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SCOTTISH HEALTH ACTION ON ALCOHOL PROBLEMS

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SARN

Alcohol Occasionals: Seminars 2013–2018

Foreword

Scottish Health Action on Alcohol Problems (SHAAP) and the Scottish Alcohol Research Network (SARN) are delighted to publish this compendium of the discussions from our 'Alcohol Occasionals' seminars, 2013-2018.

These seminars are free and provide the chance for researchers, practitioners, policy makers and members of the public to discuss alcohol-related research. Summaries of the discussions are disseminated, so as to have as wide an impact as possible on critical thinking about alcohol in society.

We hope that you will enjoy reading these papers. We are grateful to all who have contributed to our discussions, as well as to Paulo Nunes de Moura, Jennifer Fingland and Felicity Garvie, who summarised them.

With 22 deaths in Scotland from alcohol-related causes every week, it remains urgent to use findings from effective research to develop strategies and activities to reduce harms. The 'Alcohol Occasionals' seminar series continues, with the upcoming theme for 2018-19 being 'Alcohol and Recovery'.

Dr Eric Carlin, Director, SHAAP

Professor Aisha Holloway, Chair, SARN

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2013–2014 Seminars

Alcohol and Young People

'You want people to say you have a fun life': The role of alcohol in young adults' identity creation on Facebook

Jemma Lennox, University of Glasgow

Thursday, 31st October 2013

Lennox started by explaining that 91% of 16-24 year olds in the UK use Facebook. Her research is concerned with how alcohol drinking occasions are used by young people in the West of Scotland in an attempt to create a social identity. She asserts that they create such an identity in a noticeably classed and gendered manner. As well as this, the identities portrayed on social networking sites, often with the alcohol industry's participation, influence young people's drinking behaviours.

Lennox had recruited 21 discussion groups, with four to six participants in each of these. Participants were aged between 18 and 29 years old and came from varied social and cultural backgrounds. She had also carried out 14 Facebook interviews.

These young people use Facebook to organise drinking occasions and other parts of their social lives. For example, they use Facebook to get invitations for nights out and they also post messages on it while they are out. Lennox also found that young people are constantly attempting to portray the image on Facebook that they are out partying all the time.

Jemma Lennox

Lennox also found that many young people also feel compelled to have a drinking image and behaviour which is perceived as appropriate to their gender and class. This informed drinking behaviours; for example, she talked about how young men drink using pint glasses, which they hold in a manner considered as masculine. They said that they would vary their 'masculine' demeanour by perhaps drinking rum, but that they would avoid drinking wine; above all they would not drink it in a wine glass, which they considered 'feminine'. Young men also indicated that they would display their masculinity in dressing for a night out in a way which looked 'effortless', e.g. just a shirt and chinos. They would also not pose for photos, since this is also sensed to be feminine; but they would not care if Facebook photos showing them drunk emerge on line. They also put up photos of other male friends on Facebook to make fun of them.

As for young women, Lennox found that they also consume specific kinds of alcohol beverages and in specific ways. These

were affected both by gender and class. For example, working-class women would drink half-pints because a whole pint was deemed 'masculine', whereas middle-class women would drink in whole-glass pints. Working-class young women described a strong pressure to put an effort into their appearance by dressing in a way which was deemed 'feminine', e.g. mini skirt, high-heel shoes and make-up. Working-class young women did not want to be photographed in a way that they looked drunk. Rather, they wished to look pretty and glamorous.

Lennox also argued that middle-class young women exhibit different, possibly more casual, versions of 'femininity' depending on the occasion, e.g. they would allow themselves to wear jeans on a night out. However, although the middle-class young women included in the study asserted that they did not care very much about their appearance, they also admitted that when they are approached by a professional photographer in a club, they pose for the photos in an attempt to look attractive. It was also felt to be socially acceptable for middle-class young women to be photographed by each other in such a way that they looked drunk, because they found it humorous.

The alcohol industry has been active in understanding and influencing young people's identity construction. Lennox described alcohol promotions carried out by pub and club venues on Facebook, which used photos of actual customers, presumably based on the premise that seeing friends attending clubs motivates others to go out to join them. This photographing was welcomed by the young people. They broadly felt that even though the venues are getting free advertising, customers like to see themselves in nice photos. In any case, the images shown are precisely the types of images they wish to portray online. The Facebook posts by the venues also offer drinking promotions and motivate young people to organise their night out drinking in their establishments.

Issues raised in the discussion:

- Lennox had not specifically sought to analyse alcohol-related identity construction in relation to either ethnicity or sexual orientation as a central focus of her work. However, she had noted that a group of Greek men did not put photos online as this would breach their 'masculine' code. She also found that some drinks were favoured more by specific groups; for example, drinking Guinness seemed to be associated with an Irish identity. Several people commented that Lennox's findings were relevant for learning for health promotion activities, emphasising that a 'one-size-fits-all' alcohol education campaign would not work. For example, going on these findings, a campaign telling people not to drink so they will not look drunk might have little impact on young men and young, middle-class women.
- Having frequent alcohol drinking featured on social media as acceptable and fun has implications for drinking awareness campaigns. It was suggested that health promotion interventions in this field can be difficult, not least because people drink for a range of reasons at different times. Moreover, in the context of 'fun' identity constructions, it is possible that young people do not allow themselves to talk about the negative effects of alcohol and their drinking behaviours; Lennox noted that her research participants did not mention being anxious about this.

- It was noted that the alcohol industry invests heavily in marketing to young people using social media. Although young people might believe that they are independently creating their identities online, this activity is highly influenced by others, including the alcohol industry, who promote drinking as central to the construction of a confident and outgoing social personality.

Drinking patterns and violent behaviour amongst young people in England and Wales, secondary analysis of the Offending Crime and Justice Survey

Dr Carly Lightowlers, Liverpool John Moores University

Thursday, 19th December 2013

Dr Carly Lightowlers

In her PhD research, Lightowlers had analysed data about alcohol and violence from the Offending, Crime and Justice Survey (OCJS), an annual Home Office survey conducted between 2003 and 2006 in England and Wales, which attempted to measure the prevalence of offending and drug use in the general population. Lightowlers had focused on young people aged between 16 and 29. She explained that she had been particularly interested in the mediating role of social and cultural attitudes in drinking and violent behaviour.

Reasons for drinking

Lightowlers argued that young people learn about drinking behaviour from a range of influences, including the people around them. She suggested that we should consider how and why people adopt distinct attitudes, depending upon the context and with whom they are drinking.

Lightowlers categorised the survey respondents as 'social drinkers', 'positively motivated drinkers' or 'problematic drinkers', based on how they described why they drank by selecting from a series of pre-set answers. Although 'problematic drinkers' tended to indicate that they drank to get drunk, or to forget about problems, others indicated that they simply enjoyed drinking, because it made them feel relaxed.

The relationship between alcohol use and violent behaviour

From this study, the types of violence specifically associated with frequent drinkers seemed to be outdoors interpersonal assault, e.g. public violence between strangers, kicking, punching and pushing, particularly in nightlife settings when alcohol had been consumed.

Several audience members suggested that attitudes valorising violent behaviour, for example, by young males, are found outside drinking contexts. For example, there are pervasive messages in some magazines targeted at young men.

Lightowlers suggested that drinking per se does not necessarily make violence more likely to happen; rather, increased risks of violence and severity of incidents may be associated with drinking contexts and different drinking patterns, including 'binge' drinking. Factors influencing the alcohol-violence relationship also include social and cultural contexts, e.g. the influence of family, friends and peers. Lightowlers' research suggested that the more young respondents drank, the more likely they were to engage in violent behaviour. However, the young people who drank a lot and became involved in violent behaviour might also have done this at times other than when they had been drinking.

Lightowlers stressed that although she had found a concurrence between drinking and violent behaviour, this was a minority pursuit and caution must be taken in order not to demonise and stigmatise certain groups, and in particular, young drinking males. There was a noticeable pattern that young men were more likely than young women to engage in violent behaviour around the age of 18. However, after this, the difference between males and females decreased with age.

It was also noted that young men are prone to becoming victims as well as perpetrators of violence.

Implications for policy and practice

It was argued that the concurrence between increased drinking and violent behaviours meant that prompt interventions were necessary. Appropriate responses needed to be framed within both public health and criminal justice contexts. A health intervention approach which simply told young people not to drink because of health harms, would be insufficient and, in criminal justice settings, it was felt that there was a need to raise the profile of alcohol interventions, just as there was already a focus on other drugs. It was also proposed that attitudes towards violence, as well as attitudes towards drinking alcohol, should be the focus for interventions.

The theory of 'pluralistic ignorance', whereby a majority of group members privately reject a norm, but assume incorrectly that most others accept it, could help in structuring interventions. There are, for example, young males who are individually uncomfortable with certain behaviours (e.g. towards violence and/or drinking), but who think incorrectly that such behaviours are broadly accepted amongst their peers. Changing such perceptions might conceivably lead to changed behaviours.

The discussion highlighted that the relationship between alcohol use and violent behaviour is multi-faceted and dynamic. The same young people who describe themselves as problematic drinkers also experience many of what they regard as benefits in drinking alcohol. However, we must avoid over-individualising problems. Some young people who indicated that they drank to forget about problems might actually experience daily struggles, linked, for example, to social deprivation. Population-level measures to reduce structural social and economic inequalities will also reduce heavier drinking in poorer youth populations.

Further research is needed to interrogate all of these complex areas. However, Lightowlers lamented the fact that the survey had been discontinued in 2007 and that, as far as she was aware, there were no other similar national surveys in the UK.

Alcohol without the Hangover

Professor David Nutt

Wednesday, 19th February 2014

Professor David Nutt, psychiatrist and neuropharmacologist, has undertaken a wide range of research in the UK and abroad on the effects of alcohol and other drugs on the brain. He is also known for the controversy surrounding his dismissal from the Advisory Council on the Misuse of Drugs (ACMD) where he was first a Council member and then Chair of the Technical Committee. He was dismissed because he had said publicly that drug regulations were unjust, because they did not reflect scientific evidence and unhelpfully incriminated people.

Speaking to an audience of around 140 people, which included doctors and nurses, academics, policy makers, addiction workers and students, Prof. Nutt's talk began with a discussion on how the media represents stories relating to young people dying from causes related to alcohol and other drugs. This is within a UK context, where he pointed out that around three young people per week die of alcohol poisoning.

He quoted the case of Amy Winehouse, whose death had been widely assumed to be caused by illegal drugs, when in fact it was specifically due to alcohol poisoning. In another case, the press had reported the case of a young man who had died of alcohol poisoning, following a drinking game. His family did not want him to be remembered as a 'druggie', in spite of the fact that alcohol is a drug.

Professor David Nutt

Prof. Nutt also referred to the concerted campaign, which had included billboards, publicising the case of Leah Betts who had died in 1997 after taking ecstasy. Her death had actually been caused by excessive water consumption, which may have been related to the public advice being given out at the time to ecstasy consumers. Prof. Nutt also described the case of the death of two young people which the police reported was due to mephedrone intake. In fact, the scientific evidence at the time had not indicated that mephedrone could kill. In this case, the young men had been drinking alcohol for at least seven hours and had also taken a different drug named methadone, which is particularly toxic in combination with alcohol.

The cases above, Prof. Nutt argued, are only a few of the many misunderstandings about alcohol and other recreational drugs being disseminated by the police and the press. He also suggested that the alcohol industry has an interest in misleading the public into thinking that alcohol is not as dangerous as the illegal drugs – or

indeed that alcohol is not a drug, when in fact alcohol is the most harmful drug of contemporary use.

Prof. Nutt argued that the UK Government has been banning drugs because of media hysteria, instead of scientific evidence. Since any new recreational drug being released is automatically banned, he argued that if alcohol were invented nowadays, and we applied the same rules that we apply to other recreational drugs, then alcohol would be banned, because it is highly toxic.

Prof. Nutt also discussed the way in which some politicians talk about their (past) recreational drug use. For example, when politicians are asked what drugs they have used, they might say that they used cannabis when they were young – and that they did not enjoy it. However, they are very likely to forget to mention that they often drink half a bottle of wine at night.

Another example of the ambiguous relationship which politicians have with alcohol is the number of bars in Parliament, which could indicate that they are dealing with legislation while intoxicated, which would be unacceptable in any other profession. This also means, he argued, that politicians have a complete disregard for the effect of alcohol on themselves.

Alcohol is the drug which causes most harm not only to the user, but also to society. This, he argued, is a view shared widely by many researchers, who consider that alcohol may be the number-one public health problem in the UK and the world. Prof. Nutt also referred to data comparing cirrhosis cases in France and in the UK, and how there was a time when the French died four times more of cirrhosis than the British. Nowadays, however, Britain has the highest rate of cirrhosis in Europe - and Scotland is of special concern. Prof. Nutt linked this outcome to failed UK alcohol policy which has facilitated the increase in alcohol consumption, which has doubled in the last 60 years.

There has been a massive promotion of alcohol, which is widely available and far cheaper than in previous decades. Over the last 30 years, we have also been changing our drinking habits, by consuming much more alcohol at home – and passing out in front of the TV, rather than going to bars.

Talking about what can be done to start resolving this health problem, Prof. Nutt argued that we could start by telling children the truth about alcohol through education. He also explained that the introduction of the Minimum Unit Price (MUP) policy would impact positively on the most problematic drinkers. Even where there is a possibility that people might not drink much less, even small changes in consumption can generate big improvements in health and avoid death.

Prof. Nutt also indicated that less than 20% of people suffering from alcoholism get treated, even though there are efficient treatments for alcoholism around, which are not being used widely, in comparison with treatments for other disorders, such as depression. There are also drugs which can be used successfully to control the amount of alcohol that people consume.

Alcohol is fashionable. Prof. Nutt gave the example of the character James Bond, who is always drinking a lot. However, just as alcohol has been made fashionable by the industry, it could be made unfashionable. Alcohol consumption could be framed as a health problem which we need to address, similar to other issues, such as our blood pressure, weight or cholesterol.

Prof. Nutt also suggested that, similarly to the way in which e-cigarettes seem to be less harmful than ordinary cigarettes, a much safer alternative to alcohol, could be invented – and that, he suggested, would be well within the compass of modern neuroscience. However, neither the industry nor the government are supporting the scientific exploration of such a venture.

The audience discussion included praise for Prof. Nutt's book (details below). The book discusses in a very straightforward and informative way how the relationship between cannabis - and other illegal drugs – and schizophrenia is unsubstantiated, while alcohol can cause brain damage. People also discussed how alcohol consumption causes damage both to the person who is consuming it and to society, more than illegal drugs.

In response to a question regarding changing elements on alcohol to make it less harmful, Prof. Nutt argued that the alcohol industry would not accept such initiatives. Regarding the topic of measuring alcohol consumption through units, it was pointed out that countries are adopting different methods and that indicating alcohol content on bottles can have unintended and contradictory outcomes. Rather than checking labels so as to reduce one's alcohol consumption, some people might do so in order to select products with high alcohol content.

Regarding the effectiveness of regulation, Prof. Nutt argued that in countries such as France, cirrhosis is going down, because they have stopped advertising alcohol, halved the drink-drive limit and introduced a minimum price on wine, which has led to people benefiting from drinking better quality wine and the industry operating in a highly profitable market.

