by 16-24 years at 37.39 grams (4.67 units) per day. Lowest consumption for men is in the 75 years and over group (23.01 grams or 2.88 units per day) followed by 35-44 year-olds (28.9 grams or 3.6 units per day). For women, overall consumption is lower than men for all age groups with the highest consumers being the 16-24 years age group with a mean daily consumption of 21.27 grams or 2.66 units per day.

The Scottish Health Survey¹⁴ for 2015 breaks down alcohol consumption by household income quintile. It finds that the proportion of harmful and hazardous drinkers (over 14 units of alcohol per week) is highest among men with the highest household income (46%) with the two lowest income quintiles having similar proportions of harmful and hazardous drinkers (25/26%). The same gradient is seen in the data for women with 24% of women in the highest income quintile reporting harmful or hazardous drinking levels compared to 11% of women in the lowest two quintiles. However, the self-reported data on units consumed shows higher mean weekly units of alcohol consumed by harmful and hazardous drinkers in the lowest income quintile, compared to the highest in both men and women (Men: 54.8 units compared to 28.3 and women: 39.1 units compared to 23.3). The report acknowledges the issue of under-reporting and the likelihood that there is some responder bias as non-responders are more likely to engage in riskier health behaviours¹⁴.

From 2003 to 2015 there has been an increase in the proportion of non-drinkers in both men and women (8% to 13% for men and 13% to 18% for women)¹⁴. Over the same period the proportion of harmful and hazardous drinkers has also decreased from 47% to 36% for men. For women, the proportion reduced from 23% in 2003 to 16% in 2013 rising to 17% in 2015. However, there were also slight rises in the mean units consumed per week by drinkers of alcohol between 2013 and 2015 for both men and women. Mean weekly units consumed by men dropped from 21.8 in 2003 to 15.7 in 2013, then rose to 17.2 in 2015. For those women self-reporting alcohol consumption at harmful or hazardous levels, mean alcoholic units consumed on the heaviest drinking day dropped from 6.2 to 5.6 in 2012/3 only to rise again to 5.7 in 2015.

Declining consumption generally can be seen in self-reported data with this being driven by higher rates of abstinence in younger age groups and reductions in the heaviest-drinking men, and the proportion of 13-15 year-olds who reported ever having an alcoholic drink was the lowest ever in 2013.

3.4 Evidence of groups at increased risk of alcohol-related death (ARD)

Despite a greater proportion of harmful and hazardous drinking in the least deprived quintiles, there is a clear social gradient to ARDs with those living in the most deprived areas suffering the most ARDs. Alcohol consumption data (stated above) shows higher mean consumption among hazardous and harmful drinkers in the most deprived categories. Individual and societal factors mentioned in Section 3.2 may also play a part in the higher level of harms. Health selection theory posits that poor health status *causes* loss of socio-economic position. The possibility that alcohol use came prior to deprivation - effectively that heavy drinking causes individuals to 'drift' into areas of greater deprivation - was examined in a recent Scottish study¹⁵. It concluded that while those who die from alcohol-related causes are more likely to experience social drift than those who die from other causes, health selection appears to contribute less to the deprivation gradient in alcohol-related mortality in Scotland than initial deprivation category.

There is evidence of increased vulnerability to harms for other groups within Scotland. For example, Smith et al¹⁶ found that Scottish children had a higher exposure to adverse childhood experiences such as exposure to violence and addiction than English children. The authors hypothesised that this increased their risk of death from suicide and it is feasible that the same factors would also increase their risk of ARD. Graham et al¹⁷ showed that those who had been imprisoned in Scotland were more likely to die an alcohol-related death. For men the risk was nearly three times higher than those not imprisoned and for women the risk was nine times higher. McCartney et al¹⁸ found evidence of a vulnerable cohort experiencing a wave of alcohol-related deaths, increasing in the 1990s and decreasing from the mid-2000s as that cohort aged and died. It was theorised that economic, social and urban environment changes, between the 1950s and late 1970s, left the Scottish population vulnerable to negative impacts of the economic policies from the 1980s onwards, and that there would be a cohort of people (especially young working-class men) who would be subsequently at increased risk of alcohol-related harms (due to increased consumption and/or increased vulnerability to the effects of alcohol misuse). Furthermore, work into what has become known as the 'Scottish effect' or 'Glasgow effect' suggests that people living in West Central Scotland (WCS) are more vulnerable to premature death than would be suggested by deprivation levels alone¹⁹. The suggestion has been made in recent years that this excess mortality is the result of interacting, cumulative exposure to poverty, deprivation and deindustrialisation and the unique nature of urban change in Glasgow²⁰.

In combination with other drugs, alcohol poses a heightened risk. One study found that alcohol was a factor in 27.5% of drug-related deaths in the West of Scotland in 2006/7²¹. A more recent Scotland-wide study suggested that alcohol potentially contributed to the cause of 112 (12.9%) of 867 drug-related deaths registered in Scotland in 2016²².

3.5 Effective and cost-effective policy and treatment

WHO guidance³ suggests that effective policy for the reduction of alcohol harms falls into the two broad categories of policy-based options and health services provision. Policy-based options aim to reduce population level consumption and may reduce harms through a number of mechanisms²³:

- Helping people who are not in contact with services to reduce drinking;
- Creating a lower risk environment for those who have been advised to reduce drinking; and
- Preventing people from starting to drink too much.

Policy-based options include those that impact on pricing, availability controls such as licensing outlets and controlling hours of operation, as well as controlling the advertising and marketing of alcohol. Interventions at this level are cost-effective ways of reducing alcohol-attributable deaths at the population level. Drink-driving legislation would also come into this category as although its primary aim is to

reduce road accidents, it is likely to reduce alcohol consumption among drivers. Scottish policy-based provisions are discussed in Section 3.7.

According to WHO guidance³, health services provision should include the monitoring of alcohol consumption and providing brief interventions, counselling and pharmacotherapy. Screening and brief interventions for hazardous and harmful drinking have a good cost-effectiveness evidence base. These interventions are intended to reduce harm through:

- Making people aware of risks and potential harms at an early stage before they have damaged their health; and
- Preventing the extension of damage that has already begun.

An analysis of the effectiveness of treatment for alcohol problems suggested that on a UK level for every £1 spent on alcohol treatment, the public sector saves £5²⁴.

3.6 Health service provision in Scotland

Health services provision in Scotland follows a stepped care model with four tiers based on best practice guidance for adults affected by alcohol misuse²⁵. An outline of the tiers is set out in Table 3.

Table 3: Four tiers of interventions from models of care for alcohol misusers²⁵

	Definition	Settings	Interventions
Tier 1	Alcohol-related information and advice, screening, simple brief interventions and referral	<i>Where services have necessary competence:</i> Primary care, A&E departments, psychiatric services, social services, homelessness services, antenatal clinics, general hospital wards, police and prison settings, educational and vocational services and occupational health services.	Alcohol advice and information, targeted screening and assessment, provision of ABIs for hazardous and harmful drinkers, referral for more specialised alcohol treatment, shared care with specialised alcohol treatment services
Tier 2	Provision of open access facilities and outreach	<i>Where services have necessary competence:</i> Specialist alcohol services, primary healthcare services, acute hospitals (e.g. A&E departments, liver units), psychiatric services, social services, domestic abuse agencies, homelessness services, antenatal clinics, probation services, the prison services, occupational health services.	Alcohol specific information, advice and support, extended brief interventions and brief treatment, assessment and referral, shared care with Tier 1, Tier 3 and Tier 4 provision, mutual aid groups (such as Alcoholics Anonymous), triage assessments
Tier 3	Community based, structured, care-planned alcohol treatment	Specialist alcohol treatment services with own premises in the community. Outreach. Community settings. Prison services.	Comprehensive substance abuse assessment, care-planning and review, community care assessment and case management, evidence-based prescribing for detoxification and reducing risk of relapse, psychosocial therapies and support for alcohol and co-existing mental health conditions, structured day programmes, liaison services (for example with ante-natal care, mental health services, social care or housing services).
Tier 4	Alcohol specialist inpatient treatment and residential rehabilitation	Specialised statutory, independent or voluntary sector inpatient facilities, residential rehabilitation units, inpatient units if psychiatric/other co-morbidity (with specialist alcohol liaison support)	Comprehensive substance abuse assessment, care-planning and review for inpatient structured treatment, evidence-based prescribing for detoxification and reducing risk of relapse, psychosocial therapies and support, shared care and advice to other tiers.

A&E – Accident and Emergency Department, ABI – Alcohol Brief Intervention

Psychological interventions are the mainstay of dependence interventions. Several drugs are also available to support psychological interventions in certain groups of people trying to withdraw from alcohol dependence²⁶. They work by affecting levels of chemicals in the brain thought to be partially responsible for inducing a craving for alcohol (Acamprosate), blocking the effects of alcohol (Naltrexone and Nalmefene) or causing unpleasant physical reactions when any alcohol is drunk (Disulfiram). In 2016/17, 9,270 patients were dispensed drugs for alcohol dependency, a 2.2% decrease from the previous year²⁸. The gross ingredient cost of drugs for alcohol dependence was £2.3 million in 2016/17, this is a 35% increase compared with 2015/16²⁸. Changes in the price of Disulfiram account for much of the increase in expenditure on drugs for alcohol dependence²⁸. Over the last eight years (where patient detail was captured), treatment with drugs for alcohol dependence has been most common in patients between 45 and 49 years of age. In 2016/17, seventy one percent of the patients dispensed drugs for alcohol dependence were aged between 35 and 59²⁸. Treatment in younger age groups has decreased and in older age groups slightly increased. Treatment with drugs for alcohol dependence is much more common in the more deprived areas; in 2016/17 there were 5.3 times more patients living in the most deprived quintile compared to the least deprived quintile.²⁸ Around two fifths of patients dispensed drugs for alcohol dependence lived in the 20% most deprived areas²⁸.