Comments from the audience suggested that it seems to be wrong to tell young people that other drugs are safer than alcohol. It was suggested that the correct message should be for young people not to use drugs at all. It was also pointed out that young people use alcohol because it is what is available - and alcohol happens to be the most dangerous drug. Prof. Nutt pointed out that, whatever the drug, the later you start using it, the less harmful it will be. He also said that the safest thing is not to use drugs at all, but at the very least young people should know what they are doing.

Another topic which Prof Nutt discussed with the audience was the possible changes in the availability of alcohol. He argued that we could stop selling alcohol in supermarkets and consider an increase in the legal age to buy it. In the USA, increasing the legal age from 18 to 21 had a positive impact on the number of road deaths. Research has also indicated that alcoholism in under-age people seems to become established three years before the legal age. Therefore, while in the USA young people start becoming alcoholic at 18, in the UK they do so at 15.

During discussions on how other countries deal with the alcohol consumption issue, Prof. Nutt indicated that in Sweden people have to plan ahead in order to consume alcohol, because going to a bar is expensive and state shops have limited hours. The Swedes, he explained, drink half of what we drink and have a third of our health harms.

During a discussion of how politicians and the press deal with issues involving alcohol and other recreational drugs, Prof. Nutt argued that they seem to reflect misinformed public opinion. The discussion moved onto the issue of Minimum Unit

Pricing (MUP) of alcohol, a policy which the Scottish Government has legislated for but which has not yet been implemented due to legal challenges by the Scotch Whisky Association and other alcohol industry actors. Prof. Nutt said that we would probably have a different debate on MUP if newspapers explained the issues correctly. He suggested that journalists seem to be against MUP, maybe because they do not know the facts, or perhaps because the industry has bought some of the media. He pointed out that MUP policy targets the people who are most harmed by alcohol use, including people who are dependent.

Prof. Nutt concluded by emphasising that alcohol is the biggest health problem we are facing today and that we need to do more to face up to this.

Prof. Nutt explained that all the proceeds from the sale of his book (details below) are donated to the Independent Scientific Committee on Drugs (ISCD), a charity which does not receive donations from government or from the alcohol industry.

For further details and information on Prof. Nutt's work see *Drugs without the hot air: minimising the harms of legal and illegal drugs*, David J. Nutt (2012).

Effecting multilevel change through dialogue: experiences of teenage project leaders in the AlcoLOLs project

Dr Magda Pieczka and Emma Wood, Queen Margaret University

Thursday, 24th April 2014

Pieczka and Wood started their presentation by stating that although they would be focusing only on the AlcoLOLs project, their work is part of a much wider interdisciplinary academic research on communication and alcohol at Queen Margaret University. The project was piloted in 2010 with pupils from Portobello High School, and that phase included the production of resources such as a film which is still being shown and discussed in current project sessions. So far, the project has reached around 1,500 pupils.

They described the AlcoLOLs project as a dialogue-based peer-led project that attempts to combine small group learning with large scale impact with school peers, family and community. In AlcoLOLs sessions, the researchers explained, young people receive training, including facilitation skills. They also listen to presentations by guest speakers, such as experts from NGOs and the Government. The intention is that they will then pass their knowledge on to their peers, through workshops which they run themselves in their schools.

Dr Magda Pieczka

Emma Wood

They suggested that a dialogue-based peer-led approach can be contrasted with other communication tools, such as those used by social marketing, which focus on persuasion and manipulation of behaviour. It is intended that the learning dynamics in the project are set and managed by young

people themselves, without teachers or other professionals in the workshops. Young people can have group conversations and presentations which are focused on collaborative learning and openness to other perspectives and experiences, with use of critical reflection.

During the discussions with the SHAAP audience, Pieczka and Wood explained that the AlcoLOLs sessions also provide an opportunity for young people to explore attitudes to – and perceptions of – alcohol use, such as those portrayed in advertisements and in social media. They acknowledged that drinking is a social and cultural practice, and that young people's drinking behaviour is influenced by the behaviour of others within their social world. However, the researchers argued, the social processes underlying this influence cannot be reduced to simple ideas of peer pressure.

In the discussions, Pieczka and Wood were praised for carrying out their project under such heavy marketing of alcohol from industry actors. The audience also commented that the dialogues taking place in the project seem to be very different from those taking place on Facebook, where young people typically portray themselves as having a lot of fun with alcohol and as being very confident.

Discussants commended the researchers' enthusiasm for the project. Pieczka and Wood said that their enthusiasm is also shared by the young people running the workshops, who make sure that they make the sessions enjoyable, even though they are dealing with a very serious issue.

The researchers explained that they normally recruit around 22 pupils from a school and might end up with 12 participants. They argued that when participants drop out, it is hoped that they will still have gained something valuable from the project, such as information and presentation skills.

The researchers suggested that their experience with the AlcoLOLs project challenged some common gender stereotypes, such as the idea that young men can find it more difficult to self-organise than young women. The young men in the project have been very efficient in running administrative tasks. Most young people have been running the project enthusiastically, independently from their gender or social background.

Comments from the SHAAP audience included questions regarding the wider impact of the project on the community. The researchers explained that they had heard very positive remarks from parents and from the schools. For example, they had heard that the project participants had become much better communicators and also that their school attendance had improved. There has been a reduction in local alcohol-related incidents with young people in Portobello since 2010; however, it is of course difficult to relate this causally to this project.

Project participants have being telling the researchers that while in the past they had motivated each other to drink, now they are becoming confident enough to say that they do not want to drink alcohol at all. The researchers argued that young people participating in the project have been realising that drinking is not necessarily a norm to which they must aspire. They also argued that the skills which the young people have gained by taking part in the project can help them with other aspects of their lives.

Further information about the AlcoLOLs can be accessed through this link: www.qmu.ac.uk/mcpa/CDial/AlcoLols.htm

Alcohol marketing and young people

Dr Richard Purves, University of Stirling

Thursday, 26th June 2014

Purves opened by placing the *Alcohol marketing and young people* research within the context of a broader work programme at the Institute for Social Marketing (ISM) at the University of Stirling. The research, which is still in an exploratory phase, has been funded by Alcohol Research UK.

Purves' study had two stages: the first consisted of focus-group work with participants aged between 14 and 17, while the second phase involved a 'netnography' to identify, observe and analyse online communications regarding alcohol products on social media pages of certain brands. Research participants were young people who were already consumers of alcohol.

Mentioning that previous studies had suggested that exposure to alcohol marketing is a determinant element in drinking uptake and frequency, Purves argued that the research is also important because alcohol use can aggravate matters that are already problematic for young people, such as poor educational performance and teenage pregnancy.

While substantial academic investigation has already been carried out on more traditional forms of alcohol advertising, Purves explained, researchers need to keep pace with an ever-changing, multi-platform marketing environment. He illustrated this with the case of adverts on

Dr Richard Purves

Facebook, which is predominantly used by younger people. He argued that, although the adverts ought to be targeting only adults, they are being seen by minors, such as the study participants.

For the study, he said, packaging, labelling and branding of alcohol products were deemed to be of special concern, when they have been specifically created to be shown online, where they will reach a large proportion of under-age consumers. Explaining that the study is also attempting to provide insights into the ways in which alcohol advertisers have been adopting marketing strategies that encourage an online engagement with different brands, Purves' presentation included an advertisement for the FA Cup.

The advertisement showed young men passing to each other a beer can that had an animated feature, which was only visible with the help of an app. In the advert, the young men take pictures of each other, and then share the pictures, where they appear to be holding the Cup,

online with other friends. Other adverts shown in the presentation included those which promoted the consumption of drinks on special days. For example, for Pancake Day, advertisers suggested that alcoholic drinks could be added to pouring-sauce recipes. Purves' presentation also included examples of how alcohol promoters engage young people in online prize competitions, to discuss football or to undertake market research, for example about alcohol availability.

The drinks advertised, he said, are often highly attractive to young people – and possibly even more appealing to children than to adults. The young people in the study do not seem to see drink advertisements as publicity, but rather as something which is 'just there', as part of the whole Facebook experience and of their lives, e.g. defining beer as a 'social product' rather than a substance, which they drink with friends.

Purves showed statistics indicating a substantial – and ever-increasing – presence of alcohol advertising on platforms such as Facebook. So why do young people continue to use Facebook, when many other successful platforms have been emerging? Purves found that Facebook can become a part of their routine; a place where they put very personal information, where they organise their social lives - and they, therefore, hesitate leaving to join a new platform, because they do not want to miss out on anything.

The findings also suggest that young people see Facebook as a place where they can express themselves freely, and where they can create a new identity for themselves. Alcohol marketing, Purves argued, is very much concerned with influencing drinking behaviour by promoting what types of drinks will help you to convey a desired identity – which implies an expected drinking behaviour.

Purves said that young people are becoming increasingly familiar with alcohol brands, in the same way that they are familiar with other products targeted at their age group. The young people also associated certain drinks with specific youth cultures, such as 'Goths' or 'Skaters'. Some youth cultures, however, such as 'Geeks', do not seem to be associated with alcoholic drinks. Some participants said that they have outgrown vodka-based alcopops, which they consider too sugary and with very low percentage of alcohol. They associate this type of drink with NEETs (the so-called 'young people who are not in employment, education or training'), or with pre-teenagers trying to look grown-up.

Purves found gender distinctions related to specific brands and their visual emblems. For example, young men indicated that they favour drinks such as beer from more established brands, or spirits such as whisky – preferably in conservative or in plain-design packaging, which they see as more masculine. Young men also indicated that they are keen to distance themselves from drinks and behaviours which they think are more appropriate for women; therefore, young men would not want to be seen holding a wine glass.

When aiming to create a more grown-up image, e.g. of someone who can handle stronger drinks, young men would rather consume the more traditional vodka brands – and the higher alcohol content is part of the appeal. Young women indicated that they prefer drinks such as wine, and other types of spirit drinks – in colourful and innovative packaging.

Following Purves' presentation, the audience discussions started with a comment about how the alcohol industry varies its activities depending on the target. On the one hand, the industry employs innovative branding which is especially attractive to very young people, but on the other hand, in the reports which they send to policy makers, they use rather dull and conservative designs - which are more suitable when attempting to convey an image, for example, of public health commitments.

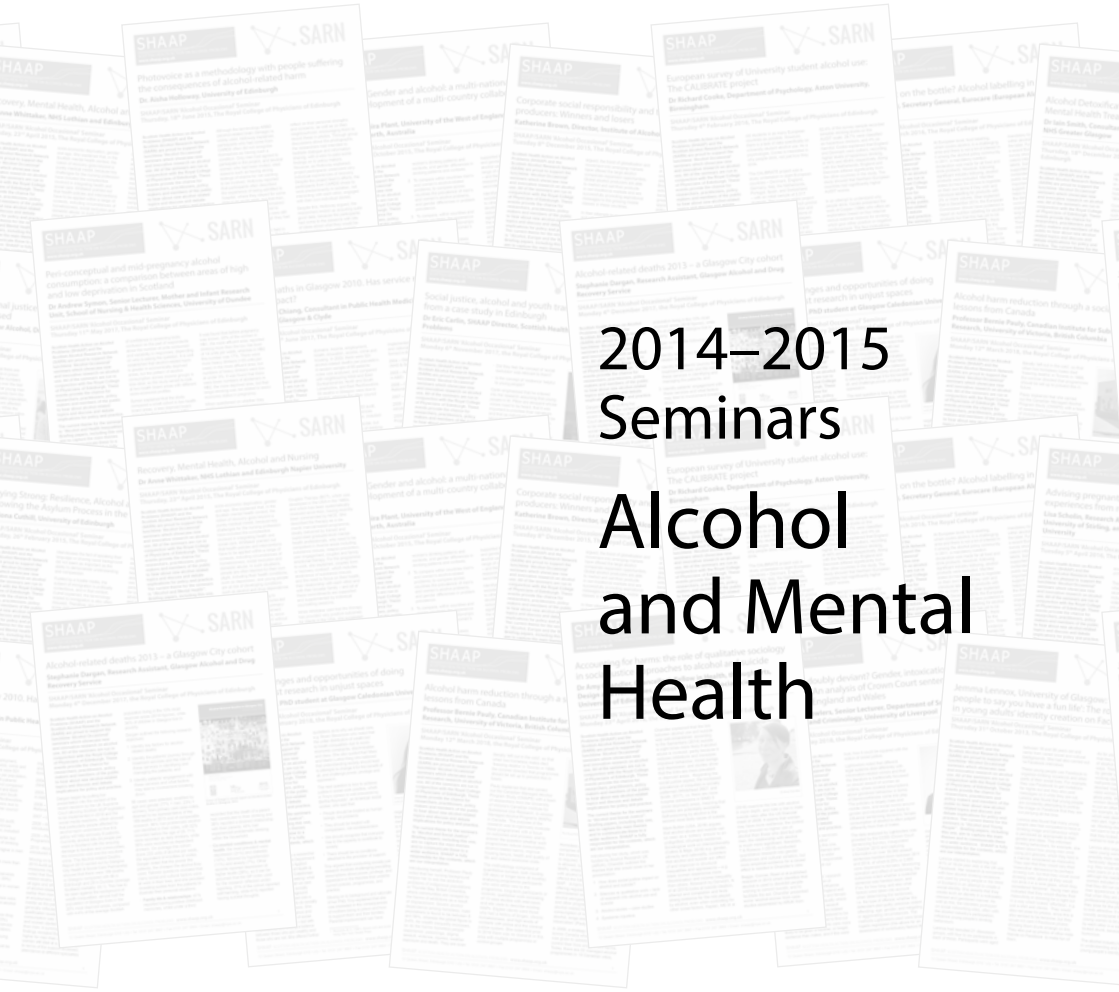
Answering a question about the usefulness of health warnings on drinks, Purves explained that the messages from Drinkaware, for example, were hardly mentioned by young people. They see a contradiction when they are told not to drink, while at the same time drinks are widely advertised and available. They had commented on the oddness of having a message asking them to "drink responsibly", written on the packaging of a very small drink can, which is clearly made to be drunk quickly, 'downing in one', and which they are consuming to get drunk faster.

Purves said that young people had mentioned that they know that they may be doing harm to themselves through their alcohol use. However, in the discussion, there was consensus that young people using social networks seem to be getting very little information about how to get advice and support. Some people suggested that they do not see enough messages about negative consequences of drinking alcohol.

Members of the audience suggested that advertisers seem to be engaging with consumers in a way which is irresponsible, since their advertisements are having an impact on the drinking behaviour of an under-age group. It is of concern if industry players are engaging online – even if unintentionally – with under-age people. In response, industry representatives stated that advertisements are aimed at their consumers, who are adults – and that they are not meant to impact on the behaviour of under-age people, with whom they have no intention to engage. Nonetheless, other discussants argued that the advertisers have-in depth marketing research information, and that, therefore, they must know whom they are reaching *de facto*.

One person commented that it had been suggested that in the past young people drank because they were bored. Therefore, social media should have emerged as a positive thing in young people's lives, that would keep them away from drinking, but this does not seem to be the case.