Alcohol-related conditions accounted for 36,235 hospital stays in 2016/17, a rate of 685.2 per 100,000 population²⁷. This was an increase compared to the previous year (673.2) but prior to this there had been a steady decline in alcohol-related stays since 2007/08³⁷. Stays in general acute hospitals for alcoholic liver disease continued to rise for the fourth consecutive year, with a rate of 140.0 stays per 100,000 population during 2016/17²⁸. This is similar to 2007/08 (140.1 per 100,000 population), which is the highest recorded since 1997/98²⁸. The rate of alcohol-related stays in psychiatric hospitals in 2015/16 is unchanged from the previous year (2014/15) at 54.4 per 100,000 population²⁸. There is a difference in the pattern of alcohol-related admissions by deprivation²⁸. In the general acute setting in 2016/17, there were nearly eight times as many people (per 100,000 population) admitted from the most deprived areas compared to the least deprived areas²⁸. In the psychiatric setting in 2015/16, the difference was more pronounced, with just over 15 times as many people from the most deprived areas²⁸. For both sexes and all age groups, mental and behavioural disorders were among the top three causes of alcohol-attributable hospital admissions⁸.

For primary care the latest figures available are for 2012/13 when there were an estimated 94,630 alcohol-related primary care consultations by 48,420 patients, a substantial fall from 109,170 consultations by 57,470 patients in 2011/12²⁸. This is likely to be an underestimate. There were two-and-a-half times more patients consulting for alcohol misuse in the most deprived quintile compared with the least deprived quintile³⁶.

3.7 Scottish policy response and impact

As a response to the high level of harm relating to alcohol and the cost attached to it, the Scottish Government published a new strategic approach to reducing alcohol-related harms in 'Changing Scotland's Relationship with Alcohol: A Framework for Action' (subsequently referred to as 'the Framework') in 2009⁶. The strategy drew on international evidence that an "effective alcohol policy is one that encompasses a range of interventions (including regulatory measures, support and treatment interventions and changes in culture and attitudes) delivered via a comprehensive approach aimed at the whole population, with particular targeting for high-risk groups"²⁹. The Framework set out proposals that aimed to reduce consumption and improve support and treatment as well as change attitudes to alcohol and support families and communities. Several pieces of legislation were enacted:

- The Licensing (Scotland) Act 2005³⁰ implemented in September 2009 introduced restrictions on irresponsible promotions, licensing objectives, over-provision assessments, mandatory training, the recruitment of licensing standards officers and measures to reduce underage selling. It also included a relaxation of restrictions on opening hours. Evaluation concluded that the Act had changed licensing practice but overprovision assessments and the public health objective were proving difficult to operationalise. It was not possible to determine if such policy-based changes were influencing either licensing decisions or alcohol availability².
- The Alcohol etc. (Scotland) Act 2010³¹ was implemented in October 2011 and included a number of measures designed to reduce alcohol consumption, most notably the multi-buy discount ban in the off-trade, which prevented offers such as '3 bottles for the price of 2'. Evaluation suggested that The Alcohol Act resulted in a small reduction in wine sales.² The evaluation could not detect any measurable, short-term impact on ARDs. The long-term impact on ARDs and on alcohol-attributable deaths remains unknown².
- Implementation of the Alcohol (Minimum Pricing) (Scotland) Act 2012³² was delayed by legal challenges but has now happened on 1st May 2018. The Act set a minimum unit price below which alcohol cannot be sold⁷. The aim of the policy was to reduce consumption by harmful drinkers, thus reducing alcohol-related harms. Modelling suggests that a 50p minimum unit price would be effective in reducing alcohol consumption among hazardous and, particularly, harmful drinkers³³ and that these consumption reductions would lead to reductions in alcohol-related mortality and hospitalisations. The impact on consumption and alcohol-related harms will be evaluated in due course.

In December 2014 the legal limit for driving in Scotland was reduced from 80 mg to 50 mg of alcohol in 100ml of blood³⁴. Evaluation of the impact of this change on road accidents, alcohol consumption and health harms is currently underway.

In addition, the Framework⁶ introduced some other important non-legislative changes including providing additional funding to extend and improve delivery of

alcohol brief interventions (ABIs), additional investment for treatment and care services, a target to reduce waiting time for specialist alcohol and drug treatment, reform of local service planning structures through the introduction of Alcohol and Drug Partnerships (ADPs) and guidance aimed at improving the quality and consistency of services³⁵. An additional £85 million was invested in treatment, early intervention and prevention over the years 2008-9 and 2010-11, then funding was maintained at that level until 2015-16⁷. Funding for ADPs for 2016-17 and 2017-18 was £53.8 million per annum compared to £69.2 million per annum for the previous two years. This compares to £12 million per annum pre-2008 funding for Alcohol and Drug Teams (predecessors to the Alcohol and Drug Partnerships)⁷.

The need for, and use of, specialist services during 2012 was measured to develop a prevalence-service utilisation ratio (PSUR). This ratio compared the number of people accessing Tier 3 and 4 services to those thought to be in need (those with an AUDIT score over 16). The PSUR for Scotland was estimated to be 1 in 4 which was high by international standards. No comparable PSUR for alcohol services in Scotland prior to 2008, or for England & Wales was identified. It was therefore not possible to assess whether the PSUR had changed as a result of the increased investment, or if it was higher than in England or England & Wales. The study found that it was plausible that the increased investment since 2008 contributed to improved availability of support for high-risk individuals⁷.

An NHS performance target (a so-called HEAT target - Health improvement, Efficiency, Access and Treatment) for ABI delivery in primary care, accident and emergency departments and ante-natal care settings was introduced in 2008. The target was revised in 2012 to extend delivery to other NHS and non-NHS settings and to increase funding, training and coordination in order to improve the reach and quality of ABIs delivered. Between 2008/09 and 2014/15 an estimated 569,792 ABIs were delivered, representing 145% of the combined targets set over this period. It was estimated that the programme reached 43% of hazardous and harmful drinkers over the five years. The programme is now embedded in routine practice and 86,560 ABIs were delivered in 2016/17. This number has fallen for three consecutive years from a peak of 104,356 in 2013/14³⁶. 55,950 of the ABIs delivered in 2016/17 were in priority settings (primary care, Accident & Emergency and antenatal settings). The number of ABIs in 'wider' settings (settings other than priority settings) has increased for the fourth consecutive year from nearly 10,500 in 2012/13 to over 30,500 in 2016/17. ABIs delivered in wider settings account for 35% of all ABIs recorded in 2016/17. Within ABIs delivered in wider settings 4,230 were delivered in prison compared to 1,060 the previous year³⁷. There is a large variation in the settings of ABIs delivered by health board²⁸.

Following the introduction of a target to reduce waiting times for specialist alcohol and drug treatments (HEAT target A11), waiting times have reduced and performance has been constant over the three years to September 2017 with 94.5% of the 6,532 people seeking alcohol treatment starting treatment in three weeks or less in the quarter July to September 2017³⁸. This report now includes people in prison where in the same quarter, 99% of 1,223 people starting their first drug or alcohol treatment waited three weeks or less. However, at 30th September 2017,

266 people (8.8% of people waiting) had been waiting more than six weeks and five health boards failed to meet the quality standard³⁸.

Summarising the impact of the Scottish Government's alcohol strategy, the evaluation team concluded that there was evidence that the interventions studied were implemented; there was evidence of impact on several of the intermediate outcomes; and it was possible that the strategy may have contributed to the overall decline in alcohol-related harms in recent years².

4 Findings from audits in Glasgow

4.1 Glasgow audits for 2003, 2010 and 2013

Three audits have been undertaken in recent years looking at ARDs in the Glasgow area^{39 40 41}. The region has a higher concentration of deprivation than in the rest of Scotland, but there are also significant variations within the region.

Each of the audits selected a random sample of the ARDs of a particular year and reviewed case records from multiple sources. The purposes were:

- to identify key risk factors
- to examine the contact with services of individuals
- to identify any consistent patterns of engagement with alcohol treatment services and discover where they break down
- to identify opportunities to intervene at an early stage
- to assess the effectiveness and impact of services.

Data reported in the audits is attached as Appendix 3. A brief narrative summary of the findings is given below.

4.2 Risk factors

All three reports identified that white men aged 45-64 living in the most deprived areas were more likely to die from alcohol-related causes, though the average age of women who died of alcohol-related causes has been less than men in the last two audits and was most notable in 2010. Most lived at home when they died, many were alone (either single or divorced), were socially isolated and had a close friend or family member with an alcohol problem. The latest report found that just under three quarters of the cohort were unemployed at the time of death⁴¹, though all three audits found that both men and women had held down jobs when younger. All three audits found that housing problems were common. There was evidence of involvement with the criminal justice system but not for the majority of the cohorts. There was mixed evidence of the level of use of other substances. A majority of all cohorts appeared to have co-existing mental health problems. There was physical evidence of alcohol misuse recorded on the primary care files for the majority of all three cohorts. The 2013 audit reported that 32% of individuals in that cohort reported problems with alcohol before the age of 25 years. The Glasgow audits also highlight the relationship between alcohol use and domestic violence, though becoming a victim appears to be more common than becoming a perpetrator for females in each year audited.

4.3 Contact with services

The data from the three studies indicate that there was a high level of awareness of problematic alcohol use at primary care level. In the latest cohort⁴¹ most individuals appear to have been referred on to specialist services. There was a high level of contact (reported for all cohorts) with social services and with acute medical services

(A&E, outpatient and inpatient services) as well as general mental health services. Attendance rates appear better for GP and outpatient appointments than for alcohol specialist services.

4.4 Interventions

The audits suggest that screening using an established tool is only completed in a minority of cases^{39 40 41}. Alcohol consumption was recorded in primary care notes for a large majority of the 2003 and 2010 cohorts, although in all three audits it was noted that patients were rarely asked to complete drink diaries^{39 40 41}. GP advice was provided to over 90% of patients in the 2010 and 2013 audits^{40 41} and the 2003 and 2010 audits record that advice to abstain was given in 79%³⁹ and 89%⁴⁰ of cases. Thiamine was prescribed for 71% in 2003 rising to 88% of the 2010 cohort^{39 40 41}. Hepatitis C screening was undertaken for 26% of the 2010 cohort⁴⁰ and 59% of the 2013 cohort⁴¹. Alcohol Brief Interventions (ABIs) were reported as having been provided to 23% of the cohort in 2003³⁹, 6% in 2010⁴⁰ and 25% in 2013⁴¹.

Referrals to the addiction specialists (CAT) from the 2010 audit rose from 22% in 2003 through 32% in 2010 to 59% in 2013^{39 40 41}. Disengagement is raised as an issue in the 2013 report as 85% of discharges from the Community Addiction Team were unplanned⁴¹. The audits report difficulty engaging with some groups, with no women engaging with the Community Addiction Teams in the 2010 cohort⁴⁰; and recommendations were made about reaching young men through outpatient clinics in the 2013 report⁴¹.

The most detailed information on detoxification was provided in the 2010 audit⁴⁰. In this cohort 72% of women and 60% of men underwent detoxification at least once. Detoxification took place in a number of settings but the most common was an acute inpatient detoxification which the authors of the 2010 audit state would probably be unplanned⁴⁰. In addition a large proportion of detoxifications were unsupported⁴⁰. Women were more likely than men to undergo detoxification in most settings⁴⁰. The majority of individuals in the two later cohorts had undergone at least one medication-assisted detoxification. All three audits report low levels of support for relapse prevention, whether that is in the form of prescribed medication, day centres or residential care^{39 40 41}.

There is evidence of a high level of mental health co-morbidity across all audits with a high number of referrals to psychiatric services and prescriptions for antidepressant^{39 40 41}, anti-psychotic⁴⁰ and anxiolytic medications⁴⁰. Attendance rates at psychiatric appointments were reported to be low in the 2010 cohort with only 11% attending all or most appointments⁴⁰. The 2013 audit reported that 70% of the cohort had been in contact with a non-addiction specific mental health service in their lifetime⁴¹.

5 Qualitative study, methods and findings

5.1 Research questions:

A topic guide was used for all discussions, with two main questions:

- What do you think are the factors and circumstances that might lead to alcohol-related deaths?
- What could be improved to reduce these?

5.2 Methods

The qualitative research was informed by discussions with fifty people:

- Five people currently drinking at harmful levels and fourteen who self-defined as 'in recovery'
- Eleven family members
- Twenty alcohol-related professionals.

For all interviews and focus groups, contemporaneous notes were made and the interviews coded and analysed. Data was analysed, according to the three groupings.

5.3 Research participants

- **People drinking at harmful levels or 'in recovery'**

Eight of these people took part in individual interviews. Two of these interviews were carried out by workers from Glasgow Homeless Network, three by a development officer from the Scottish Recovery Consortium and three by the main researcher. All interviews were transcribed, coded and analysed. The main researcher was able to make contact again within the timescales with eleven individual(s) who took part in the interviews or focus groups to share the notes made to give them a chance for any further comments.

Three focus groups also took place, one in Glasgow, one in Edinburgh and one in Aberdeen. In all three cases the individuals were well known to one another and part of a wider recovery community.

With this group, as well as exploring the factors and circumstances that might lead to alcohol-related deaths and how support might be improved, researchers tried to explore personal perspectives about why people had been and/or were continuing to drink at hazardous levels. However, interviewees were not probed for any information that they seemed uncomfortable to reveal.

- **People affected by a family member's alcohol use**

Eleven family members took part in the study. Five had had someone close to them die, either their partner or child from alcohol-related problems. Three were continuing to support someone who was drinking excessively and three had family members now in recovery.

Two family members were interviewed individually and the remaining nine took part in three focus groups: in Edinburgh, Aberdeen and near to Glasgow.

- **Alcohol Professionals**

Twenty professional workers took part in individual interviews.

In addition, professionals who were attending the North Community Forum, part of the Aberdeenshire Alcohol and Drug Partnership (ADP), a multi-agency partnership of agencies, were consulted. All were asked the main question 'What do you think are the factors and circumstances that might lead to alcohol-related deaths', and 'what could be improved'.

5.4 Findings and perspectives of people drinking at harmful levels, or now 'in recovery'

5.4.1 Overview

Many of these people described their harmful alcohol use as being related to having a range of other deep-seated problems. Eighteen of nineteen research participants in this group said that they been suicidal at one point, relating this to their alcohol use. The following table presents a summary of the main reasons given by those who took part for their harmful drinking. However, for many people, a range of issues interacted, both contributing to the drinking problems and being impacted by them.

Main Reason for drinking	Number (n19)
Addiction	6
Get confidence	4
Deal with past child abuse	4
Adult trauma	2
Self-hatred	1
Mental health	1
Stopped caring about self	1

Six people suggested that they had simply become addicted, not citing any explanatory factors. Four people said that they began drinking to get confidence and 'slipped into' addiction. Four people revealed that they had been abused as children and that this had led to heavy drinking. In one case an interviewee revealed physical and mental abuse by a mother, for another it was from both parents. Adult trauma, including sexual abuse, was also mentioned by two people. One man said that he began drinking heavily after being at the hospital with his child and watching other children die over the month that they were there. Another man spoke about feeling deep self-hatred for himself, for being gay and religious and having to deal with a double life and this drove him to drink to excess. Mental health issues were prioritised by one man, who had now been diagnosed as bi-polar, who suggested that he had used alcohol beforehand as a form of 'self-medication'. Lastly, one man argued that his heavy drinking was associated with becoming bored with life and no longer caring about himself.

5.4.2 Discussion

5.4.2.1 A disease/illness and/or inheritance

All of the research participants spoke about getting to a point where they were drinking to function as they had become dependent. Some participants suggested that 'addicts' have similar traits, specifically 'an oversensitivity to life', 'low self-esteem', 'Not feeling that they fit in', 'drinking to get blank', 'feel that they

are bad people', 'feel lonely.' Many described alcoholism as a disease, suggesting that it was genetically inherited or related to common social experiences in some families:

I had alcoholic parents, alcoholics going back on either side and that was what I was born into – abusive alcoholics. It was everywhere. My first memory of it is chaos – alcohol is chaos. (R8)

Almost all of this group reported having had serious mental health problems in their lives, with almost half explicitly suggesting that alcohol had been used as a form of 'self medication'. One person, who was eventually diagnosed as having bipolar disorder suggested that stigmatising judgements from health professionals about the fact that he was drinking at harmful levels may have blinded them from recognising and providing treatment and support for the mental health condition:

I have now been diagnosed as being bi-polar and that was a struggle. I was even sober six months and they still tried to pin it on the alcohol. People who have mental health issues do not get good access to support. You just get passed around. (R19)

5.4.2.2 Related to social problems and trauma

Whether or not they believed that alcoholism was an illness, and/or inherited, most people described their own harmful alcohol use as being related to social problems, which often originated in early childhood. For one young man, drinking began at the age of eight, and was related to experiences of abuse and parental neglect:

I started drinking when I was very young and was allowed to drink when I was 8 years old. My mum was a drinker. I started drinking of my own accord when I was 10/11. Any sort of emotions, I would drink. At 11 I got chucked out of my dad's and moved back with mum and her new boyfriend who was an addict. Drinking was always my coping mechanism. (R5)

At eight, I had my first blackout. It was a reward, you would get lager if you did this or that, if the extended family were in a good mood, it was funny to give the wean a drink. I remember when they would go out, my pal and I would drink. (R8)

Many other research participants also linked experiences of physical and/or sexual abuse with why they drank in harmful ways:

My dad was an alcoholic, he used to come home and leather us. (R1)

I was abused when I was younger and my mother knew about it and allowed it to happen. I hate my mother, she has never done anything for me and if I was told she was dead tomorrow it would make me happy. (R4)

I had very low self-esteem growing up and my mum used to call me stupid and be abusive. It was so hard because no one else seemed to be going through this and my dad dare not stand up to her either and tell her to stop. (R10)

However, trauma was not necessarily limited to childhood or 'growing up' experiences. One man (R1) related his harmful drinking to having been shot and stabbed while he was serving in the army. Some others talked about drinking to cope with the effects of feeling helpless to support their own children in difficult situations. For R2, 'It all began when my daughter was born with Down's Syndrome and then she had leukaemia'; for R4, drinking was self harming to cope with losing a much-loved son several years earlier:

My son died 20 years ago and I just can't get over it. I have nothing, no one in my life now. I self harm to try and get through it all. (R4)

Even more often than this, however, people described what seemed like a more generalised sense that alcohol simply helped them to deal with not 'fitting in' or enabled them to feel that they did 'fit in', either as an adult or a child:

I grew up as a kid that didn't fit into my own family. The memories of my childhood...I didn't have the ability to make friends and I was a misfit and was very unhappy. Immediately when I left school I worked in a hotel and got into serious hard drinking and all of a sudden I felt part of the world. (R6)

I always felt left out growing up. I started drinking when I was 10 and I remember tasting the whisky and thinking 'this is me.' (R10)
Initially in my younger years it was to fit in, give me confidence and to act how others were acting. I always felt never good enough, almost psychologically uncomfortable, I didn't know myself and felt strange in social situation and alcohol helped that. At twelve or thirteen, no one spoke about things, so you just run with the pack. (R7)

I couldn't cope because I was gay, religious and leading a double life, one for my family and one for me. (R9)

As well as 'not fitting in', 'feeling stupid', and not wanting to feel either of those emotions were cited by many as contributing to their harmful alcohol use. People described name-calling, including by parents, as contributing to a sense of stigma and isolation. Five interviewees suggested that their undiagnosed dyslexia had contributed to this stigmatisation.