Policy recommendations which can be drawn from this research include that there should be restrictions on online alcohol advertising to challenge the position whereby young people regard alcohol consumption as a norm in their teenage lives.



2014–2015 Seminars

Alcohol and Mental Health

Alcohol Detoxification in Specialist Settings and Mental Health Treatment

Dr Iain Smith, Consultant Psychiatrist in Addictions, NHS Greater Glasgow

Thursday, 18th December 2014

Dr Iain Smith

Commenting on the theme of the new season of Occasionals, Smith said that he was very keen to see how the subsequent speakers, all of whom come from different backgrounds, would explore the association between alcohol misuse and mental health.

As a psychiatrist specialising in the field of addiction, whose research interests include the history both of psychiatry and of alcohol treatment, Smith discussed historical reasons for why psychiatry has been concerned with alcohol misuse treatment. He gave different examples such as claims linking gin drinking with melancholia and dementia, and cited historic medical journals' articles on "alcohol insanity".

Coming up to the present, Smith drew attention to the fact that conditions such as hallucinosis and alcoholic hallucinosis receive similar medical treatment, and that this is also the case with alcohol depression and depression. He pointed out the overlap between alcohol misuse and mental health, so that alcoholism might itself be treated as a mental disorder. He also asserted that, despite hyped-up claims through the media that alcoholism might be genetic, or that alcohol and other drugs cause mental illness, such cause and effect links have not yet been established by aetiology, the medical field that considers the causes of diseases. Smith showed that such ideas can be traced back to the 19th Century, when it was already thought that alcohol could be a cause of mental health conditions such as insanity.

Smith also talked about how alcohol misuse is nowadays often associated with a wide range of psychological and physiological complaints, and his presentation listed conditions such as insomnia, depression, anxiety, self harm, amnesia, cancer and heart disease. He explained that alcohol misuse has been associated with attempted suicide and suicide, and that alcohol has also been connected with other issues, including homelessness, sexually transmitted infections, unwanted pregnancies, offending behaviours, domestic violence and child neglect.

Smith argued that, although it is said that people drink because they are depressed or, conversely, that they are depressed because of their drinking, different

conditions might co-exist with alcohol. It might be the case that a condition only becomes evident when alcohol is ingested, since chronic heavy drinking has been associated with many harmful effects, such as the impairment of functions of the central nervous system. It might also be the case that a person is not only drinking heavily, but has other unhealthy behaviours as well, such as smoking or not eating well.

Moving to the specific Scottish clinical context where he works, Smith explained that, following best practice guidance detailed in Models of Care for Alcohol Misusers (MoCAM), a DH publication, NHS treatment for alcohol problems is delivered through four tiers. Delivery of services varies from those provided by generic community-based organisations to high intensity medical settings, such as the day and residential detoxification clinic where he practises. As clinical settings handle the toughest cases, what he and other NHS practitioners see might be the tip of the iceberg of what is happening within the communities from which patients come.

Smith's slides illustrated how contemporary alcohol detoxification clinics, such as the one where he works, fit within broader historical contexts. He gave examples of different places where people used to be sent to try to withdraw from drinking alcohol. Historical researchers had documented over centuries that, undergoing the withdrawal process, patients presented physiological and psychological complaints, which were sometimes new and often extreme.

Smith explained that many researchers now consider the withdrawal process to be as significant as addiction itself, and that they are investigating what takes place during the process of withdrawal from alcohol (as well as other drugs). In the past, researchers had sought agreement with subjects in order to induce addiction to substances from which they would then be managed to withdraw. Smith indicated that, nowadays, this would be considered ethically unacceptable.

Smith then discussed the withdrawal process. For any drug, this is often characterised by symptoms and signs which are opposite to those manifested following the intoxication. Therefore, while some patients report that drinking helps them to deal with their anxieties, they might become anxious during the withdrawal process. He also explained that the mood of patients with underlying alcohol problems undergoing detoxification can improve with withdrawal from alcohol.

Smith then went on to discuss the use of new technology in the form of breathalysers in treatment contexts. There is obviously some overlap here with other contexts, such as the policing of drivers. In both contexts, however, those being breathalysed – drivers and patients – have found various methods to try to avoid detection. The most bizarre he had come across was a man who had tried to eat his underpants, probably thinking that the cloth would soak up some alcohol from his system. The audience was interested in the types of breathalysers and how they were used. The serious question was raised in discussion, however, of where such scientific tests interacted and potentially interfered with the trust relationship that needs to exist between medical practitioners and patients.

Smith commented that practitioners have been using other tests, such as analysis of samples of blood, hair or urine, and that there are also bracelets available. He also highlighted that there is evidence indicating that it is helpful for treatment when patients

know that they are being monitored. However, scientific tests are not foolproof. Sometimes patients test positive, but they say that they have not been drinking and, conversely, there are cases when the test comes out negative, but the practitioner has an intuition that the patient has been drinking. This is often confirmed afterwards in conversation with the patient.

While testers are sometimes used to detect if patients have been drinking, Smith explained, the technology cannot indicate how much alcohol people are consuming over time or what their drinking patterns are. As well as this, people who are highly tolerant of alcohol may metabolise the substance very quickly. He also argued that the reasons why patients continue to drink while undergoing detoxification deserve analysis too, so that effective support responses can be put in place. Evidence indicates that patients not drinking while in detoxification do better.

Smith rounded up with some comments and recommendations for policy makers. First, he pointed to the clear evidence that in-patients benefit significantly better than day-patients from alcohol treatment services. He also argued for the importance of evidence-based, 'whole population' approaches as part of a comprehensive alcohol strategy. This includes elements such as prioritising public health concerns in granting alcohol licences and action to raise the price of the cheapest, most harmful alcoholic beverages through implementing Minimum Unit Price legislation.

Staying Strong: Resilience, Alcohol and Destitution following the Asylum Process in the UK

Dr Fiona Cuthill, University of Edinburgh

Thursday, 26th February 2015

Dr Fiona Cuthill

Dr Fiona Cuthill presented the findings from her qualitative study in the North East of England, with 22 men and 2 women who had come from Sudan, Libya, Eritrea, Somalia and Palestine. In documenting the lived experiences of people who had found themselves destitute following the asylum process, she wanted to explore not just the adversities they had faced, but also their descriptions of the structures that helped maintain their strengths. Participants in the research had been recruited by word of mouth, and, although Cuthill had used interpreters, she suggested that, in her view, for the interviewees the fact of speaking their language or sharing racial background did not seem as important as the ability to demonstrate understanding and compassion.

Fuelled by a hostile media, the subject of immigration is politically contentious, and in that context, Cuthill explained, the terminology related to immigration is also often misused. Therefore, she explained some definitions as follows. A 'refugee' has fled his/her country of nationality because of a well-grounded fear of persecution for illegitimate reasons, such as one's race, nationality, religion, political membership or views. As a refugee, you might not have had travel documents, or you might have left these behind in the haste of fleeing for your life. You are regarded as an 'illegal entrant', for example, when you enter the country using false documents, or hidden in a vehicle. Under international law you can apply to become an 'asylum seeker', through a six-month process where you face detention or deportation, depending on whether or not the Home Office staff see you as a refugee.

As an asylum seeker, Cuthill continued, you are allowed to remain in the UK, and you might eventually become a British citizen, although after a lengthy process. Nonetheless, many people slip through the official system, including people whose fear of persecution is genuine. In such cases, she explained, people risk becoming destitute and homeless, having to survive in marginalised spaces, often sleeping rough amidst others who, in many cases, are suffering from poor health, with illnesses including those associated with alcohol and drug use. Her intent had been to explore personal experiences and

strategies for coping with and surviving extreme adversities, such as torture, destitution and mental health problems. She had been especially interested in hearing from people who had become destitute, making use of the limited resources available to them, but who still had not got into problems related to alcohol and drug use. Cuthill suggested that such 'resilience' should not be regarded as an internal trait; rather, it should be seen as the structural-social resources available to an individual trying to overcome adverse conditions, which, she stated, is also seen as an asset in public health terms.

"the newspapers – they think we are all bad – criminals or terrorists. I escape danger in my country but I have not respect here. I started to drink – I have not had alcohol before. It helped me to forget. It was like a friend. I hate myself but I cannot stop. Now I am afraid. It is bad. What can I do?"

The foregoing are the words of a male refugee, one of a set of short statements which Cuthill read to the audience from her notebook. She explained that it might not be untypical for refugees who have escaped deadly situations in their country of origin, to find safety in the UK, under a system where they continue to suffer disrespect and a lack of compassion. Being labelled by others as an 'asylum seeker' could be experienced negatively, because the interviewees previously had more positive views of themselves, since they had, in fact, survived social and political persecution.

Cuthill summarised her key findings, which included the following.

Besides the fear of being caught and the dangers of violence, interviewees faced daily challenges to have enough food and to secure a place to sleep overnight. As they were often afraid of statutory services, interviewees had to rely on friends who were also often in difficult situations. They resorted to food banks, meals and cash donations provided by local charities and faith-based groups. For those resorting to illegal work, long hours of exploitation and unreported accidents were common experiences. However, the simple act of being believed by the people with whom they related had made interviewees feel stronger and more hopeful, and had helped them to maintain a sense of dignity. Finding strength in spirituality was often mentioned, and interviewees illustrated their experiences through the use of metaphors associated with their individual languages and cultures; for example, using expressions alluding to feelings of 'going through fire' and proverbs relating to camels.

In the discussions, a question was posed about how destitute refugees' experiences overlap with those of other groups, including people of UK origin who are destitute. Cuthill suggested that, from this study, destitute asylum seekers see themselves as quite separate. For example, when using the same services as others, they kept separate at mealtimes. They also constantly tried to present a persona of 'normality' in order not to call attention from statutory agencies. However, she added, this was not the case for those who were becoming involved with problematic use of alcohol and other drugs, because they often mixed with other users, and inevitably sometimes with dangerous criminals. Cuthill also mentioned that the introduction to use of alcohol and other drugs had often occurred after arrival in the UK. She explained that because a great deal of shame was felt by those using alcohol and other drugs, it was unlikely that

they would turn to their religious leaders for support.

Cuthill argued that, since they felt that they needed to hide from the authorities, destitute asylum seekers often felt apprehensive about using statutory support services. This fear was especially accentuated where people had come from very repressive states. The NHS seemed to be the most accessible of services, but she suggested that staff providing services within statutory alcohol policy structures feel confused, and sometimes fearful, about what they are allowed to do for this group. Discussants suggested that GPs would find it complicated to refer destitute asylum seekers to specialist alcohol services. Cuthill also explained that, in the field of criminal justice, when destitute asylum seekers come out of detention, they are unlikely to find statutory support when released. This becomes especially problematic, she added, because this is a very contentious political subject, where a lot of prejudice needs to be challenged, before any new systems can be put into place.

Based on this research, Cuthill's recommendations for public health included that asylum processes policies leading to destitution need to be challenged. She also argued that further research is needed to uncover organisations, people and places supporting resilience for the destitute. Finally, speaking about the healthcare context, Cuthill argued that it is important to asylum seekers that the feelings of respect, understanding and hope that they valued immensely, are expressed.

Recovery, Mental Health, Alcohol and Nursing

Dr Anne Whittaker, NHS Lothian and Edinburgh Napier University

Thursday, 23rd April 2015

Whittaker explained that the concept of recovery can be influenced by personal and political interests, which can promote the views and maintain the status of certain groups, while not necessarily making a positive impact on the lives of individuals affected by addiction. She suggested that it can be difficult to measure recovery if practitioners and service users have conflicting views of expected outcomes, and if recovery theory does not fit with treatment provision.

In the fields of addiction and mental health, Whittaker argued, there are many factors which need to be taken into consideration in alcohol recovery processes, such as coexisting health complaints which patients might have, as well as issues such as socio-economic deprivation, gender and age. She explained that, in the Scottish mental health context, the notion of recovery goes beyond a purely medical model, because key challenges for the nursing profession have included the complexities involved in integrating health and social care. Whittaker pointed out that health policies and interventions have to be applied within a range of contexts, including circumstances of homelessness, social exclusion and domestic abuse. In such situations, people are often blamed for their own plight, including their health conditions, such as depression, and young

Dr Anne Whittaker

people are at risk of developing conditions such as alcohol and drug dependence.

In an ideal future, according to Whittaker, we would have nurse-led multi-disciplinary services, primary-care based, with the involvement of patients and their families, since substance misuse treatment without the involvement and participation of family members might hinder treatment success and the likelihood of long-term recovery. Whittaker proposed 'couples therapy' and 'adolescent substance misuse family therapy' as effective family interventions. She described how such treatments should aim not only at promoting the entry and engagement of the user into treatment, but also at involving the family in the process, with a view to responding to the needs of family members affected by the problem in their own right.

As an illustration of effective therapies for the treatment of substance misuse problems, Whittaker spoke specifically about her interest in Behavioural Couples Therapy (BCT), which was developed

in the USA in the 1980s, and which has been systematically reviewed since then, having recently been commended by NICE. She described the therapy as a six-month manual-based programme, ideally delivered by trained and supervised graduate-level mental-health professionals, who need to be competent in diverse areas including substance misuse, relapse prevention, user engagement, couples and family emotional therapy. For the programme to work, she explained, couples form a 'recovery contract', which includes abstinence of substance misuse, and the need to focus on their health, their relationship with each other and with their broader family – and all of these commitments are supported and supplemented by individual counselling sessions.

While Whittaker said that the therapy has provided very positive outcomes for clients in the USA, she suggested that barriers to dissemination in the UK have included resistance from patients, clinicians and managers. In her view, there is also a need for research evidence of effectiveness of the therapy in a British context. To that end, Whittaker, in partnership with researchers from other universities, has been looking into the feasibility of a study in Scotland, and a grant proposal has been submitted to have a group of nurses trained and supervised by the therapy developers.

Whittaker finished her talk, and the audience were invited to ask questions and make comments. There was agreement with her view that it would be helpful to have a patient's family heard in treatment decisions, but discussants commented that supporting families of service users in their own right, while also important, is a rare and recent experience in primary and secondary care settings.

Another comment was that, from a service-user perspective, the implementation of a nurse-led recovery 'treatment' might continue to feel like a very medically based model. It was also suggested that, for many people with alcohol and/or drug problems, charities can feel more approachable than statutory agencies, and also more creative and able to respond more promptly to the range of needs that people have.

Whittaker responded that while treatment does not necessarily need to be nurse-led, there are clients who have very specific needs, which are clinical. In any case, she added, nurses do operate outside clinical settings, e.g. by going into a community, where they can spend vast amounts of time dealing with social aspects of patient's lives. She also explained that clients sometimes only get to see a clinician when they are already in a very bad state. A discussant who worked in clinical settings agreed with Whittaker, and added that, ideally, clinical treatment should start earlier.

A doctor in the audience suggested that, based on his clinical experience, it would be unlikely that spouses of patients would agree to go to couples therapy. Whittaker replied that a survey in Lothian had suggested that around one in four of people receiving treatment would be interested in this kind of service. An audience member drew on personal experience to support this assertion, saying that she had sought medical help for alcohol problems in her family, and that she would have appreciated an offer to undergo couples therapy. She also said that she felt that she had not been understood by her GP. Other discussants commented that family therapy seems to work; however, while therapists needed to

be competent, a university degree was not essential.

In her discussions with the audience, Whittaker indicated that she would want to see BCT in Scotland adopting a holistic approach, including signposting patients to other services, outside clinical settings. In addition she said that there would be a need to verify the relevance of the therapy, for example for couples from minority communities and LGBT groups.

Finally, discussions on policy recommendations with the audience concluded with comments that it is important that practitioners learn from clients, because the latter also often 'wear many hats' and have valuable experiences to share.

Photovoice as a methodology with people suffering the consequences of alcohol-related harm

Dr Aisha Holloway, University of Edinburgh

Thursday, 18th June 2015

Holloway presented the findings from a research project exploring the lived experiences of people suffering the consequences of alcohol-related harm. Innovative technologies had been used in the form of photovoice, a technique bringing together photographic art and narrative. The research had been led by Dr Sarah Rhynas, from the University of Edinburgh, and was supported by SHAAP, the National Portrait Gallery of Scotland and NHS Lothian. Participants had been recruited from Rowan Alba's Community Alcohol Related Damage Service (CARDS) and from the Serenity Café.

Although the terminology ARBD (alcohol-related brain damage) is widely used, Holloway explained, participants who had come from CARDS often did not recognise themselves as having such a condition. Only men had agreed to participate in the project, and several women who had been invited, cited reasons such as having strong feelings of shame for not wanting to be involved. Holloway reported that participants often described the experience of being admitted to hospital, where they stayed for some time in an acute state, but that then, afterwards, although they

Dr Aisha Holloway

remained in hospital, not much seemed to happen. Some participants were still consuming alcohol, although they had been trying to abstain.

Three workshops had been held in the National Portrait Gallery. The first consisted of an introduction to the project and explanations about how to use the digital cameras. Participants then had gone away to take pictures of their environment. They returned to another meeting, bringing the cameras back in order to have the photos viewed and selected with the help of a photographer, while a creative-writing expert helped the participants to explore the meanings of the images. In the final meeting, participants selected the 'photovoices', which would be used in their individual photobooks.

The project team had worked to enable participants to record and reflect on their personal strengths and concerns, as well as on their neighbourhood, encouraging them to record these in photos. Through group discussions about the photographs,

the researchers had intended to facilitate dialogue and information sharing, with a view to passing some findings on to policy makers. However, as Holloway explained, project participants underwent very individual experiences of recovery. Despite the project team's efforts, the participants from CARDS chose to work predominantly in isolation, not interacting with each other, engaged with their own individual stories.

Despite this, Holloway argued, the researchers ended up acquiring quite good data, because the participants had come to the sessions with lots of ideas about what they would be photographing (e.g. pets, scenes for a particular reason), and some had specifically intended to use their photos to generate a positive impact on others.

The following are some of the comments provided by the participants describing their experiences in the project:

> *I thought that it was going to go on for 6 months or something, I really really liked that place, you know, the folk, all of them, they were all really nice. I wish we could go back, you know, together, they were all so relaxed. It relaxed me.*
>
> *I enjoyed it. If I can make one person look at my pictures and think twice about drinking then that's a good thing. Its made me think about how I can help others, like maybe mentoring or something.*
>
> *It has made me think about asking that social worker about getting access to my money to buy a camera, I'm allowed the money for things like that. They keep it to stop me buying booze, but I'm sure they'd agree to this.*

Following Holloway's talk, her conversation with the audience started with a discussion on the possible reasons as to why project participants from CARDS had not interacted very much with each other in the workshops, despite the project team's efforts. It was suggested that this might relate to the stage of recovery of individuals. It was also suggested that at an earlier stage at CARDS, clients might interact mainly with professionals. However, in settings like Edinburgh's Serenity Café, founded and managed by people in recovery, a safer, more peaceful environment can be experienced, with peers working to create a community atmosphere.

Talking about how the participants carried on drinking while in recovery, discussants commented that while stopping drinking might be easy, especially when a crisis point has been reached, it is far more difficult to maintain abstinence, because alcohol is widely available and advertised in many settings. It was also noted that while on social media, for example, on Facebook, depictions of alcohol contexts are often imbued with images of sociability, where people are having loads of friends and fun, the photovoice pieces were mostly about bleak and depressing experiences. It was suggested that this could have been influenced, to some extent, by the participants' assumptions about what the researchers would be expecting them to present.

An audience member, talking about his own alcohol problem, commented that he had stayed in hospital for a while to receive treatment, but that, when released, he had had to return to his usual accommodation, surrounded by the places and the people linked with his problem drinking. There was broad agreement that alcohol recovery processes need to focus not only on individuals, but also on neighbourhoods. While it might not be possible to support people to move house, social services

ought to be able to support people to engage in pursuits that do not involve alcohol drinking.

Finally, Holloway explained that the photovoices had been exhibited and mentioned in a debate in the Scottish Parliament. She also explained that while a permanent project display had been set up in an ARBD unit, volunteers at the Serenity Café had also set up their own exhibition. The researchers would be interested in developing a toolkit to support other organisations willing to undertake a similar project.

2015–2016 Seminars

Alcohol, Europe and the World

GENACIS (Gender and alcohol: a multi-national study) – The development of a multi-country collaborative initiative

Professor Moira Plant, University of the West of England and Curtin University, Perth, Australia

Thursday, 29th October 2015

Professor Moira Plant

Plant presented the history of the GENACIS (Gender and alcohol: a multi-national study) project since 1993, which, she argued, has made a significant contribution to international understanding about women's alcohol-related behaviours. The GENACIS project's objectives have been:

1 To compare within countries men's and women's drinking patterns and drinking contexts; to compare across countries men's and women's drinking patterns and contexts, and gender differences in drinking patterns and contexts.

2 To compare within countries men's and women's alcohol-related problems; to compare across countries the prevalence of men's and women's alcohol problems, and gender differences in problem prevalence.

3 To compare, within countries and across countries, the experience of violence in close relationships as regards men's and women's drinking behaviour.

4 To compare, within countries and across countries, gender differences in social inequalities in alcohol use/abuse and the influence of social role combinations on heavy use.

(http://www.genacis.org/6, accessed 5th January 2016)

As with international studies in other fields, differences between cultural beliefs and systems can present challenges for researchers in analysing data and making comparisons between countries. GENACIS developed from the merging of three previous projects, the International Research Group on Gender and Alcohol (IRGGA) and two BIOMED projects, funded by the European Union in 1998. The merger supported the development of reliable and gender sensitive measures of alcohol use/misuse across a wider range of countries – a total of 34 – and the undertaking of primary research, rather than having to rely on secondary data.

Identifying individual, social and societal predictors of alcohol's harm to others is a

critical first step in developing strategies and policies to reduce these harms. Plant cited as a significant achievement of GENACIS the establishment of a 'life stage' context around which data could be gathered and assessed. Plant also argued that GENACIS had enabled individual country researchers to undertake comparative research both within their own country and across other countries. She suggested that its impact had been huge in terms of influencing data analysis across countries, so that gender-related analysis is now accepted as a norm in alcohol research studies. This had not necessarily previously been the case. Plant also argued that GENACIS has supported the establishment of an important network of alcohol researchers and promoted the practice of survey research in countries where this had not previously been a tradition.

Plant explained how the support and involvement of the World Health Organization (WHO) with GENACIS from 1999 onwards has been critical to the recognition of culture as a vitally important aspect of measuring and assessing drinking behaviours in different countries. Keeping in line with WHO's Gender Policy, the GENACIS project has addressed the need to recognise the significance of gender as a major variable in project development, data analysis and presentation (http://www.who.int/substance_abuse/activities/genacis/en/, accessed 5th January 2016). It has been recognised that having researchers who understand social customs and practices and the status of women in different countries can be vitally important in obtaining accurate representations of drinking patterns. Plant suggested that the more 'emancipated' women were in societies, the smaller was the gap in drinking rates between genders. Other findings from the project included that research participants in 'dry' countries were more likely to attribute the negative consequences of drinking to alcohol than in 'wet' countries. Within countries, Plant also argued that it was important to recognise that there could also be a dynamic mix of different cultures, which would mean that attitudes and behaviours would vary.

The audience followed up to discuss the relationship between women's drinking behaviours and their social roles or position in society. Plant suggested that it might have been expected that women with the greatest number of social roles might have higher levels of alcohol consumption, related to their need to alleviate stress. However, the GENACIS findings suggested that this was not the case and women with fewer social roles, i.e. those who are not wives or mothers for example, seemed to drink more. Possible reasons for this might include using alcohol to reduce feelings of social isolation and simply having more time to drink. An audience member suggested that choosing not to drink might be the preferred option for busy women whose ability to carry out a number of social roles might be impaired by alcohol consumption. Plant also suggested that alcohol producers, conscious of women's increasingly 'emancipated' social positions in many countries, were heavily targeting such women.

There was then a discussion about how, in health and research discussions about alcohol, insufficient attention may have been given to the pleasures alcohol can offer. Plant commented that all types of drinkers, whether or not they defined themselves as having problems with alcohol, mentioned that, at least part of the time, they enjoyed drinking and it

made them feel good. It was suggested that the persistent focus on the negative aspects of alcohol failed to fully ascertain the true reasons behind individual's drinking behaviours and could reinforce the stigma that people with alcohol problems often experience. Moreover, our ability to comprehend the processes that turn some individuals' alcohol consumption from pleasure to harm can be missed.

Corporate social responsibility and the global alcohol producers: Winners and losers

Katherine Brown, Director, Institute of Alcohol Studies

Tuesday, 8th December 2015

Katherine Brown

Brown began her talk by outlining the current global alcohol production market. The majority of the world's total alcohol is produced by only a handful of companies. More than half of the world's beer production is owned by just five companies and Brown argued there were two main reasons for this. Firstly, there have been a number of large-scale mergers and acquisitions, which has reduced the number of players involved in the market. The most recent example was ABInBev's takeover of SAB Miller. As a result of this takeover, 30% of the global beer market is now owned by just one company. Secondly, Brown argued, the trend of globalisation and movement into emerging markets has offered the large alcohol companies expansion opportunities. Global alcohol producers are able to market and sell their products in non-traditional markets and are successfully promoting aspirational messages to the growing middle classes in these countries.

In their attempts to engage with and influence public health policy, Brown discussed various strategies used by many parts of the alcohol industry. These include influencing trade agreements, threatening and instigating legal action, and funding seemingly worthwhile projects to build constituencies of support for policies that often seek to shift responsibility for harm to individuals. A further activity in this area is their attempt to influence the evidence base by funding research.

Brown outlined some findings from a project that she is involved in with Professor Tom Babor, which aims to analyse the corporate social responsibility (CSR) statements and activities of the alcohol companies and align them to the implementation of the World Health Organization's Alcohol Strategy. The project involves categorising CSR activity to identify what area of action it is helping/aiming to influence. Brown argued that clear discrepancies can be identified between industry CSR reports and their activities. The majority of industry CSR activity showed no evidence of effectiveness and had no or very small population reach, with no determination if this was positive. Brown also argued that this CSR activity also has potentially significant benefits for industry including

greater marketing potential and the opportunity to have an impact on policy.

Brown outlined four categories which CSR activity can fall into, ranging from none through altruistic and risk management to strategic. Risk management, the study found, was the most common as this was mandated by law and covered by existing legislation. Over 60% of industry CSR activity was undertaken before the WHO strategy was in place and 65% did not conform to a recognised WHO area for action. Only 6% of all action was deemed to be effective and this activity had a low population reach. From this evidence, Brown argues that Corporate Social Responsibility has major limitations from a public health perspective. So-called CSR activity is rarely evidence based and can actually be damaging to public health by compromising the legitimate work of public health research. Corporate Social Responsibility primarily benefits the global alcohol producers.

Discussants suggested that calls to follow the tobacco policy example (http://www.who.int/fctc/about/en/, accessed 5th January 2016) and establish a UN framework convention on alcohol have declined and argued that advocacy at the global level could be more cohesive. It was argued that the current political preference at UK government level for a governance model based on the involvement of all stakeholders, including the alcohol industry, in policy, was likely to continue to present as a challenge. Brown argued that at UK level opportunities existed to influence present policy, for example, with the review of minimum drinking guidelines and emerging evidence about alcohol-related harms, for example, related to cancer.

Brown argued that the UK government is currently a ‘loser’ in relation to alcohol. The UK government makes on average £11 billion per year in taxation from alcohol; however, it is estimated that alcohol-related costs, including indirect social costs, total some £21 billion per year. The public health field, Brown argued, should offer itself as the key stakeholder to shape the agenda more favourably for a public health perspective. A discussant added that there have been significant wins by health NGOs against the global alcohol producers. For example, with the ongoing Scottish MUP case, a consortium of European NGOs significantly influenced and changed the opinions of many EU member states who had opposed the Scottish policy in 2012.

It was suggested by an audience member that the development of the harm to others agenda became a tipping point in tobacco policy development. Far more emphasis could be put on this in alcohol policy. Brown stated her regret that, in contrast to Scottish policy, the UK government often seems focused on individual responsibility, blame and culpability. She finished by expressing a hope that the Scottish MUP case will be a tipping point for alcohol and public health policy.

European survey of University student alcohol use: The CALIBRATE project

Dr Richard Cooke, Department of Psychology, Aston University, Birmingham

Thursday, 4th February 2016

Dr Richard Cooke

Cooke began his talk by outlining the background to the CALIBRATE project. Data on adolescent alcohol consumption includes the ESPAD - European School survey on Alcohol and other Drugs - data and report, which provides information on substance use and misuse among adolescents across Europe and identifies some marked differences and variations across the region. The overall aim of ESPAD is to repeatedly collect comparable data on substance misuse among 15-16-year-old students in as many European countries as possible. However, there is a lack of data specifically on university student alcohol use. As a psychologist, Cooke is interested in why people drink, not just how they drink.

The CALIBRATE project was a study undertaken in eight European countries – Denmark, England, Germany, Italy, the Netherlands, Portugal, Spain, and Switzerland – with an initial sample of 2,317 students. The purpose of the project was to identify variables which predict alcohol harm and consumption and to measure student perceptions of alcohol harm-reduction strategies. The study measured demographic and psychometric variables and psychological constructs and also asked about awareness of alcohol marketing and perceived effectiveness of alcohol control strategies. The overall aims of CALIBRATE were to compare results across countries to identify if there were similar motives for drinking, differences in harms experienced, and differences in student perceptions of alcohol control strategies and policies.

To ensure consistency in measurement across countries, the AUDIT tool was used to measure alcohol-related harm. The AUDIT tool classifies drinking as hazardous, harmful or dependent. Overall, 62.4% of the survey sample recorded sensible drinking levels on the AUDIT scale; 29.7% were classified as hazardous drinkers; and 4% as harmful. Cooke explained that England and Denmark were outliers, recording higher levels of hazardous drinking, at 44% and 49.6%, respectively. Along with the Netherlands, England and Denmark differed significantly from the other countries in the study. The study showed that northern European

countries had significantly higher AUDIT scores.