At odds, however, with the perception that alcohol might support pro-social behaviours, several interviewees discussed how being alone and feeling lonely both led them to drink and isolated them even further.

It got really bad for me when the children had moved out. (R10)

I was taken away from all my pals and felt alone. I had pals but they weren't from where I lived. (R11)

One man described what he sensed as a growing dependency illustrated by the fact that he left social drinking situations to drink on his own at home:

I would be out drinking as I was a sociable person but to be honest I couldn't wait to then get home and really start drinking.' (R18)

Almost half of the interviewees suggested that, while alcohol use contributed to relationships breaking down, harmful drinking and the impacts of this got worse when the relationships were over; as R17 said,

You lose your friends and your family and then you are drinking to try to feel better but it is all part of a vicious cycle. (R17)

5.4.2.3 'Numbing'/'blacking out'

Given the traumatic experiences that several people described having had in their lives, it is hardly surprising that many described the use of alcohol as a way to numb and even blank out painful experiences. Until 1981, consenting sex between men in Scotland was illegal and stigma still resides in some communities, influenced by attitudes of some religious leaders. One man recounted his experience of carrying guilt for being gay and religious. He explained:

I was trying to deal with who I was and I hated myself. I would be drinking first thing in the morning just to get me going.... I was drinking to numb myself from my self-hatred. (R9)

A perhaps even more distressing story was told by another man who had been raped forty years earlier and had not discussed this with anyone, but who also, perhaps by taking part in this research, was recognising that using alcohol to excess was not going to help him to face and get over his horrific experiences:

I was raped when I was 14 and the truth of it is I only told my brother who didn't believe me at the time. I never got any help. I have had to live with that. I can't even look at myself in the mirror... I still carry what happened to me all those years ago. (R1)

Unfortunately, he suggested that it was 'too late' for him now to recover from his trauma.

5.4.2.4 Drinking cultures

Several research participants discussed how the fact that alcohol was ever-present in their daily environments influenced their drinking; as one person (R8) put it, 'That is what everyone else is doing and that is what you did'.

Environments saturated with alcohol began at an early age for many, becoming an adult dependence:

It would be at the weekends and then at the summer holidays and then going into school drunk and I drank for a good ten or 15 years. It was binges, going off it and back on it and then an everyday thing. It was like I was dependent on it to function daily. (R7)

However, some people described how, rather than feeling peer pressure to drink, peers were selected who shared the same harmful behaviours. For example, one man described being part of a group who would share their wages to spend on alcohol every night, with risks to personal safety that resulted from such situations:

Before, I used to even be a part of a group that whoever got paid that day, that is how we would then get our booze paid for. People take advantage of you too when you are in that mess. (R9)

Such behaviours were sometimes compounded by working arrangements, such as, for one man, working on oil rigs, which contributed to harmful patterns of behaviour, abstinent when off shore, then bingeing when back at home:

...weeks on, weeks off. I went from being really busy working 16 hours a day to then being at home with nothing to do and not really knowing what to do with myself. You can't drink at all when you are offshore and I was too busy anyway. I binge drink and it went from bingeing for three days to then more. (R2)

Whatever their gender, people also discussed strategies for covering up harmful drinking in social contexts, which was perceived to be easy in some settings, such as for those working in many leisure contexts. Some men spoke about heavy drinking behaviours as part of a pervasive culture of hegemonic masculinity; in such contexts, the more you could 'handle' your drink, the more masculine you might be perceived:

As I was tall and a big guy, I could handle it and so I was drinking more than everyone else. It started off socially drinking but then was drinking pretty much all the time. (R11)

Whereas for this man, living up to normative gender expectations may have contributed to his harmful drinking behaviours, one woman described the social unacceptability of being a drunk woman, which also created barriers to accessing help.

5.4.2.5 Changing environments

All of these research participants emphasised that they lived a constant struggle not to return to harmful drinking behaviours. Several urged action to change

social spaces, so that they were not always promoting the 'norm' of drinking, which had both contributed to their own problems and also made staying healthy hard.

5.4.2.6 Intervention and maintenance of support

Earlier intervention in family situations to prevent abuse and neglect and to recognise behaviours of young people affected by these were suggested as important. R6 believed that this might have been possible to prevent him drifting into self-harming drinking behaviours:

If only someone had taken the time to wonder why I was such a strange child, unable to make friends and socialise. How different life might have been. I think we know so much more than compared to when I was a kid, but we don't really seem to be able to spot the kids who are going to drift into addiction. (R6)

Services to support recovery, such as Alcoholics Anonymous (AA), support from specialist professionals and some online services were cited by several people as life-saving:

What finally got me to AA was that if I didn't turn my life around I was going to end up homeless and I don't have the personality to cope with that. (R6)

My life had disintegrated to such an extent, I was living off people and was suicidal and couldn't figure a way forward. I went to the doctor about being suicidal and got no help there. I went to AA and when I went online it started to make sense that I could crawl my way out of it. (R8)

For themselves, several people suggested that professionals who treated them seriously, but with care and attention had been instrumental in supporting change in their drinking and other areas of their lives:

It was a GP who was in a homeless hostel at Easterhouse who really helped me. My experience with that GP was that I wasn't just another person, I was an individual. That made a big difference. (R8)

I had given up on life and it was my care manager that saved me and made me realise that people cared. (R18)

However, there is inconsistency in support services. People also felt that many GPs needed to be more skilled and encouraged to recognise and respond to both mental health and alcohol problems, and also to explore their experiences with patients. At odds with this, G2 described having been given 'so many leaflets and sleep CDs', rather than talking about alcohol. Many described feeling that they had had to reach 'rock bottom' to mobilise them to fight to recover. R16 described this as "The gift of desperation". All had had experiences where they felt that GPs

and/or other professionals had possibly not comprehended the seriousness of their predicaments:

I felt like I was just a number at the Doctors and brushed off. I don't want to make myself vulnerable. (R5)

The CAT team were not that bothered, they gave me a drink diary to control my diary rather than abstinence. I was in a hostel and 30 years old and the guy came out and told me to keep the diary and when I was telling him how I was feeling, he was quite dismissive. My CJ worker was fighting to get me into rehab, I was dragging my heels, and he was saying that I had to go to a day programme. They didn't believe me, because I had kept my job and looked alright. Unless you are on benefits you don't get any help. (R7)

I remember an attitude of 'you are alright, don't worry about it.' (R8)

Once people had accessed help, it was also suggested by one person that 'assertive outreach' approaches should be employed to support people to maintain contact with support services. Several people also suggested that professionals needed to recognise that some people feel that they cannot reduce drinking and maintain a healthy lifestyle; they need to be supported to be abstinent:

Doctors don't understand alcoholism and tell you to cut down but the reality is that you can't handle it. (R9)

5.4.2.7 Recovery communities and a recovering society

In one focus group, metaphors such as being 'in a big, black hole' and being 'crab trying to climb out of a bucket' were employed to describe feelings about trying to stop drinking. However, although many people were in contact with supportive groups, in rural locations, such as Orkney for one woman (R17), recovery was more challenging due to geographical isolation. In contrast, the interviewees who were in recovery emphasised the importance of having other people with 'lived experience' of alcohol-related problems and recovery around them. For those who felt that they were 'walking the same journey' with others, the informal support that could be gained from others was stressed as vitally important in maintaining recovery:

They know and understand what I am going through. (R14)

People can call another person at any time if they are feeling low or want support and a key aspect of this is that there is no judgement. You listen to that person because you trust them. (R15)

Several research participants talked about the need to discuss alcohol-related problems and the complexity and challenges more in mainstream society:

People give you advice like ‘well why don’t you just stop drinking’, they don’t understand. When you begin this, you have to just focus on you and face your fears, confront your guilts, shames, list them and you feel exposed but then you also are coming to terms with who you are. You have to change your friends, sometimes your job. (R16)

Many people emphasised how important it was for them that others around them provide love and care and that they feel that they belong in the wider community. For example, R2 expressed that her family have ‘made me always feel loved and cared for and that is what has helped’. However, in R9’s comment,

I have now met someone and am in a good relationship and they helped me see that I am a good person...Now I know that I cannot drink because I have too much to lose.

there is also a sense of precariousness, or at least not ever taking recovery for granted and ceasing to work at it.

From all of these informants, there was a strong sense that the whole community needs to change, so that, for example, people such as R18, should no longer be told ‘Don’t tell anyone anything about what is going on at home’. Research participants argued that, ‘There is a lack of compassion and understanding about addiction in society and people think it is a choice’ (R11); ‘Services and society need to be more understanding, open and compassionate’ (R10). R14 suggested that the media ‘needs to understand that the clichés and portrayal of alcoholics is damaging’. Telling stories, as these people have done, can help heal the social wounds that have been caused by misunderstanding and stigma, as well as by the direct effects of alcohol use.