In an attempt to understand why people drink, Cooke presented the work of Cooper (1994) who offers an explanation based on four internal versus external reasons for drinking which give either positive or negative reinforcement. The four motivations are enhancement, social, coping and conformity. Cooke suggested that the first two were positive and the last two negative. Cooke used his study to examine if the results (reasons why people drink), based on these motivations, were the same or different across countries.

The first negative motivation is conformity, which is defined as drinking to avoid social exclusion. Across all countries, the score was low, and this was not really a reason for drinking. England displayed a significantly higher score than other countries. Cooke argued that, as an external factor, the higher score among English students may be explained by a perceived social norm of drinking. For the second negative motivation – drinking to cope – there were again no significant differences between the countries examined, with the exception of Italy. The survey showed that overall drinking is not being reported for negative reasons. At the positive end of the scale, both England and Denmark were significantly different/higher compared to the others when drinking for enhancement and drinking for social reasons. Social motivations scored the highest in all countries. Where differences in motivations for drinking across countries arose, Cooke suggested a number of reasons to explain this. Patterns of consumption differ across the countries studied. For example, in Portugal the common pattern of consumption is frequent, light drinking, whereas in England, infrequent, binge drinking is more the norm. This influences an individual's motivations to drink. Perceptions of alcohol-control policies may also differ across countries.

When discussing alcohol-control strategies, Cooke outlined the work of Anderson (2009) who divides these strategies into two categories – educational and restrictive. Education strategies are information giving policies such as educational campaigns, and teaching refusal skills to servers, and are dependent on the will of the individual, whereas restrictive strategies are policies designed to restrict and change behaviours. These include policies around price, availability and marketing and it is these policies which Anderson believes are most effective.

At odds with this, among the student sample across all countries, there was a clear preference for educational strategies. Treatment was viewed as significantly more effective than all other strategies. When broken down to country level, England and Norway differed in that educational strategies were perceived as slightly less effective than in other countries. Overall, northern Europeans were less positive about the (perceived) effectiveness of educational strategies relative to their southern European neighbours. Although viewed less positively than educational strategies, Cooke believes that we can still be optimistic about student perceptions of restrictive strategies. Policies to increase the price of alcohol, to reduce the number of outlets, and to ban sports sponsorship were all perceived more positively than negatively in the majority of countries. However, raising the legal drinking age was perceived as the least effective policy in all countries.

Discussants began the conversation by stressing the importance of ensuring cross-cultural understanding. The example of drunkenness was raised. In some countries this is frowned upon and would have an important impact on the choice of policies in these countries, and implications for the perceived effectiveness of such policies.

An audience member raised the issue of drawing conclusions from the study – how can we do so if the students are recommending policies known from research to be ineffective? Cooke stressed/reiterated that the purpose of the study was to establish which strategies university students felt were effective rather than which strategies/policies would make them drink less. Another discussant questioned how we can prevent the findings from being misrepresented, e.g. the study being used to show that educational strategies and policies are effective. In response, Cooke pointed to the study finding which showed that, although less popular, a significant majority still viewed some restrictive policies positively and as effective. Cooke believes it is important to stress the interaction between education and enforcement strategies; they should be viewed as being supportive of one another rather than as mutually exclusive.

Educational strategies were discussed further. One discussant raised the issue of determining which educational initiatives students were exposed to as this is likely to alter their perception of the impact of such initiatives. There are likely to be large-scale variations in the level and type of education across countries.

Cooke concluded his talk by clarifying that his results provide findings from a sample of students at a particular point in time. He would like to extend this study to other universities and to other countries

What's not on the bottle? Alcohol labelling in Europe

Mariann Skar, Secretary General, Eurocare (European Alcohol Policy Alliance)

Tuesday, 1st March 2016

Skar began her talk by providing a brief history of Eurocare. Eurocare was established in 1990 with membership from nine countries, including the UK. Today, there are sixty member organisations, from twenty-five countries, and a central secretariat based in Brussels. The main goals of Eurocare are to lobby European institutions to raise awareness and make sure alcohol remains firmly on the agenda; and to promote the development and implementation of evidence-based policies. Eurocare are partners in a range of European projects with a main role of dissemination of information.

At European level, food labelling, which covers alcohol, is a challenging area and there is not a lot of interest in it among the alcohol policy community. In 2011, a mandatory nutrition declaration was made for all food and drink products. However, following significant industry lobbying, alcohol products were excluded. Member states do have the choice to legislate on their own terms if they wish and introduce labelling for products with 2% or more by volume. Skar explained that in December 2014, the European Commission should have published a report on nutrition labelling for alcohol products but that

Mariann Skar

this has yet to be delivered. According to Skar, there were a number of reasons for the failure of the legislation in 2011. These included a lack of a sound evidence base of health harms; the burden for small producers would be significant; the persistence of 'alcohol has nothing in it' rhetoric; and arguments that alcohol is different and so should rightly be excluded.

There is a clear evidence base to support health-related information on labels for alcohol products. Calories from alcohol make a significant contribution to overall levels of calorie intake. In the UK, alcohol accounts for nearly 10% of the total energy (calories) consumed for drinkers[1]. Given this significant level, as consumers, Skar argued, we have a right to know what is in the products we are consuming and the calorie content of those products. Some progress has been made. In 2012, it became mandatory for details of all allergens within alcohol products to be shown on the label. Furthermore, evidence from a recent Eurobarometer[2] public opinion survey shows high levels of

support for calorie information on alcohol product labels. Some 70% of people surveyed supported the idea. Crucially, Skar contended that such high levels of public support could be used as an important lever for political action and support. Health-related information helps to remind consumers about the dangers and health risks from consuming the product; it can help change perceptions of risk and change long-term attitudes; and can lead to actual behaviour change over time. These are important lessons we can draw from other products and take forward.

Skar outlined Eurocare's main recommendations for action in relation to labelling. Health information on containers of all alcoholic beverages should be mandatory. Labels should also contain information on product ingredients, allergens, nutritional information such as calorie content, and alcoholic strength. This information should also be placed in a standard location on containers, should be clearly separate from other information on the product and should be written in a sufficiently large font size and bold text. For greater impact, such information should be regularly revised to ensure the messages remain fresh and attractive to consumers. The current industry preference for information on underage drinking, pregnancy warnings and drink-driving does not go far enough.

Overall, Eurocare believes that alcohol labelling in Europe deserves to be more prominent in the field of European alcohol policy. Skar believes that there is significant potential for change. The current legislative environment offers an opportunity for dissemination of health information at the point of sale and consumption. Health-related information on alcohol product labels would contribute to a paradigm shift which would be an important first step in awareness raising, increasing knowledge and changing perceptions of risk associated with alcohol. Nevertheless, important questions remain to be answered about how consumers respond to health messaging and which mechanisms for implementing alcohol labelling policies would be most effective. Going forward, understanding and answering these questions will be crucial.

Discussants began the conversation by arguing that there are important parallels which can be drawn and lessons learned from the tobacco industry. It was argued that rather than focusing on changing behaviour, which was deemed to be largely unachievable, we should form realistic and measurable goals. We need to think carefully about what we want to evaluate. For example, do we want to evaluate opinions, unintended consequences, or the impact of different types of labels? Being clear about our aims is fundamentally important for influencing the policy decision making process and provides clear direction for taking action forward.

An audience member raised the issue of human rights and suggested that this could be used as a frame when arguing for mandatory health labelling. As consumers, we have a right to make an informed choice about the products we buy and consume, even if it is the wrong choice. As such we can question how much right the industry has to keep such information a secret. However, another participant stressed that the alcohol industry is not monolithic. There is a big difference between small cottage industry-type businesses and large multi-national corporations. We need to be clear about messaging, what we are trying to achieve, and who we are trying to work with. A

one-size-fits-all approach is unlikely to be effective.

Another discussant raised the point that, although public health advocates have a preference for mandatory rather than voluntary regulation, we need to argue in favour of any expansion of information giving. The example of the producers of Tennent's lager (C&C Ltd.) deciding to display calorie information on all product labels was raised as an interesting example of what happens when one producer or sector within the industry (in this case beer) breaks ranks. The discussant argued that this has the potential effect of making the position of other sectors, such as the wine industry who are stringently opposed to health information labelling, untenable and this could force change from within.

One person argued that the no drinking in pregnancy warnings favoured by industry have been deemed largely ineffective as they are predominantly read by non-pregnant people. It was also argued that people do not want to read that alcohol is bad for them and often, as a result, shock tactics will be ineffective. Defining what information with regards to health labelling will be effective is very complex and dependent on the individual reading the information.

Skar concluded her talk by raising the dilemma of how public health advocates counteract the effect of high levels of spending on advertising by the alcohol industry. Adverts are very powerful and in public health we will need similarly powerful tools to effectively counteract their influence.

[1] Bates B, Alison Lennox in Obesity and alcohol; an overview (2012) National Obesity Observatory, NHS

[2] http://ec.europa.eu/public_opinion/index_en.htm

Advising pregnant women about alcohol – experiences from research in England and Sweden

Lisa Schölin, Research Assistant, Institute for Social Marketing, University of Stirling, and PhD Student, Liverpool John Moores University

Tuesday, 5th April 2016

Lisa Schölin

Schölin began her talk by providing an overview of the main themes around alcohol in pregnancy. Alcohol use in pregnancy can damage the foetus, particularly with high levels of drinking, and can cause foetal alcohol syndrome (FAS). For low or moderate levels of drinking there is no conclusive evidence that alcohol harms the foetus. Alcohol use in pregnancy is also associated with a range of conditions and disorders, known as foetal alcohol spectrum disorder (FASD). There is no accurate measure of global prevalence of FASD.

There are a number of predictors which increase the likelihood of alcohol use during pregnancy. These include a higher age, intimate partner violence, and higher levels of drinking pre-pregnancy. Research undertaken by O'Keeffe et al[1] found that around 70% of women in the UK reported any drinking during their pregnancy. This is in contrast to Sweden where only 6.5% of women drank in pregnancy[2]. However, comparing prevalence data across countries poses a number of methodological issues including under-reporting and different measurements of consumption.

Schölin outlined the findings from her PhD research. Using a cross-cultural mixed-methods approach, the aim of the research was to explore differences and similarities in countries promoting abstinence versus lower limits in regards to practices, perceptions and values of new mothers and their partners, and also those of midwives. England and Sweden were the countries studied and compared. Participants were recruited through children's centres, GP practices, social media, and online parent groups.

1 O'Keeffe, L. M., Kearney, P. M., McCarthy, F. P., Khashan, A. S., Greene, R. A., North, R. A., Poston, L., McCowan, L. M., Baker, P. N., Dekker, G. A., Walker, J. J., Taylor, R. & Kenny, L. C. 2015. *Prevalence and predictors of alcohol use during pregnancy: findings from international multicentre cohort studies*. BMJ Open, 5, e006323.

2 Skagerström, J., Alehagen, S., Haggstrom-Nordin, E., Arestedt, K. & Nilsen, P. 2013. *Prevalence of alcohol use before and during pregnancy and predictors of drinking during pregnancy: a cross sectional study in Sweden*. BMC Public Health, 13, 780.

The findings showed significant differences between the countries. In England, 44% of women reported having drunk any amount of alcohol during pregnancy, compared to only 6% in Sweden. In relation to advice given in antenatal care, 23% of women in England were advised that drinking small amounts of alcohol was okay compared to only 2% of Swedish women. Furthermore, 37% of English women in the study believed there was a safe level of drinking during pregnancy, compared to only 5% in Sweden. Schölin believes the significant differences between the two countries can be largely explained by the messaging, advice and values in each country. Advice given to women in England varies greatly. In contrast, Swedish advice is very clear, with messaging emphasising abstinence. The majority of English parents reported uncertainty around the risk and harm from low level consumption, and emphasised the personal choice of the mother as important.

In both countries, all midwives recommended abstinence and all felt prepared to talk about alcohol. However, there were differences between the personal and professional opinion of midwives in the two countries. In England, midwives, although professionally recommending abstinence, reported personal scepticism in relation to whether a small amount of alcohol is harmful and emphasised the importance of adapting and tailoring information to fit the individual. In Sweden, this conflict/difference was not apparent. Swedish midwives talked about using the AUDIT screening tool and the good structure and consistency this gave to screening. English midwives reported using standard 'screening' questions although these did not reflect the full range of drinking behaviours, especially occasional drinking. The challenge for midwives is to balance the need to maintain a good relationship with the mother/parents with also providing important information and advice about a healthy pregnancy. Schölin concluded her presentation by arguing that risk is culturally framed. In the case of alcohol in pregnancy, there is a maternal-foetal conflict, with differing ideas of what is a 'good mother' in both countries. The cultural framing of risk influences the advice given to women in each country and how it will be perceived. We need to appreciate that women make decisions about drinking in relation to a number of different factors, such as social, risk, events and pleasure, and how these factors interact to influence behaviour.

Since 2012, Scottish guidelines have recommended 'no alcohol, no risk' messaging for pregnant women. This was rolled out to all midwives by NHS Scotland and appropriate knowledge, support and training were key facilitators for this. One discussant asked whether it is easy for midwives to believe what they are telling pregnant women. In response, a practising midwife stated that all midwives are clear on the abstinence message.

Alcohol availability and costs are very different in Sweden. Schölin reported that heavily pregnant women in Sweden would not go into the state monopoly stores to buy alcohol for their partners, as the social norms around not drinking alcohol in pregnancy were so strong. It had been hypothesised that the drinking of partners might influence womens' drinking. However, this did not seem to matter significantly.

A representative from the alcohol industry in the audience was questioned on the industry's support for pregnancy warnings on packaging. He stated that they were supportive of both pregnancy warning

labels and the government's guidelines, and he argued that labels should be prominent and consistent across alcohol brands to ensure reach and consistency of message. It was suggested that the symbols used are sometimes not recognised by consumers. The industry representative agreed that this needs to be communicated more effectively.

The discussion concluded with a consideration of some of the implications of the research for policy. The usefulness of the terms 'responsible' and 'irresponsible' drinking with regard to policy outcomes were questioned. They are difficult to define and cannot provide details of categorical or measurable effects of alcohol. More broadly in relation to policy, discussants suggested a need for consistent messaging across Scotland, with a consistent approach to screening. It was suggested that an emphasis should be placed not only on what questions are asked, but also on how they are asked, to enable the provision of appropriate advice, information and support.

Adolescent binge drinking in Chile: Does it matter which school they go to?

Francisca Maria Roman, PhD Student, University College London

Tuesday, 14th June 2016

Francisca Maria Roman

Alcohol consumption in Chile has a significant health impact. One in ten or 9,500 deaths annually in Chile are directly attributable to alcohol. In terms of morbidity, alcohol is the second greatest specific cause of loss of disability adjusted life years (DALYs) in the male population and is the greatest cause in males aged 20-24. This mortality and morbidity impact is not equally distributed. It is socioeconomically patterned. Frequency of alcohol consumption increases with income yet it is lower socioeconomic status (SES) males who are at the highest risk of harmful drinking and alcohol dependence (measured using AUDIT). Chile has the greatest disparity in the probability of hazardous and heavy episodic drinking in males of lower education.