5.5 Findings and perspectives of people affected by a family member's alcohol use

5.5.1 Overview

All of the family members emphasised that they believe that alcoholism is an illness, which affects not only drinkers but also those around them. Common to all were feelings of shame and embarrassment, which had often meant that problems within families had been covered up over long periods of time. All said that meeting others going through similar journeys had helped them and made them feel less alone and helpless. Unlike the other research participants, the impact of 'drinking cultures' in Scotland was not mentioned by these people; nor was the need to change drinking environments emphasised.

5.5.2 Discussion

5.5.2.1 A disease/illness and/or inheritance

As with the other research participants, there was a strong belief within many families that alcoholism was an illness that was inherited. One interviewee (F2) argued that, because of this, 'People should be more aware of their family history'.

5.5.2.2 Related to social problems and trauma

Almost all of the family members said that they believed that alcohol was used as a coping mechanism to deal with other issues: this might range from an 'underlying mental health problem' (F7-F10) to having low self-esteem because of an illness or disability, e.g. dyslexia (F11). Some people related the harmful drinking of their loved ones to specific life events; for example the death of parents, coinciding with stopping working:

Previously her social life had been very important and she took on care of parents who died and had to deal with the pain of this bereavement as well as isolation after stopping work. (F4)

5.5.2.3 'Numbing'/'blacking out'

There was a consistent sense that the family member who had been drinking in a harmful way, did so to tune out, 'to forget'. (F7-F10) One person (F2) suggested that the drinker had 'escaped' into 'a disassociated state'. Such behaviours could lead to increasing isolation from other family members. For example, one person (F4) felt that for a long time her mother had not understood that her family and friends loved her. Along with believing that others did not care about them, family members noted that the drinkers appeared to reach a point where they no longer cared about themselves either.

5.5.2.4 Drinking cultures

Broader cultural issues were not discussed very much by family members. However, the problem of providing therapeutic support for men in the Scottish cultural setting was repeatedly stressed as a problem. For example, people argued that 'men don't talk', which had contributed to them becoming dependent on alcohol in the first place also prevented them from accessing services, such as talking therapies, that might help them deal with psychological problems.

5.5.2.5 Intervention and maintenance of support

These family members regarded services for their loved ones and for themselves as often being inconsistent and inadequate. For example, when one woman's husband would not leave the house, she (F5) could not understand why health professionals could not come out to him. However, while all felt that services could do more for the person with alcohol-related problems, the main barriers identified to accessing support by families were the shame and stigma felt about alcohol-related problems, as well as the lack of awareness or consideration of the family's needs by service providers. All of the families discussed how they had covered up for their loved ones, with this causing them substantial stress:

I kept it a secret from my own work and didn't tell the children half of what was going on. When I would go to work I didn't know what I was coming home to. (F11)

Many families felt like they had been left to cope by services:

Families who are just about coping are left to cope and help not given until they crack (and even then not always).
(F2)

Many people recognised the practical pressures that affected front-line health staff and blamed these for the poor service that they felt they had experienced:

GPs and nurses only have ten-minute appointments and so their ability to really support people is constrained. They have no time to help people open up and as a result these problems are continuing to fester. (F2)

However, some people felt that attitude was as much a problem among staff as practical considerations:

Service provision sometimes is very poor and even negligent and there is nothing families can do to challenge this. For some people this really is just a job and they don't even do that well e.g. taking people to groups and leaving them there...Addiction workers should focus on commitment and direction. They should fully commit themselves to looking after the person and doing what they can to support and help the person into recovery. There should always be direction when a person goes into treatment, they should work together and come up with a plan for treatment and what they

want the final outcome to be rather than just a one hour session every two weeks where the discussion for the week is decided when the person walks through the door. (F4)

One person (F5) also suggested that, because there were supportive family members around, health services de-prioritised providing care for the harmful alcohol user.

Many people described feeling blamed by others, including health professionals, for their role/relationship with the family member with alcohol problems. Some described a sense of 'pessimism' by professionals who seemed to doubt their ability to affect people's drinking behaviours, with one person (F2) describing such attitudes as cynicism, based on a judgement that harmful drinking was a personal choice, rather than an illness.

Where they had been in touch with medical services, families described a lack of consistency in the compassion and understanding and practical help provided shown by medical staff and services. In some cases appointments were set up quickly, in others not. One family waited nine months to get access to detoxification services. Other situations were revealed such as where a family member was supposed to go to detoxification, but then they had been told that it had been decided without explanation that this was no longer the right option. One interviewee (F7) suggested that it had been necessary for her to become 'a pain in the arse' in constantly trying to get support:

You have to go on, and on, and on and on and no one wants to be that person. (F7)

One person (F4) argued that service providers consistently failed to understand and respond to the needs of her mother, who was continuing to drink at harmful levels:

They don't listen to what my mum wants and they need to. After all these years she wants help and she is not getting it...Hospitals need to play a bigger part. People are always going to end up in A&E because of alcohol-related illnesses or injuries. What support is offered then? My mum has been to the hospital countless times – she is given a vitamin jab, then is able to discharge herself, walks out the hospital and goes and buys more alcohol. (F4)

One group (F2) argued that there was a prejudice or lack of understanding about the range of options, including 'talking therapies' to support recovery. Maintaining people with alcohol problems in services was seen as important:

This should be about understanding what the person wants to do and offering options rather than the same thing again or nothing at all - that didn't work last time. There seems to be a lack of foresight with services because although they may be saving money in the short term they don't in the long-term. (F7)

At odds with this, however, some people described service providers as seeming happy to see a person dropping out. Many families also felt that their loved one had been passed around from mental health to addiction services, with no one providing adequate support:

When someone has a dual diagnosis they won't be seen or helped by either the psychiatrist or alcohol support- they are refused support. (F2)

5.5.2.6 Recovery communities and a recovering society

While the families said little about changing alcohol environments, several people did discuss how stigma about people with alcohol problems needed to reduce, so as to enable the people who were drinking at harmful levels and their families to recover.

Even in situations where the harmful drinker had died, family members could still be experiencing trauma and need support. For example, F11 described the mental anguish that she had had through the period of her husband's heavy drinking, as well as after his death:

I didn't know who to turn to...I felt as if no one cared and I was all alone. I still feel isolated. When he was dying, he was no longer the man that I married...since he has died I have found it so hard. I have gone from being busy to not knowing what to do with myself. (F11)

Family support groups were regarded as providing invaluable support for families who had often suffered over long periods of time:

When the family group was set up they were inundated. The reality is that many people are dealing with this issue or have dealt with it and so the taboo around this is that everyone is keeping silent. Families can often feel alone and by bringing families together they become their own source of support. You realise you are not alone. (F4)

5.6 Findings and perspectives of professionals

5.6.1 Overview

Professionals working in the alcohol field tended to agree with each other that the drivers of alcohol-related harms in Scotland were related to poverty and social inequalities, as well as cultural context. They emphasised that, by addressing alcohol within a public health paradigm, problems (and solutions) would be reviewed and addressed at the level of the individual, their family and friends, the community and wider society.

5.6.2 Discussion

5.6.2.1 A disease/illness and/or inheritance

As with the other groups involved with this research project, most of the professionals believed that alcohol problems were, to a large extent, inherited. Although in some cases these beliefs were based on scientific evidence – for example, if someone were to inherit a physical susceptibility to liver disease – more often, they were based on experiences of working with families where several people had alcohol problems.

5.6.2.2 Related to social problems and trauma

Across all groups, there was a strong sense that people drift into harmful alcohol behaviours as a result of social problems and sometimes trauma that they experience:

This is about life and what it throws at people, sexual abuse, mental health, lives destroyed. (P16)

The idea that alcohol is used as a form of ‘self-medication’, related to mental health problems and disturbing life experiences was repeatedly suggested; as two people (P10 and P11), suggested, ‘alcohol...is used as a painkiller’. P19 suggested that harmful alcohol use was related to low self-esteem, and self-blaming for experiences that have traumatised them.

However, although underlying mental health issues, such as clinical depression were acknowledged as playing a role, it was also felt that,

Depression is created by dealing with the realities of poverty and the misery of these people’s lives...there is a sense of hopelessness and alcohol in turn can precipitate that. (P3)

Several people suggested that social isolation experienced in rural areas contributed to harmful drinking. However, poverty and isolation in cities is also a problem, as discussed in a number of groups:

I work in the East End of Glasgow where it is very deprived and I think the social context has a lot to do with this, where people use alcohol as an escape. The fact that strong cheap alcohol is readily available is a factor that plays into that, and it is affordable. (P3) (P9) (P12)

The people who come into real problems are those who feel don't have much to lose. Mostly this is people in bad circumstances. If things are bad in your life anyway, the prospect of losing relationships, money, housing, health may not be a disincentive. (P6)

Some people suggested that changing local circumstances contributed to harmful drinking behaviours. All of the respondents spoke about middle-aged men being the most risky population coming to their attention. It was argued that men who had experienced de-industrialisation since the 1980s might be especially vulnerable to having problems with alcohol, due to increasing isolation and social inclusion that having a stable job had previously provided. Professionals in Aberdeen drew attention to the importance of recognising the impact of industries on drinking habits. For example, with the oil, farming and fishing industries having difficulties, clinicians were seeing a rise in people with alcohol problems and it was reasoned that this is because there was 'no brake', with people no longer having jobs to go to, to stop drinking. The 'routine' they had was now gone and relationship breakups were coming to the fore. Domestic violence was also said to have risen. In one focus group, professionals summarised the challenges for health promotion:

How can we expect people to make good decisions about their long-term future when right now things are so bad. You know, who cares? People who have nothing feel like they have nothing to lose. It is hard for us to properly appreciate that. (P1, P2, P13)

5.6.2.3 Drinking cultures

The drinking culture in Scotland was viewed by professionals as presenting a major challenge to public health. It was suggested that peer pressure, not just to drink but to 'go out and get drunk' (P8) is very strong, affecting all sections of society. Thus, as P1 pointed out, alcohol dependence 'can just creep up on people'. P3 pointed out that 'not drinking in Scotland draws a comment'. Many people emphasised the idea that being able to 'handle drink' is revered as a sign of masculinity, with one person going so far as to suggest that, 'you are not seen as a man if you are not drinking'. (P12)

5.6.2.4 Changing environments

The fact that alcohol had become cheaper and was more widely available and promoted than it had been in the past was seen as contributing to health problems. Professionals all emphasised the importance of actions to change the environment, so that alcohol would be less readily available and marketed. It was suggested that,

Alcohol is too readily available – there are more aisles dedicated in shops to alcohol than there are fruit and veg. (P10 and P11)

Several people suggested that the way that alcohol licensing operates should be reviewed, especially in relation to overconcentration of off-sales establishments in certain localities. There was also general support for Minimum Unit Pricing (MUP). It was suggested that health warnings on alcohol would be useful; also that sporting bodies should dissociate themselves from alcohol industry partners.

However, professionals also expressed concern about the power of opponents in the alcohol industry and it was suggested that organisations and role models were needed to challenge this.

5.6.2.5 Intervention and maintenance of support

The nature of alcohol dependence was seen by some as presenting specific challenges in supporting people to seek help and support. The sense of there being a 'fine line' between having an alcohol problem and being a 'responsible' drinker was repeated:

There is no hard line between those drinking heavily and functioning and those who have a problem. (P20)

This is not an all or nothing issue and that confuses things. So it is not like smoking where we know that even one cigarette is bad, with alcohol one drink is good for you. So that makes it difficult too. (P9)

In terms of service provision, it was suggested by one group that support for young people under sixteen years of age with alcohol problems was non-existent. Instead, there was a reliance for this age group on educational approaches, for which there was little evidence of effectiveness. In terms of accessing services that do exist, women with children were thought by some to have problems, due to lack of childcare support.

Time pressures on GPs and other staff were felt to affect adversely the services they could provide. Treatment challenges that were mentioned included concern about long waiting for access to detoxification services, which could mean that 'the motivation for change could be lost'. (P10) It was also argued that the length of time that people can be supported for was unhelpfully being reduced:

The treatment being offered now is being reduced from 6 to 3 months, which means that very few people are going to be supported. (P10 and P11)

It was also suggested (P1) that, while linking people from one service to another sometimes happened, following clients up could sometimes take too long to happen.

More positively, it was argued that trauma and psychologically informed practice is now coming to the fore. This was welcomed as supporting people to get the

treatment they need, recognising that ‘addictions’ are often symptomatic of deeper issues. Several examples of existing good practice were also discussed as providing models that could usefully be rolled out to support recovery. A joined-up approach in Aberdeen also involves addiction nurses linking to patients in acute services who might benefit from accessing alcohol specialist services. ‘Assertive outreach’ services have also been established in Aberdeen, whereby people who do not turn up at a GP appointment are called and receive a prompt letter. This has resulted in a substantial improvement in service uptake. There are also plans in Aberdeen to provide mental health training so that different professionals, e.g. housing providers, can identify if someone might need support and know where to signpost them. Therapeutic communities, such as LEAP (Lothians and Edinburgh Abstinence Project) were also praised for offering personalised support and individualised plans, as well as for following up after people had left the service.

Common themes that were emphasised as important included mapping out what local alcohol-related services exist, so that people can be signposted to appropriate support. There is a need to improve partnership arrangements, and the links between mental health and addiction services specifically mentioned.

Professionals also stressed the need for investment in monitoring, evaluation and research to learn more about what is effective and what is not effective.

5.6.2.6 Recovery communities and a recovering society

There was a shared sense that recovery strategies need to involve the whole community. In common with other research participants, the professionals emphasised that reducing the stigma that pertained to people with alcohol problems and the shame that could be associated with seeking treatment needs to change. One person (P20) suggested that treatment and recovery were almost seen as ‘abnormal pathways’, arguing that ‘We need to normalise recovery and de-normalise marketing’.

There was some regret that what was termed ‘professional pessimism’ (P1) had sometimes infiltrated into service cultures, so that professionals would sometimes seem to give up on clients. One case was cited where ‘It seems that the services have given up on him because he is 70’. (P10 and P11) In contrast, it was strongly asserted (P2) that ‘Hope is the most important factor to kickstart recovery’ and that ‘Family and friends are needed to sustain hope’. In line with this, examples of effective practice that were cited include projects that encouraged peers to support each other. In line with other research participants, professionals also argued that, for some people, support for abstinence is the only way that they can recover; however, there is a need for a range of different options for different people, and abstinence. As well as this, within an abstinence-based service, there needs to be a compassionate approach, understanding the challenges involved in maintaining recovery and excluding someone from a service if they have relapsed should be strongly discouraged.

5.7 Conclusions

This qualitative study has aimed to summarise the perspectives of some of those who have been and/or are still being harmed by their own or others' alcohol use, including people who have been affected by alcohol-related bereavement, as well as alcohol professionals, including health service staff. Alcohol-related problems are complex in their origins and development. Alcohol harms affect individuals and others around them. They are caused by environments and cultures, as well as by actions of individuals.

Two important themes that have emerged in this analysis are the shame and stigma that many people with alcohol-related problems and their families experience. It also highlights the variability of some service provision and attitudes of staff, while drawing attention to what might be effective in reducing harms, preventing deaths and supporting recovery for individuals and communities.

The steps towards recovery and sustaining recovery are about relationships and not doing this alone but with the support of others, within environments that promote and support changes in people's relationships with alcohol.

6 Summary of key findings

- Alcohol-related deaths peaked in the mid-2000s and have been reducing since, although recently the decline has stalled.
- The two main causes of alcohol-related deaths in 2017 were alcohol-related liver disease (738 deaths, 60%) and mental and behavioural disorders caused by alcohol (321 deaths, 22%). Total ARDs in 2017 were 1,235.
- The largest number of ARDs occurred in the 55-64 age group for both men and women over the period 1981-2017.
- Alcohol-attributable deaths (AADs) include an appropriate proportion of a further 30 causes of death which are partially caused by alcohol⁸. Using this wider definition, there were an estimated 3,705 deaths attributable to alcohol in Scotland in 2015.
- The main causes of AADs for people under 35 are intentional self-harm, road/pedestrian accidents and poisoning.
- The main causes of AADs for people over 35 are alcohol-related liver disease, mental and behavioural disorders and neoplasms of the breast and oesophagus.
- Men are approximately twice as likely to have an alcohol-related death as women and this has remained constant over time.
- People living in the 10% most deprived areas are at least six times more likely to die because of alcohol use than those living in the 10% least deprived areas.
- Greater Glasgow and Clyde and Lanarkshire account for a disproportionate number of deaths, compared to their population size.
- Health harms from alcohol at a population level are primarily driven by overall consumption and pattern of drinking.
- A series of reports from Glasgow has found that:
 - White men aged 45-64 living in the most deprived areas were more likely to die from alcohol-related causes.
 - Most were socially isolated and experienced mental health issues, housing challenges and unemployment.
 - There was mixed evidence of the level of use of other substances.

- In one study, a third reported having problems with alcohol before the age of 25 years.
- There was a high level of contact with social services and with acute medical services (A&E, outpatient and inpatient services) as well as general mental health services.
- In one report, 85% of discharges from the Community Addiction Team were unplanned.
- A large proportion of detoxification was unsupported.
- There was little support for relapse prevention, whether that is in the form of prescribed medication, day centres or residential care.

The qualitative study included interviews with individuals currently drinking excessively, those in recovery, family members and professionals working in this area. Key findings are that:

- Alcohol-related problems are symptomatic of many deep-seated and personal issues. The main reasons given by those continuing to drink and those in recovery were addiction taking hold; to gain confidence; deal with abuse as child; adult trauma; self-hatred; mental health issues and no longer caring for oneself.
- User voices are both invaluable and necessary, and those with lived experience have to be a part of the conversation around strategy and service development.
- The steps towards recovery and sustaining recovery are about relationships and not doing this alone but with the support of others. Importantly, all people, at all levels in society, including though not limited to professionals, can play a powerful role in challenging stigma, showing care to help build hope, and demonstrating in daily actions the value of compassion and humanity.
- Alcohol harms are complex, affecting individuals and people around them. This research brings to light the shame and stigma families feel about dealing with this issue, the variability of service provision, and in some cases a lack of compassion and understanding they face, both by 'society' and professionals.
- The major factors contributing to alcohol-related deaths according to professionals were inequality and a drinking culture.
- Issues need to be addressed within a public health paradigm, i.e. at individual, social and societal levels.
- Resources invested 'upstream' in prevention will save money, and more importantly, lives in future.

7 Limitations of this study

- This was a short term study, relying on and benefiting from the active and dedicated participation of stakeholders through the Expert Advisory Group and those who helped with and participated in the qualitative study.
- The desk-based review was reliant on published data, where 'official' statistics were analysed.
- The Glasgow audits have been invaluable in highlighting the contributory factors to alcohol-related deaths in that part of Scotland, and especially given the links between alcohol-related harms and deprivation. However, caution should be taken about overgeneralising from these findings to other locations and other local surveys are required.
- There was some exploration of 'grey' literature in the study, but the timescales limited the scope of this part of the research.
- The qualitative research was reliant on people being prepared to tell what were often traumatic stories. Gaining access to people who were still drinking excessively was challenging within the timescales, ensuring that the research was ethical at all times.
- It was clear that there is a need for further exploration of the life circumstances of people who experience alcohol-related harms, their friends and families, and also that there is a willingness on behalf of many to tell their personal stories to help prevent harms and deaths in future.