Binge drinking is associated with a number of health risks and secondary consequences and with an increased risk of alcoholism in adulthood. Roman outlined the findings of her PhD research which looks at the effect of the school attended on alcohol consumption patterns of adolescents. The Chilean school system has three types of school – state-funded, private subsidised and private. Every school is quite homogeneous, with all students from a similar background, and is highly socially stratifying. The majority of students attending state-funded schools are from lower SES groups and the majority attending private schools are from the highest SES. The school system sits within a social context influenced by parental knowledge and peer influence which are both further influenced by the broader (macro) economic and education environment. The school socioeconomic environment is thus determined by a network of reciprocal interactions shaped by available resources and structural characteristics.

Using data from the 10th National School Population Substance Use Survey (2013), the aim of Roman's research has been to understand to what extent school socioeconomic environment impacts upon adolescent drinking and whether this effect would be related to parental and peer influences and gender difference in Chilean adolescents aged 13 to 18. More

specifically, Roman's presentation focused on assessing if the school socioeconomic environment is associated with adolescent drinking, after taking into account individual factors and unmeasured characteristics at local level. To measure outcomes, in the survey, adolescents are categorised into three groups – non-drinkers, non-binge drinkers and binge drinkers (consuming more than five drinks on a single occasion in the last month).

The findings of the research show that boys aged 13-18 are both more likely to be non-drinkers (19.7%) than girls (16.4%) and are also more likely to be binge drinkers (31.9% compared to 29% of girls). In both genders, non-drinking decreases with age as young people approach the legal drinking age of 18. Binge drinking increases with age as adolescents approach 18 years of age, although this increase is steeper in boys. Patterns of both non-binge drinking and binge drinking are associated with the socioeconomic status of the school. The findings show that a higher proportion of adolescents attending lower SES schools consumed alcohol and this pattern holds for both genders. Roman demonstrated that gender differences were more apparent in relation to binge drinking. For girls, the more socioeconomically deprived schools reported greater incidence of binge drinkers; for boys, binge drinking was more common in the most affluent schools. Overall, the findings suggest that school socioeconomic status is associated with both non-binge drinking and binge drinking among adolescents in Chile. The effect of socioeconomic status on non-binge drinking appears to be stronger for boys, while the effect on binge drinking seems to be stronger in girls. For all of the findings, Roman stressed the importance of taking into account individual and parental factors as key explanatory variables.

Roman then moved on to outline alcohol policy in Chile. Chile has a written national alcohol policy with a legal minimum purchase age of 18 and restrictions governing the physical availability of alcohol. Price is controlled through excise duty. However, the country has no regulation on sales promotions, sponsorship or advertising; health warning labelling is not compulsory as there is no regulation; and Chile lacks a national monitoring strategy for its alcohol policy.

There is a widespread belief among parents that it is okay for young people to drink alcohol at home and with their families and is far better for them to do so. Recent national statistics show that 45% of minors were able to purchase alcohol in the off-trade and 16% were able to consume alcohol in on-trade premises. Alcohol prices are very low. A 750ml bottle of vodka can be purchased for as little as £3.30, and a 12-pack of 330ml cans of beer for £4.40. The economic burden of alcohol in Chile is greater than its economic contribution.

In an effort to raise the price of alcohol and reduce the burden of alcohol on Chilean society, Roman explained that the government in 2014 proposed raising rates of excise duty but this was strongly opposed by the industry. Under current law, there is tax of 21.5% on wine and 31.5% on spirits. The reform introduced an 18% baseline tax plus an increase of 0.5% per degree of alcoholic content. Prices increased by around 5% which Roman argued had an insufficient impact on public health. The overall impact on consumption was minimal. Taxes on spirits remain low and the concentration of pure alcohol in a standard drink in Chile has increased as a

result, leading to a higher concentration of pure alcohol among drinkers.

The discussion began with a participant making reference to the fact that the data presented was from the tenth school survey in Chile and asked if it would be possible to compare this with the findings of the first survey in 1995 to develop a time series. Roman informed the group that the question of binge drinking was only introduced into the survey in 2011. The discussant then asked, based on the survey data, if the prevalence of binge drinking differed in mixed-gender or single-sex schools. Roman reported that mixed schools increase the effect of engaging with binge drinking in girls but not boys. Possible explanations for this are girls being influenced by male friends or older boyfriends with jobs who purchase alcohol for them, and more boys choosing to abstain.

A discussant asked whether there is a social recognition of alcohol as a problem in Chile, as is the case in Scotland. Roman stated that Chilean society is very consumer driven. Alcohol consumption is not seen as a problem, at least not in any great magnitude, yet the data shows that it is a major problem. In recent years, disposable incomes have risen and Roman suggested that alcohol is increasingly used by individuals and families as a way of demonstrating wealth.

2016–2017 Seminars

Alcohol and Health Inequalities

Tackling Health Inequalities in Scotland and Implications for Alcohol Policy

Dr Katherine Smith, Reader, Global Public Health Unit, University of Edinburgh

Thursday, 13th October 2016

Dr Katherine Smith

Smith began her presentation by explaining that, in 2015, the Scottish Parliament's Health and Sport Committee found that, despite significant investment in tackling health inequalities, the gap between rich and poor in the nation persisted. The Committee, she continued, identified the primary causes of health inequalities as lying outside health, e.g. income and deprivation. Smith argued that the Scottish Government has invested in public health campaigns to tackle smoking, alcohol and poor diet, and that such campaigns are often taken up disproportionately more by affluent populations, widening health inequalities.

Possible explanations for the lack of progress in tackling health inequalities, Smith explained, include insufficient knowledge about what works, as well as failure to implement policies known to be effective. She also listed lack of public support for the required actions, in a context where there is substantial lobbying on behalf of commercial interests.

Smith stated that, while on the one hand, health inequalities and related issues can be seen through a public health frame with an evidence-based focus, research and policy are inherently political. She explained that she had attempted to establish what kinds of policies and interventions researchers believe are likely to reduce health inequalities, while also looking into possible consensus on what should be advocated. 99 policy proposals, from a variety of sources, had been reviewed, evaluating the impact of the policy proposals on reducing health inequalities and considering if these could be appropriate in the current social, political and economic context.

When evaluated based on the researchers' expert opinions, Smith explained, the findings showed that there was a preference for policies which changed working and living conditions, with little reference to individual behaviours. When evaluated based on the strength of the evidence, upstream determinants were still identified as important but lifestyle behaviours were also identified as highly significant. Smith highlighted that there was a clear consensus among the researchers

that the most effective policies for reducing health inequalities are those which do not depend on individual voluntary action, but rather those which involve changing the environments in which people live.

Concluding her presentation, Smith argued that there is agreement that political, structural and economic factors are the main cause of health inequalities in the UK, yet the solutions presented do not mirror this and remain focused on downstream interventions such as health promotion. She recommended that interventions to reduce health inequalities must not be voluntary and that actors should work collaboratively to tackle upstream determinants.

During a discussion on the role of industry and business in contributing to health inequalities, Smith argued that these play an important role, particularly in relation to their lobbying activities. A discussant raised the point of whether it is more helpful to have one organisation to lead the advocacy activities or for multiple actors to be involved, and Smith argued that it is more helpful to have multiple actors involved to emphasise consensus and cross-sector support.

The discussants also considered whether we should maintain such a strong focus on health when the main issue is inequality, and it was suggested that health is an issue that commands high levels of public support and consensus. A participant commented that the focus nevertheless needs to be broadened out because policy audiences are not predominantly health focused. There followed a comment that, in health policy discussions and decisions, it is important to involve other actors such as trade and finance.

In her concluding comments, Smith stressed the importance of discussions with members of the public. She mentioned the Citizen's Jury approach which involves actively engaging with a small cohort of people over an extended period.

Does harm from drinking differ by socioeconomic status? Exploring the alcohol harm paradox

Dr S Vittal Katikireddi, Senior Clinical Research Fellow and Honorary Consultant in Public Health, MRC/CSO Social and Public Health Sciences Unit, University of Glasgow

Monday, 5th December 2016

Dr S Vittal Katikireddi

Katikireddi began his presentation by explaining what the alcohol paradox is and presented a range of hypotheses to explain the paradox. Survey data shows that individuals in lower socioeconomic status groups consume alcohol at similar levels to their counterparts in higher socioeconomic groups; however, those lower socioeconomic status individuals suffer greater harm from this consumption – this is the alcohol harm paradox. Hypotheses to explain the paradox include that there may be differences in drinking patterns between socioeconomic groups; there are also differences in other risk factors such as smoking and obesity. There could also be reverse causation where as a result of drinking too much, people can fall down the social scale; and effect modification, where an individual is of lower socioeconomic status and drinks in a higher risk way, and it is the combination of the two which puts them at a greater risk of alcohol-related harm.

Katikireddi then moved on to present findings from his current research which aimed to offer some explanations for the alcohol harm paradox, and determine why harms appear to be socially patterned. Using linked data from the Scottish Health Survey (SHS), Katikireddi explained that this enabled him in his research to look forward and backward at key trends. The key outcome analysed was alcohol-related harm. The analytical sample for the research was 50,236 participants, comprised of 21,777 men and 28,459 women.

The results show there is a strong gradient between deprivation and alcohol-related harm. The binge drinking hypothesis does not explain the SHS data and the paradox. In relation to other risk factors, such as obesity and smoking, there was some reduction in harm when these factors are removed, although this was not the case when accounting for some of the factors in relation to inequality measures. In terms of reverse causation, there was little or no evidence of this, in terms of either upward or downward mobility.

Going forward, Katikireddi argued that there are a number of policy implications from the research. Addressing health inequalities through individual behaviour change requires people to act against societal norms. There is also the potential for stigmatisation and the population-based impacts on health inequalities are underestimated.

The discussion began with participants questioning how smoking and obesity can be controlled for. Katikireddi explained that the data can and do control for this. A participant argued that chronic stress from a very early age can potentially lead to greater harm. It is likely that a mixture of early childhood exposures, and subtle dietary differences, are elevated by the chronic stress response. There needs to be a linked approach which looks at all factors. The overall approach to tackling the problem should not be viewed as an either/or – there needs to be both alcohol-specific policy, as well as overall health policy which effectively addresses the broader factors and determinants.

When discussing the effect on different socioeconomic groups, it was argued that if both lower and higher socioeconomic groups were to reduce their alcohol consumption by the same amount, lower socioeconomic groups would benefit more. Katikireddi responded by stating that this may potentially happen, although there would need to be monitoring, and update, of individual level interventions for this to arise as there are issues with stigmatisation, and that uptake of interventions is socially patterned with higher socioeconomic groups more likely to take up interventions. Asking those in lower socioeconomic groups to reduce their consumption by a greater amount, will not lead to a much greater reduction in inequality. Inequality will still reduce if all groups in society reduce their consumption by the same amount.

A discussant argued that the focus should be on wider material and social (population level) factors, not just on individuals. Often, population-wide interventions/guidelines are socially patterned and so do not affect everyone equally, with the effect of interventions dependent on the nature of the intervention. Health policy is also about improving health overall, not just reducing inequality.

The discussion ended with consideration of the impact on policy and recommendations for policy action going forward. The Scottish Government have put inequality at the heart of their strategy and programme - how do we push them towards making relevant choices? One discussant argued that the new devolved taxation and welfare powers offer opportunities to strengthen and develop a prevention-led policy agenda.

Katikireddi summed up by reaffirming that we know that harmful drinking differs by socioeconomic status. It would be helpful to know how to shape the socioeconomic circumstances that can influence the risk of alcohol-related harms. There is currently a public willingness for accepting too much inequality in society. There is therefore an opportunity to alter this willingness and to influence politicians to act through the taxation system, for example, to become more progressive.

How inclusive are we? A trans perspective on alcohol and drug services in Scotland

Vic Valentine and Oceana Maund, Scottish Transgender Alliance

Tuesday, 24th January 2017

In this seminar Maund gave a testimonial about her experience of being a trans woman who has also faced alcohol and prescription drugs addiction, and Valentine presented the details of the findings of a survey conducted by the Scottish Trans Alliance into transgender inclusion in drug and alcohol services.

Vic Valentine

Oceana Maund

Maund emphasised that, although other trans people may have similar experiences to her own, individuals have their own personal journeys. She explained that although born with a male body, she had felt that she was a woman from childhood, when she was already dressing up with girl's clothes. At some point during her childhood, she explained, she was told that it was inappropriate for her to dress up like a girl, which made her feel ashamed and isolated, and such feelings became worse during puberty, when she also started experimenting with alcohol in order to manage her suffering.

In those pre-internet times, Oceana explained that it was very difficult to find information about what she was going through, and the feeling that she was the only person in her situation added to her unhappiness. Still living as a man, she went on to marry a woman with whom she had a child. After the break-up of the marriage, Oceana decided to undergo therapy to transition from man to woman.

She explained that she had been avoiding looking for help to treat alcoholism,

because of worries of being mistreated, but when she actually used the services she was generally well received, although the staff did not know much about trans people. She concluded that the fear of being mistreated perhaps would be stopping other transgender people from accessing services, and it was then that she approached health agencies in North Ayrshire to see what could be done, and their partnership led to the survey, the details of which would be presented next by Valentine.

This was an online survey open to any trans person living in Scotland, Valentine explained, which was focused on people's use of alcohol or other drugs, the way in which their trans identity impacted on their substance use, as well as their concerns about approaching – or experiences of using – specialist services. The report of the survey is intended to be useful for addiction and recovery services across Scotland.

The survey had 202 qualified respondents, including 'trans women', 'cross-dressers', 'trans men', 'non-binary persons', living in places in the most diverse regions. 99% of the respondents had drunk alcohol, and 35% of these said that their alcohol consumption had become problematic. The findings also indicated that 26% of the respondents had used illegal drugs, and that, among these, 16% said that their use had become problematic. When compared with findings from research with the wider population, Valentine explained, trans people in Scotland seem to have higher rates of alcohol and drug use. The survey findings showed that 50% of the respondents said that they had been using alcohol or other drugs to cope with gender dysphoria, social anxiety, relationships and sex due to being trans, as well as difficulties in accessing the help they need as a trans person, such as long waiting times for gender identity clinics.

Other survey findings included reports of anxiety about approaching alcohol or other drug services, due to the expectation that these would know very little about trans issues, as well as the fear of different forms of harassment and even physical violence. Respondents also indicated that they feared that their trans-specific healthcare, such as access to hormones and surgeries, would be stopped if they talked about their substance addiction. Only a small number of respondents had engaged with recovery or addiction services, and, according to their answers, trans people's concerns about using services were more commonly based on fears and expectations rather than actual experiences, although some reported that they had been addressed by their birth pronoun, rather than by the one associated with their new gender identity.

The report recommends that staff working in different services, including GP practices, need to become aware that trans people seem to be a group using alcohol or other drugs at higher problematic rates than the general population. Such knowledge can be acquired through training which can also explore the type of language and questions it is appropriate to ask trans people.

Another main recommendation is that services need to ensure that trans people know they will be welcomed even before they visit, through information on leaflets, websites and posters stating that all people are welcome, including trans people. The report also suggests that addiction services should promote themselves in trans community spaces, both online and offline, with messaging aimed at trans people, to

let them know that services are welcoming, knowledgeable, and supportive of their needs.