8 Recommendations

Overriding recommendation for Scottish Government: Population-level measures to increase price, reduce availability and marketing of alcohol should continue to be prioritised in national alcohol policy.

8.1 Communications/partnerships

Key players	
Scottish Government, NHS, Local Authorities, ADPs, voluntary sector and recovery communities	I. 'Professional optimism' in all public services should promote the idea that people can, and do, recover from alcohol-related problems, with support from their communities.
Scottish Government, NHS, Local Authorities, ADPs, voluntary sector and recovery communities	II. A continuous dialogue should be established with people affected by alcohol problems, including drinkers and their families, to understand what social and health harms they experience. Their insights should inform strategies to prevent and reduce these, including though not limited to alcohol-specific harms.
NHS, voluntary sector and recovery communities	III. Links between the formal health services and third sector and recovery communities should be enhanced to improve understanding and working relationships, with resources allocated to support this.
Scottish Government, NHS, Local Authorities, ADPs, voluntary sector, recovery communities and media	IV. Stigma related to alcohol use and alcohol users should be challenged, as it adds to the barriers that people face in accessing services.
Scottish Government, NHS, Local Authorities, ADPs, voluntary sector and recovery communities	V. All public services, including housing, welfare and employment services, should be alerted to the potential risks of harmful drinking, so that triggers for intervention are understood and support is embedded in service delivery.
Scottish Government, ADPs and Local Licensing Forums	VI. Local authorities should be actively encouraged to support provision of social spaces which do not include alcohol marketing or provision.

8.2 Service development

Key players	
NHS, Criminal Justice services	I. In contexts such as criminal justice settings, or where communities experience marginalisation, which limits people's ability to access effective treatment and support for recovery, innovative approaches such as assertive outreach services should be piloted, with rigorous evaluation.
NHS, Local Authorities, ADPs	II. General practice services are vitally important to prevent and reduce alcohol-related mortality. Working in collaboration, all public services, including housing, welfare and employment services, should be alerted to the impact of psychological problems, trauma and bereavement, on harmful drinking, as part of key training for all staff who have contact with the public.
NHS, Local Authorities, ADPs, voluntary sector and recovery communities	III. Alcohol and mental health services and the relationships between them should be reviewed, drawing on evidence and input from people with lived experience, to improve service provision and access. The potential contribution of assertive outreach services to supporting engagement in services should be considered.
NHS, Local Authorities, ADPs	IV. A comprehensive national approach to Alcohol-related Liver Disease should be promoted, informed by SHAAP's 'Alcohol-related Liver Disease: Guidance for Good Practice' . There needs to be consistency re triggers for the use of the audit screening tool.
Local Authorities, ADPs, welfare and employment services, voluntary sector and recovery communities	V. Welfare services should promote support and inclusion; housing, welfare and employment services should be supported to work to maintain the stability of people with alcohol-related problems and their access to services to support recovery. This will involve a change in attitude regarding people who need these services and a more compassionate, tolerant approach.
NHS and Criminal Justice services	VI. Health service interventions in criminal justice settings need to be increased in number and improved in quality.
NHS, voluntary sector and recovery communities	VII. Options for harm reduction as well as abstinence-focussed recovery should be explored, based on evidence from elsewhere.
NHS, Local Authorities, ADPs, voluntary sector and recovery communities	VIII. More support or awareness of support already within communities for ongoing advocacy and peer support for people with alcohol problems, those in recovery and their families should take place and frontline services are key to this.

8.3 Research

Key players	
Scottish Government, NHS Health Scotland, Local Authorities, ADPs, voluntary sector and recovery communities	I. Evidence gathering, including empirical investigations with people with lived experience and desk-based research should continue, to understand more about the contributory factors to alcohol-related deaths in Scotland and to support innovation and continuous improvement in practices to support prevention and recovery.
NHS Health Scotland	II. More research needs to be undertaken to understand how use of alcohol interacts with use of other drugs and other risky behaviours to cause deaths.
NHS Health Scotland, NHS, Local Authorities, ADPs	III. A review of good practice models to support detoxification and recovery should inform service developments.
NHS Health Scotland, NHS, Local Authorities, ADPs	IV. A review of good practice in relation to interventions with young people who drink should inform service developments.
Scottish Government, NHS	V. Consideration should be given to the establishment of ongoing measurement across Scotland and at local level of the prevalence-service utilisation ratio (PSUR), comparing the number of people accessing Tier 3 and 4 services to those thought to be in need (those with an AUDIT score over 16).
NHS	VI. Community Addiction Teams need to use data gathered about reasons for non-attendance in services to review activities so as to make access easier.
NHS, Local Authorities, ADPs, voluntary sector and recovery communities	VII. In all localities, services should be mapped and publicised, so that appropriate referrals can be facilitated and support given to ensure uptake and continuity for individuals.

8.4 Monitoring and evaluation

Key players	
Scottish Government, NHS Health Scotland and ADPs	I. In primary care and other settings, outcomes from brief interventions need to be monitored and evaluated.
Scottish Government, NHS Health Scotland and ADPs	II. There needs to be improved data-gathering to provide evidence for the quality and effectiveness of interventions and to support future policy and service development.

Appendix 1 – Scope of project and members of expert advisory group

SHAAP Alcohol Mortality Review

1. Summary

Scottish Health Action on Alcohol Problems – SHAAP – was commissioned by the Scottish Government to lead work to enhance understanding of the circumstances and contributory factors of alcohol-related deaths. This work will inform the development of evidence-based services that will support prevention, early intervention, treatment and recovery from alcohol-related problems.

2. Timescale

The project commenced in December 2017. It was agreed in February 2018 that an interim report would be submitted by 30th April, which would include the desk-based review and findings to date from the qualitative work. However, it was also recognised that some additional data-gathering might be necessary and it was agreed that this would be done, with the plan being to submit a final report by 31st July 2018.

3. Scope of the work

- Review of academic papers investigating alcohol deaths in Scotland
- Review of ‘grey literature’
- Review of statistics and epidemiology
- Consultation with clinicians and relevant external agencies
- Consideration of relevant policies
- Consideration of drugs data
- Production of summary report, to include:
 - findings from the research and consultation
 - implications for a new alcohol and drug treatment strategy
 - recommendations for future research and monitoring arrangements.

4. Staffing

Project manager: Eric Carlin

Researchers: Janet Bouttell and Briege Nugent

Project support and administration: Felicity Garvie

Initial scoping review – to January 2018: Emma Plant

Expert advisers/reviewers:

- Peter Rice – SHAAP/RCPsych
- Iain Smith – SHAAP/NHS Greater Glasgow & Clyde
- Lesley Graham – SHAAP/ISD
- John Budd – Deep End GPs
- Lucie Giles – NHS Health Scotland
- Laura Mahon – Alcohol Focus Scotland
- Justina Murray and John Holleran – Scottish Families Affected by Alcohol and Drugs
- Catherine Chiang – NHS Greater Glasgow and Clyde
- Alastair MacGilchrist – SHAAP/NHS Lothian
- Denise Johnson – RAH Paisley
- Frank Dixon – National Records of Scotland
- Michael Crooke – Scottish Government
- Mark Lawson – Scottish Government
- Nick Smith – Scottish Government
- David McCartney – NHS Lothian/LEAP
- Brian Morgan – Scottish Recovery Consortium

Appendix 2 - Definition of alcohol-related death (old definition) and deaths attributable to alcohol consumption

Alcohol-related death (old definition)

Death attributable to 15 listed conditions as defined in the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD10). This definition was adopted for the purpose of UK National Statistics in 2006 and comprises the following ICD-10 codes.

ICD-10 Code	Description
F10	Mental and behavioural disorders due to use of alcohol
G31.2	Degeneration of nervous system due to alcohol
G62.1	Alcoholic polyneuropathy
I42.6	Alcoholic cardiomyopathy
K29.2	Alcoholic gastritis
K70	Alcohol-related liver disease
K73	Chronic hepatitis, not elsewhere classified
K74.0	Hepatic fibrosis
K74.1	Hepatic sclerosis
K74.2	Hepatic fibrosis with hepatitic sclerosis
K74.6	Other and unspecified cirrhosis of liver
K86.0	Alcohol-induced chronic pancreatitis
X45	Accidental poisoning by and exposure to alcohol
X65	Intentional self-poisoning by and exposure to alcohol
Y15	Poisoning by and exposure to alcohol, undetermined intent.

In Autumn 2017, a new UK National Statistics definition was introduced, covering only 'wholly alcohol specific' deaths (excluding several ICD10 codes – for example, for hepatic fibrosis and sclerosis which were previously included) (the 'new definition')⁴². The figures for Scotland based on the new definition are very roughly 10% lower than those produced using the old definition.⁴³ This report uses the old National Statistics definition because more figures are available on this basis than there are for the new definition (i.e. wholly alcohol-specific deaths).

Alcohol-attributable deaths

Published in February 2018, 'Hospital admissions, deaths and overall burden of disease attributable to alcohol consumption in Scotland'⁸ estimated deaths in 2015 of adults 16 years and over attributable to alcohol consumption. As well as the alcohol-related deaths considered in alcohol-related deaths under the old definition (which were defined using a slightly different set of ICD10 codes) this analysis included an appropriate proportion of deaths from 30 chronic or acute conditions deemed partially attributable to alcohol. The chronic conditions were: tuberculosis, six forms of cancer, diabetes mellitus type 2, epilepsy, five forms of cardiovascular disease, pneumonia, acute and chronic pancreatitis, gallstones, oesophageal varices, unspecified liver disease, low birth weight and spontaneous abortion. The acute conditions were drowning, falls, fire injuries, road or pedestrian accidents, poisoning, other intentional injuries, intentional injuries, assault, event of undetermined intent and intentional self-harm. These codes were taken from the most recent English study on the alcohol-attributable burden of disease for 2013⁴⁴ which included a review of the strength of causality.