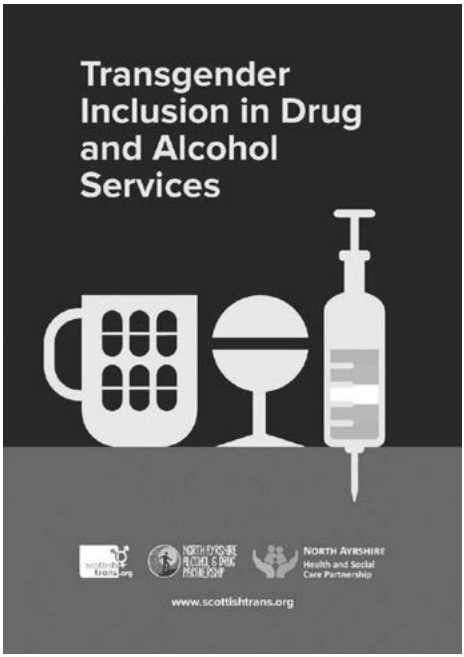
After their presentation, Maund and Valentine discussed the survey findings with the audience, and, among the initial comments, discussants indicated that drugs and alcohol services do not seem to cope well with some other groups, such as, gay men, young people and women in general. Discussants welcomed the idea of providing specific training to service providers, and suggested that making an effort to get services right for trans people, could end up benefiting the treatment of the other groups dealing with discrimination.

Commentators also remarked that there is division and discrimination even within the LGBT community, but there was a belief that recovery services users, who are already dealing with their own addiction problems, might not be more trans-phobic than the general population.

There was also a discussion about the difficulties faced by trans people wanting to have clinical transition treatment while also facing addiction problems, and it was suggested that, in such cases, patients might hide their problematic substance use for fear that this might hinder or stop clinical treatment to transition. Maund mentioned that she had to wait a long time for referral to receive the necessary treatment to transition, and this had a negative impact on her addiction. Discussants seemed to agree that clarity needs to be provided from health providers about whether engagement with addiction services will have an impact on access to trans-specific healthcare, and that this needs to be communicated to trans people.

Regarding how to address trans people, Valentine commented that trans people themselves are aware that people get confused, and that, if in doubt, it is fine to clarify which pronoun to be used.

During the final comments, a discussant remarked that people talk about their substance use differently depending on context, and that trans people, like the general population, probably would have expressed positive experiences about their drinking, if they had been asked about their experiences outside recovery services contexts. The seminar was closed with the participants thanking the presenters for the very clear list of recommendations.



The full report can be accessed through: www.scottishtrans.org/alcohol-and-drug-services

Alcohol admissions and health inequalities: is the tide finally turning?

Neil Martin, Research and Information Manager, Balance, The North East Alcohol Office

Monday, 27th February 2017

Martin presented the findings of quantitative research on alcohol-specific hospital admissions (ASHAs), from 2006 to 2015, covering 326 local authorities in England. The study used the data to try to explore how inequalities vary over time, by condition, gender and geographic region. The research looked at the impact of inequalities on the healthcare system.

Martin explained that, according to the findings, there was an increase in alcohol-specific admissions over the period, with larger increases from older groups, with a good proportion of women, coming from less deprived areas. The data also suggested a different picture between the start and the finish of the research period, with men representing a smaller increase in the admission rate, 34% vs. 43% for women. However, during 2014/2015 the admission rates were considerably higher for men, i.e. 816 per 100,000, and this accounted for 68% of the total number.

According to the study findings, men aged between 40 and 64 accounted for the majority of admissions, while people aged over 65 had the lowest admission rate. The relative threat to resources from

Neil Martin

both men and women under 40 seemed to be quite small. Men older than 65 and women aged between 40 and 64 could be seen as broadly comparable in terms of hospital admissions. The figures suggested an increase in the number of women older than 65 being admitted, but their rates are still the lowest. Admission rates of people younger than 40 reduced from 35% in 2006/2007 to 26% in 2014/2015.

Martin discussed the impact of these figures on NHS resources, i.e. the costs associated with the admissions. He explained that the organisation and provision of healthcare services contributes to an estimated one-third of the improvement in the population's life expectancy, while two-thirds of improvements have been attributed to public health activities aimed at changing people's lifestyle behaviours.

While life expectancy has increased through public health efforts, so have the demands on services that deal with chronic diseases associated with old age.

He explained that although his study had only focused on age and gender, it could also have looked into ethnicity, sexual orientation or mental health and come up with a whole new dimension of inequalities. He concluded his talk by suggesting that the data could also be used for qualitative analysis comparing different groups.

The discussion with the audience included comments about how the research findings seemed to indicate that the alcohol-related admissions decreased during the recent recession period. This supports arguments that price-related interventions, such as minimum unit pricing for alcohol could be an effective tool to reduce consumption.

Discussants also talked about how the study findings seemed to indicate that the number of alcohol admissions for women could eventually become similar to those for men, and that the same could happen with older people in relation to younger. It was agreed, however, that, overall, men are still the greatest cause for concern.

It was suggested that although the research looked into alcohol-related data, we should have in mind that many of the patients in question would also have further health problems caused by other unhealthy lifestyles, including smoking, obesity – and by poverty itself. It was also remarked that A&E services do not necessarily record that incidents are alcohol related, but that this is normally the case when people are hospitalised.

Concluding comments included a statement that while alcohol draws A&E resources, it is good that people seek and receive medical treatment for alcohol problems. There was also the suggestion that licensing and other intervention activities have been facilitating a decrease of alcohol-related admissions and crime over time, and that control of alcohol marketing and the introduction of the minimum unit price would also be beneficial for the health of the population.

The session ended with Martin's suggestion that the same data could be used by other types of research to provide reliable, robust evidence to back interventions.

Alcohol problems in criminal justice settings: an opportunity not to be missed

Dr Lesley Graham, Clinical Lead for Alcohol, Drugs and Health in Justice Settings, ISD Scotland

Monday, 27th March 2017

Graham started her talk by discussing the strong link between alcohol and crime, and the data that she presented indicated that 41% of prisoners in Scotland have reported being drunk at the time of their offence. In the case of those accused of homicide, the data also showed a link with alcohol in 38% of the cases and that 54% of victims of violent crime thought the offender was under the influence of alcohol. She also pointed out, however, that not all alcohol problems in prisoners are directly linked to their offence.

Graham explained that there are around 162,466 people in prison in Scotland, and that the numbers have been decreasing over the last years. She also said that young men from deprived backgrounds form the majority of the incarcerated population, and that many of them are affected by alcohol dependency. While the prevalence of alcohol problems within prison systems seems to be higher than in the general population, she continued, the risk of an alcohol-related death is three times higher for men and nine times higher for women, who form 5.5% of the incarcerated population. Graham

Dr Lesley Graham

also mentioned that alcohol problems in prisoners will often exist along with other co-morbidities; for example, 68% of the cases also present other medical problems, including mental health issues and substance misuse problems, making diagnosis and treatment of these complex needs challenging.

Arguing that alcohol should not be seen in isolation from mental health and economic hardship, her talk included an explanation of how prisoners with alcohol problems quite often have also been affected by social exclusion factors, such as unemployment and low educational achievement. Graham also mentioned that an adverse childhood also seems to be a common experience among prisoners, since one in four incarcerated people were in care at some point, and, particularly for women, the experience of physical and sexual trauma are common.

Graham also explained that alcohol-related crime is estimated to cost about £700 million each year, which shows how poor

health associated with justice outcomes is costly. However, she also said that there is increasing recognition by policy makers of the health needs of those in criminal justice settings, and that those working in justice policy have also been more and more interested in health interventions, e.g. alcohol brief intervention, because these have shown potential to reduce both re-offending and health inequalities.

While the prison population is arguably easy to reach, Graham suggested, effective interventions depend on willingness to recognise an alcohol problem and to accept treatment. Other barriers, she added, include staff perceptions and lack of time, as well as limited evidence of what works, since there is need for more research, evaluation and consistent monitoring. Nonetheless, one in four incarcerated people get medical attention, including alcohol brief intervention, which Graham indicated is a good proportion if compared with the general population. She also mentioned progressive work being carried out by psychiatric nurses working in partnership with the police, who have been referring people to services, and, consequently, diverting people from prison and the criminal justice pathway.

While there is a lack of robust evidence on how effective alcohol misuse treatment programmes are in reducing reoffending, Graham explained, there is some evidence that alcohol brief interventions, cognitive behavioural and mutual support approaches can reduce alcohol misuse.

The discussion with the audience included a question about the number of people in prison who are possibly affected by alcohol-related brain damage (ARBD). It was suggested that figures do not seem to be available, and that tools to detect ARBD are necessary. Graham commented about research on people affected by head injury, and how these presented similar symptoms to ARBD, such as increased impulsivity and risky behaviour. Some recovery in such cases is still possible, she indicated.

There was also a suggestion that it is likely that a good number of people affected by foetal alcohol syndrome disorder (FASD) end up in prison, although figures would need to be established. It was remarked that people affected by FASD have special needs which, in some cases, are similar to those of people affected by ARBD or head injury, and that health professionals in prison would do better in addressing the different needs. It was also argued that many conditions such as FASD are quite often identified first in school settings, and that, if many of the people who are incarcerated now had had appropriate schooling for their needs, they probably would not have ended up in prison.

Graham explained that the evidence suggests that prison does not stop people from reoffending once released, and that it is actually likely to damage chances of reintegration, as prisoners get disconnected from the community. She also explained that supervision that is not combined with some form of support is likely to be ineffective, and that the same would apply to stand-alone education programmes that do not form part of a wider package of intervention, and which are not linked to real prospects of employment and do not match offenders' interests.

Recommendations for policy included the need for putting standards in place, since produced evidence should not remain only on websites. A more effective health coordination, which could be nurse-led, is also needed, due to the complexity of the alcohol problems involved.

Peri-conceptual and mid-pregnancy alcohol consumption: a comparison between areas of high and low deprivation in Scotland

Dr Andrew Symon, Senior Lecturer, Mother and Infant Research Unit, School of Nursing & Health Sciences, University of Dundee

Thursday, 11th May 2017

Symon, whose background is in midwifery, began by outlining some difficulties encountered when gathering data on how much women drink during pregnancy, including before they realise they are pregnant (peri-conceptual stage). He suggested that these range from conflicting advice on "safe" or advised levels of alcohol in pregnancy; a reluctance on the part of doctors or midwives to broach the subject; time constraints preventing them from raising the issue; lack of confidence in screening tools; confusion on the part of respondents about the number of units consumed and variability in responses, depending on who is asking the question. It is well established that alcohol-related harm is greater in economically deprived areas, but the pattern of alcohol consumption across income groups is less clear, so the study aimed to look at two health board areas with different socio-economic profiles.

Dr Andrew Symon

Symon explained that the study compared a small cohort in two health board areas, a less deprived board area in the east of Scotland (HB1 with 3.7% of the most deprived areas (SIMD 1&2) in Scotland) and a more deprived board area in the west (HB2 with 9.6% of SIMD 1 & 2 areas) and that its main purpose was to evaluate the consumption recording tool used. In total 510 women at 19 weeks gestation were asked about their drinking in the course of one week, and this was converted into standard UK units (10mls pure alcohol). This was done using a Retrospective Diary (RD) tool with flash card prompts, in addition to the existing assessment tools used in each board area. This was to assess the levels of alcohol consumption and harmful drinking in women peri-conceptually and in mid-pregnancy, at 19 weeks. The study groups reflected population deprivation levels in the two health boards.

It was found that before pregnancy was known, 22% of the women in HB1, the more affluent area, reported drinking more

than the low risk level of 14 units per week, whereas in HB2 this number was 17%. There were more heavy drinkers (>35 units per week) in the more affluent area, but numbers of heavy drinkers were low at under 3%. It was found that there were lower numbers of abstainers in HB2, the more deprived area, but that binge-drinking was not related to socio-economic status in pregnancy.

When questioned on whether they continued drinking in mid-pregnancy, in HB1 14.9% of the women reported continued drinking, whereas in HB2, the more deprived area, this number was 21.6%. Among those continuing to drink, regular alcohol consumption over 4 units per week was rare but it became clear that 'holiday weeks' or 'special occasions', e.g. family parties, were of particular importance with a few participants reporting substantial levels of consumption on these occasions.

Symon noted in summary that there was no simple correlation between higher levels of drinking in pregnancy and deprived areas, and no significant relationship between individual deprivation scores and alcohol consumption. It was found that women in deprived areas were more likely to drink before they realised they were pregnant but less likely to drink at risky levels or heavily; and once they knew, they were more likely to drink but did so less frequently. The Retrospective Diary with visual prompts was more sensitive than other existing tools, such as AUDIT C, in eliciting higher estimates of consumption. The RD method also seemed better at engaging women in discussion and reflection about their drinking - as one participant put it, "to think about the drink". Symon noted that the study was limited as it only compared two sites and used a broad definition of deprivation. Comparisons were difficult as respondents did not necessarily realise at the same point in pregnancy that they were pregnant; they also reported varying levels of drinking, depending on whether it was a 'typical' week or a 'holiday' week.

Symon ended his presentation by giving a brief review of relevant literature and by noting that media reactions including the narrative of "women drinking to excess" were not new. He also mentioned that Phase II of the study was currently under development, with the aims being to assess maternal well-being in relation to alcohol consumption peri-conceptually/ during pregnancy/after delivery; and to evaluate the need for brief interventions and other supports during and after pregnancy.

In the discussion, a participant noted that in terms of drinking during pregnancy, substantially more women in HB2 were drinking at substantial levels, whereas in HB1 women consumed much less but more consistently. Another discussant noted that the interviews were conducted between February and September, meaning that the previous few months could have included Christmas and New Year with the associated likely higher levels of drinking. Symon explained that drinking with others was crucially important with only one woman reporting drinking on her own. Another discussant noted that there was a stigma for women drinking in deprived areas and that media narratives would contribute to this. It was also noted that partner behaviour or influence on the women's drinking was not taken into consideration; as one person noted, an Australian study showed that 40% of women said men initiated their drinking.

One participant asked how Phase II sits within the context of the Alcohol Brief Interventions strategy and Symon replied that these are even more important, given that Phase I suggests that more drinking is going on and drinking within pregnancy may be a more frequent issue than previously thought. Here, it is interesting that studies have shown that midwives who didn't drink themselves felt more comfortable conducting ABIs than those who did; the same reluctance was displayed a few years ago when asking women about domestic violence and before that with smoking; however both are now standard practice. Training was crucial if staff behaviour was to be changed and midwifery staff were sceptical about the current screening tools. Symon agreed that it would be useful to conduct a follow-up study where ABIs have been carried out using the Retrospective Diary.

Alcohol deaths in Glasgow 2010. Has service redesign had an impact?

Dr Catherine Chiang, Consultant in Public Health Medicine, NHS Greater Glasgow & Clyde

Wednesday, 14th June 2017

Dr Catherine Chiang

Dr Chiang explained that the purpose of her study was to compare the 2003 audit of alcohol-related deaths in Glasgow with the results of the 2010 audit. She noted that since 2003 both the local authority and the health board had been reorganised, so that the geographical areas covered by both audits had changed. She also noted that a further audit had been undertaken in 2013, which however was not the subject of this talk. She explained that the current deprivation measure for Glasgow was SIMD 16 measured against the following domains: income, employment, health, education, access, crime and housing. In 2003, there were 501 alcohol-related deaths per population. A random sample of 65 patients' notes was analysed, and compared with neighbouring West and East Dunbartonshire, North and South Lanarkshire, and East Renfrewshire. 53 deaths in Glasgow were due to alcohol, whereas the other council areas varied from 1–3.