Appendix 3 - Results from the Glasgow audits

Table 1: Risk factors and characteristics

First author	Morris	Chiang	Dargan
Date of deaths	2003	2010	2013
Size of cohort	65	65	56
Male	74%	77%	77%
White Scottish	98%	75%	96%
45-54 years old		18%	36%
55-64 years old		26%	
Lived in most deprived areas		66%	68%
Divorced (or separated)	19%	19%	29%
Single	29%	43%	27%
Lived at home	86%	78%	86%
Lived alone		63%	55%
Socially isolated		31%	66%
No support network	60%		
Unemployed at time of death	26%		71%
Ever worked	98%	77%	94%
Housing problems	12%	35%	38%
Alcohol problem in family	12%	25%	43%
Other substance abuse		77%	38%
Co-existent mental health problems	9%	52%	
Evidence of self-neglect	45%	65%	43%
History of contact with police			32%
History of police custody	37%		
Ever imprisoned		12%	14%
Recorded as dependent drinker		60%	56%
Abnormal liver/spleen function tests	82%	71%	93%
Physical evidence of alcohol misuse	60%	78%	57%
Alcohol-related cognitive impairment recorded	20%	31%	13%
Co-existent mental health problems	9%	52%	
Died of an alcohol-related liver condition	58%	64%	70%
Died in hospital	61%		61%

Table 2: Service contacts

First author	Morris	Chiang	Dargan
Date of deaths	2003	2010	2013
Size of cohort	65	65	56
Alcohol consumption recorded on registration at GP		51%	
Alcohol advice given on registration at GP		17%	
Completed screening questionnaire	34%	17%	41%
First presented to GP with alcohol-related problem			34%
Alcohol problem noted by GP		98%	95%
Alcohol consumption recorded in case notes at GP	86%	98%	
Drinking pattern documented - binge drinker	14%		
Drinking pattern documented - regular daily	65%		
Alcohol advice provided at GP		91%	92%
Individual advised to abstain from drinking	79%	89%	
Attended alcohol-related appointments in primary care		46%	
Received at least one ABI (number of people)	15	4	14 (25%)
Referred for counselling		28%	
Attended counselling (of patients referred)		56%	
Referred to non-statutory service (e.g. AA)	23%	27%	57%
Attended non-statutory service (of those referred)	40%	81%	
Referred to specialist nurse	46%	22%	
Attended specialist nurse (of those referred)	50%	43%	
Contact with acute service within 3 years of death			95%
A&E attendance		88%	
A&E contacts in 6 years before death			8
Alcohol-related A&E attendances over lifetime	2		
Alcohol mentioned at A&E			28%
Proportion of all outpatient appointments attended			64%
All or some outpatient appointment attended		26%	
All outpatient appointments attended		11%	
All or some outpatient/GP appointments attended	37%		
All outpatient/GP appointments attended	28%		
Outpatient appointments in 15 years before death (number of appointments)			17
Outpatient/GP appointments over lifetime (number of appointments)	19		
Inpatient episode ever		89%	
Alcohol-related inpatient episode within 5 years of death		57%	91%
Inpatient episode within 3 years of death			89%
Contact with Acute Addiction Liaison Service		46%	50%
Contact with Social Services in lifetime	38%	77%	82%
Contact with Social Services addiction team in lifetime	22%	32%	
Contact with homeless service		5%	27%
Contact with Community Care		18%	21%
Contact with non-addiction mental health services			70%

Table 3: Specialist service contacts

First author	Morris	Chiang	Dargan
Date of deaths	2003	2010	2013
Size of cohort	65	65	56
Contact with alcohol treatment services			
Contact with alcohol specific service			71%
Referred to alcohol specific service by GP	39%		63%
Prescribed thiamine	71%	80%	88%
Prescribed antidepressants		47%	55%
Prescribed CNS medication	66%	72%	
Compliance with CNS medication		over 50%	
Prescribed anxiolytics	54%	57%	
Compliance with anxiolytics		65%	
Prescribed hypnotics		54%	
Compliance with hypnotics		57%	
Prescribed anti-psychotics		12%	
Compliance with anti-psychotics		63%	
Referred to community addiction team (CAT)		60%	
Attended all or most appointments with CAT		15%	
Contact with CAT		32%	59%
Contact with social work addiction services	22%		
Proportion of discharges from CAT which were unplanned			85%
Open with addiction team at time of death		25%	
Referred for clinical psychology		18%	
Attended clinical psychology		5%	
Referred for psychosocial intervention	34%	17%	
Complied with psychosocial intervention	15%	9%	
Referred for psychiatric services	69%	62%	
Attended all or most appointments at psychiatric services		11%	
Referred for alcohol day services		17%	
Attended alcohol day services		12%	
Attended residential alcohol rehabilitation services		14%	
Screening test for hepatitis C undertaken		26%	59%
Positive result for hepatitis C (of those screened)		24%	18%
Detoxification ever	42%		
Detoxification ever (male)		60%	
Detoxification ever (female)		73%	
Undergone a medication assisted detoxification		71%	66%
Detox assisted by alcohol treatment service			45%
Mean number of inpatient detoxifications	0.5		
Undergone acute inpatient detoxification		54%	
Undergone addiction inpatient detoxification		51%	
Mean number of supported outpatient detoxifications	0.6		
Undergone supported outpatient detoxification (incl day hospital/CAT)		35%	
Mean number of unsupported outpatient detoxifications	0.6		
Undergone GP unsupported detoxification		37%	
Undergone unsupported outpatient detoxification		15%	
Day case relapse (DCR) prevention services offered	25%	12%	
DCR prevention services attended (of those offered)	24%	50%	
Residential relapse prevention (RRP) services offered	10%	8%	
RRP services accepted (of those offered)	50%	75%	
Alcohol relapse prevention medication - ever		13%	13%
Alcohol relapse prevention medication (<5 years of death)			7%
Evidence of joint working (health and social care)	17%		

Appendix 4 - Key findings: SHAAP - 'Mortality among a cohort of heavy drinkers in Edinburgh and Glasgow'

For more information please see:

Black, H. and Gill, J. (2017) *Mortality among a cohort of heavy drinkers in Edinburgh and Glasgow*. Edinburgh: Scottish Health Action on Alcohol Problems (SHAAP) and Edinburgh Napier University.

<http://www.shaap.org.uk/images/shaap-napier-report-web.pdf>

- The percentage of the original sample (n=639) of heavy drinkers who died during the time period of the study (Dec 2012-Feb 2015) was 16.4% (N=105) with a gender ratio of 3.0:1.0, male:female. (In the original sample the ratio was 2.5:1.0).
- The mean age at death was 51.1 years. At initial recruitment interview just under one quarter of these drinkers self-reported illicit drug use, 62% smoking and 55% as having a mental health condition.
- While the mean age at death of the women was lower than that of men, this difference was not significant.
- Preliminary evidence highlights aspects of concern in relation to the drinking of the Glasgow women in this sample; their consumption of alcohol in the recorded week was significantly higher than that of their counterparts in Edinburgh but no different from Glasgow males.
- By contrast as anticipated, male drinking exceeded that of females amongst participants living in Edinburgh.
- Overall Glasgow participants differed from their Edinburgh counterparts in being younger at time of death and having more self-reported drug use.
- While Glasgow was also distinguished by greater self-reported harm scores (ARPQ) than Edinburgh, this was only statistically significant when comparing females.
- The most common physical health condition self-reported by participants was liver damage (73%).
- A striking city divide is evident when comparing the prevalence of self-reported mental health conditions; 72.9% (Glasgow) versus 32.6% Edinburgh. Within Glasgow (but not Edinburgh) women reported significantly more mental health conditions than men.
- Examination of completed death certificates concluded that alcohol was not mentioned in 27% of completed certificates.
- The most common underlying cause of death (46% of cases) was linked to liver conditions, including hepatitis and hepatocarcinoma.
- In terms of underlying cause of death, only in relation to cancer did female numbers exceed males (despite the smaller female sample size).
- Where the underlying cause of death was external (not due to disease), the male to female ratio was 8:1.
- When compared to participants who were designated as 'long term' survivors, significant associations were found between being deceased and being a

hospital inpatient (not clinic outpatient), any drug use, any white cider drinking, paying a lower unit price for alcohol and reporting a higher ARPQ score.

- Within Edinburgh the deceased patients were associated with again being recruited at an inpatient setting ($p=0.031$) categorised as a white cider drinker ($p=0.041$) or a vodka drinker ($p=0.014$). Deceased patients paid significantly less for their unit of alcohol than surviving patients: median unit price of 41 pence versus 48 pence ($p=0.029$).
- In Glasgow participants, significant associations were found for being deceased and 'any drug use' ($p<0.001$) and being a white cider drinker ($p=0.04$). Like their Edinburgh counterparts the deceased Glasgow participants paid significantly less for their unit of alcohol than surviving patients: median unit price of 38 pence versus 46 pence ($p=0.002$).
- Deceased drinkers, both those who purchased 'any' vodka or 'exclusively' drank vodka, paid significantly less per unit of vodka than their surviving counterparts.
- Significant associations were found for being a male deceased participant and consuming mainly white cider ($p=0.018$) and amber cider ($<6\%$ ABV) ($p=0.025$).
- A significantly lower ARPQ score (harm score) was self-reported by the surviving patients when compared with the deceased patients.

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All links active 13 April 2018

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