The findings from the 2003 audit, which looked at the differences between men and women, included:

- Women had a much shorter, but more damaging history of drinking
- Total consumption was higher in men than women
- Men used services much more than women (67% - 37 %)
- Men accessed addiction services more than women (63% - 35%)
- GP attendance was higher in women than in men (47% - 21%)
- The most common diagnoses were Alcoholic Liver Disease and alcohol dependency
- Men were more likely to have drug and housing issues (17% - 0%), whereas women had more service contact in relation to their children.

The main recommendation issuing from the 2003 audit was that women-sensitive services should be implemented. Dr Chiang listed the local and national

agencies that have been formed in the meantime:

2004 – Glasgow Addiction Service (NHS & Social Care)

2005 – Acute Addiction Liaison (nurses in A&E)

2006 – Criminal Justice Arrest & Referral Scheme

2007 – Licensing (Scotland) Act

2008 – Alcohol Brief Interventions introduced in primary care

2009 – Persistent Offender Programme introduced

2010 - Alcohol Brief Interventions introduced in A&E.

Moving on to the outcomes of the 2010 Audit and the impact the above measures might have had, Chiang noted that there were fewer alcohol-related deaths (401), but women of all ages and ethnic groups who died of alcohol-related causes, were dying earlier than men. Looking in particular at employment, the audit showed that in so far as the patients had jobs, these generally reflected low education/ qualification levels. Average alcohol consumption was 168 units per week and women started drinking earlier than men. A summary of clinical findings revealed that all values were higher for men than women, but women still died at a younger age. In terms of the support accessed, attendance at different specialties (hospital referral) was very low as most patients only went to their GP. Of the 65 patient cases analysed, 50 patients were registered with Social Work, but only 23 with Addiction services. Only 4 patients had had an Alcohol Brief Intervention.

Chiang ended her talk by saying that although death rates had dropped compared with the situation in 2003, engagement with support services was still poor and more could (or must) be done to reach this cohort of patients.

In the discussion, it was noted that although people in wealthy areas drink as much as those in deprived areas, they don't suffer as much harm; so there are other factors that make drinkers in deprived areas more vulnerable. Eric Carlin (Director, SHAAP) explained that once Minimum Unit Pricing was implemented, SHAAP would commission research to see if it did reduce alcohol harm and whether that contributed to a longer-term reduction in health inequalities. Peter Rice (Chair, SHAAP Steering Group) explained the Alcohol Brief Interventions programme which was part of the Scottish Government's 2009 strategy and noted that the 2010 audit should have shown at least an initial impact of these interventions, but sadly didn't.

One discussant asked if the definition of 'alcohol-related death' was the same all over the country; and if alcohol was cited on death certificates as cause or contributory factor. Chiang acknowledged that this was an important issue as certification of deaths related to alcohol were handled differently, e.g. in Edinburgh and Glasgow. A discussant asked if we were putting up barriers by having drug and alcohol addiction services organised together? Others agreed and noted that in England, general clinics have been set up in hospital outpatient departments which may not carry the same stigma for patients wanting to access help for alcohol dependency rather than drug problems.

One person asked about teenage drinking; Chiang referred to the 2013 audit which showed that there is a cohort of 130 drinkers in Glasgow aged between 14-17 who are not being reached because there

are no specialised services for them. The 2013 audit (not the remit of this talk) showed that there was a younger group of people who started drinking earlier and are dying in their 40s; she would look at this.

In summary, Chiang recommended that early detection of alcohol harms needed to be improved and intervention made more efficient via joined-up thinking of the different services involved.

2017–2018 Seminars

Alcohol and Social Justice

Social justice, alcohol and youth transitions: findings from a case study in Edinburgh

Dr Eric Carlin, SHAAP Director, Scottish Health Action on Alcohol Problems

Monday, 6th November 2017

Introducing the first of the 2017-18 Alcohol 'Occasionals' sessions, Dr Carlin explained that the material for his presentation was drawn from his PhD which was completed in 2017, based on fieldwork done from June 2012 – March 2013 in West Pilton, an area with income deprivation of 35% (compared with 10% for Edinburgh City Centre and 13% for Scotland as a whole). The material was gathered in observation sessions over three months, two discussion groups and semi-structured interviews with 26 young people. They were asked about their experiences in the transition from childhood to adulthood in relation to the following issues, with their attitude to alcohol being only one of many topics raised:

- How did they experience disadvantage and stigma?
- Did they feel the concept of 'social exclusion' was relevant to them?
- Is the concept of 'resilience' helpful to young people?

Carlin emphasised that he entered into the research assuming that young people in W. Pilton are eloquent whose voices need to be heard; that it was important to prioritise

Dr Eric Carlin

their narratives and that as individuals they couldn't be separated from their families, friends and society in general. He started by defining social justice as 'equality of opportunity for people of equal natural ability; where these opportunities are not available, they must be made available'. Youth/adolescence could be defined as a period of 'storm and stress' of the physical, mental and emotional transition from child- to adult-hood.

Compared to the 2014 SALSUS[1] report, attitudes to alcohol of young people in W. Pilton were similar to the general picture in Scotland, although the average young male drinking 10 units (of mainly beer, lager) in the previous week, and the average young female drinking eight (mainly wine, spirits) was far more than the SALSUS average. They confirmed that they mainly procured alcohol from older people and at parties, and that price, and violence or trouble associated with drinking were important issues for them.

1 Scottish Schools Adolescents Lifestyle and Substance Use Survey

Carlin presented a number of case studies of young males and females aged between 16 and 23, where illness in the family was a common theme. Key themes were that drinking was part of everyday life and 'normalised'; that their drinking experiences were diverse and they accepted that as young people they make choices and take risks. There was little evidence of peer pressure, however. Several related that they would drink on the street or in the park because there wasn't space at home; they were aware of the police and that 'trouble' or violence was never far away. To obtain alcohol, they would ask 'older people' or get it from the corner shops, that 'didn't care' (that they were underage). Sometimes they would be expected to help out with criminal jobs in return for being bought booze by older individuals. When asked how much or what they drank, one 21yo male said he would drink 20/22 bottles of Stella in one night, while two females aged 18 and 19 would pre-load at home, then go to pubs/clubs and finish up at a house-party. Both males and females reported looking out for each other as they were aware of potentially dangerous individuals in their neighbourhood. One 20yo female reported that she started drinking (white cider on the street) at the age of 14/15 but had stopped drinking when she became pregnant.

In summary, Carlin recommended that research into young people should prioritise their own perspectives and recognise all aspects of their lives; and suggested that in terms of policy, action needed to be taken on price, availability and marketing of alcohol, as well as action taken to reduce stigma and prejudice.

In the ensuing discussion, questions of safety and resilience, as well as 'victim-blaming' were raised. In terms of stigma, young people's attitudes were complicated: on the one hand, they bought into society's (negative) prejudices about the area they called home; on the other they were proud of being 'from there' and felt they would have 'distanced themselves' from their origins if they moved away.

Alcohol-related deaths 2013 – a Glasgow City cohort

Stephanie Dargan, Research Assistant, Glasgow Alcohol and Drug Recovery Service

Monday, 4th December 2017

Dargan began by putting her presentation into the context of the recent decision by the UK Supreme Court allowing Scottish MUP legislation to be implemented in 2018 and the social media reactions, which showed that particularly people affected by alcohol harm understood that this policy will help seriously ill patients. Currently alcohol kills 24 people per week in Scotland with the ensuing damage to families and communities, the economic cost and the resultant crime. The Alcohol-related Deaths Report 2013 carried out by Glasgow City Health & Social Care Partnership showed that there were 189 deaths in Glasgow compared with 86 in Edinburgh and 29 in Dundee (average Scotland mortality: 22.1). This has to be seen against the background of wealth inequalities: almost half the population of Glasgow lives in the 20% most deprived areas, compared with 4.4% of the average Scottish population living in the 10% most deprived areas (2016 figures), while 34% of children in Glasgow live in poverty.

Dargan outlined the following research objectives:

1 Identify key factors for alcohol-related deaths

Stephanie Dargan

2 Identify the patients' journey through treatment services and the role of these services in identifying and managing the patients; and

3 Identify patients' engagement with these services and what factors may lead to involvement breaking down.

56 cases were selected, stratified by age and gender (77% = men; 23% = women), from primary care case notes, deemed to be representative of the 189 deaths in 2013 and of comparable research. 96% had problematic alcohol use identified in their notes, with 32% recorded before the age of 25. 71% were recorded as daily drinkers, while 56% were recorded as dependent drinkers. On average this cohort drank 233 units of alcohol per week, the equivalent of 4 bottles of vodka. Dargan noted that the poorer the patients, the cheaper the alcohol they used. Tailored questions revealed that many social and cultural factors were at work in their lives, and she provided revealing quotes from

the patients to illustrate their personal situations:

- Family life & relationships: 41% reported having positive childhood memories, whilst under a third recorded that the death of a parent had contributed to their drinking and 38% reported a strained relationship with their parents; 43% had experienced problematic drinking within the household.
- Co-morbid conditions & mental health: the most prevalent were depression (21%) and diabetes (14%), followed by hypertension (11%) and anxiety (7%). Other records reported depression at higher levels (29%), so it can be assumed that the GP notes used for the research reflected under-reporting. 21% of the cohort reported self-harming, while 41% reported having suicidal thoughts.
- Education & employment: 32% had schooling recorded in their notes as being an issue, with over half of these associating education with truanting, 'trouble', substance misuse and expulsion. Almost all had been employed at one time in their lives, but at the time of death, 71% were long-term sick and/or unemployed. Alcohol was identified as a factor in losing a job.
- Housing/homelessness & social isolation: 55% of the cohort lived alone and 66% of the case notes reflected social isolation, although only 16% mentioned this directly. Several individuals had stayed in homeless accommodation and preferred it because they felt safer there and had social contacts. 38% had experienced problems sustaining a tenancy, with some of these making contact with Housing Services for help.

Dargan noted patient involvement with the following services:

1 Primary care services: 95% had alcohol recorded in their GP case notes; 89% had been given advice in relation to this by their GP and 63% had been referred to treatment services – but there was little evidence of follow-up.

2 Alcohol treatment services, including community addiction support and mental health services, clinical psychology: 71% of the cohort reported ever being in contact with an alcohol treatment service.

3 Acute/emergency services: 95% of the cohort had been in contact with an acute service within three years of death, with the most prevalent condition reported being Acute Liver Disease.

Before concluding her talk, Dargan outlined the case study of 'Joe' which served to put a human face on much of the data she presented. In conclusion, she shared the 25 recommendations from the research that were based around key themes of: education and prevention/information-sharing and IT systems/social isolation/ the role of voluntary services/routine monitoring of the impact of alcohol-related deaths. More detailed recommendations were made in relation to the services the cohort had contact with, i.e.: primary care/ social work/mental health/treatment & care/ acute services. These would be presented to NHS Glasgow and Dargan, along with colleagues Dr Catherine Chiang and Dr Iain Smith, would undertake an audit of how services have changed and data has been collected since 2013.

In the question and answer session, one recurring theme was why there had been little/no follow-up by primary care and/or specialist services; there could be many reasons for this, e.g. it could be that GPs wanted to protect

their patients and not endanger their good relationship; alternatively patients may self-protect by concealing the true extent of their alcohol use. It was also noted that the nearer the patients come to death, the more contact they would be likely to have with acute services due to the accelerated deterioration of their health. Similarly, if they self-report, e.g. direct to addiction teams, they will bypass their own GP. Other issues related to alcohol-inflicted violence which almost always affects women; and the extent of mental health issues caused by alcohol dependence, which are often not treated with psychological interventions, despite NICE recommendations. Finally, the question was raised as to why it is so difficult to retain patients once they have presented to a service; this may in part be due to barriers, such as the '3-point test' or patients having to stop abusing alcohol/drugs before being eligible to access further treatment, which leads to 'patient dropout'. In this connection the use of 'wet houses' was raised which exist in some cities (e.g. Glasgow) and Aberdeen (now closed).

In concluding the session, SHAAP Director Dr Eric Carlin thanked Dargan for her moving presentation which showed that the 'statistics' are always real people with real lives; and that joined-up thinking, which is often lacking, is essential to achieve an improvement in the care and treatment of patients with alcohol-related conditions. Finally he suggested that it would be useful for the Scottish Government to consider the recommendations of her research for their forthcoming review of alcohol treatment strategies.

The challenges and opportunities of doing socially just research in unjust spaces

Victoria Troy, PhD student, Glasgow Caledonian University

Monday, 29th January 2018

Troy introduced herself as a researcher studying for her PhD in the Department of Psychology, Institute for Applied Health Research, School of Health & Life Sciences at Glasgow Caledonian University. She began by asking: what is social justice, why should we care and how can research be socially just; and outlined the background to her PhD which she hoped was a practical example of how to do socially just research in unjust spaces. She quoted philosophical, religious and Enlightenment definitions of social justice, involving freedom – but with responsibility, and finding a balance between those who are wealthy and those who are not. She offered further quotations as to why we should care, e.g. Bryan Stevenson who noted that the unfair distribution of wealth led to health inequalities due to socio-economic constraints, discrimination and class. She also quoted Karl Marx and Martin Luther-King who believed that understanding society should lead to attempts to change it for the benefit of all, and challenge power, privilege and oppression.

The next question is how to achieve justice in social work practice, which in

Victoria Troy

Troy's opinion is well answered by Bertha Reynolds[1], an American social worker, who said that:

- People should be treated as human beings, not problems
- They should be treated with compassion, not condescension
- We should recognise that everyone has the capacity to contribute to society
- There should be no conditions attached to the provision of support.

Troy argued that conducting socially just research involves challenging prevailing assumptions about power, privilege, and oppression in the theories that underlie current policies, programmes, and practice.

Moving on to the background and rationale of her PhD, Troy explained that she was interested in the consequences of mothers being in prison and how to support them and their families. Parental imprisonment

1 Reynolds, B. C. (1951). *Social work and social living*, New York: Citadel Press

can have negative consequences for the parent, their children and other outside family members. There is often more disruption to families when a mother is imprisoned and this can exacerbate the difficulties for everyone involved because when mothers are in the criminal justice system, it is the children who suffer due to disruption of parenting, more so than if the fathers are in prison. She noted that there were parenting and family support programmes in operation across the world, which help to maintain family relationships and may lead to better outcomes for all when the parents come out of prison. However, the research into the effectiveness of such programmes is limited. So the purpose of Troy's PhD was to conduct a systematic review[2] to establish how to make such programmes socially just, i.e. not only whether they were effective but how the participants viewed them and to find out if they felt they were 'appropriate' and 'meaningful' for them. In addition, the PhD would try to identify the needs of mothers in the criminal justice system; identify facilitators and barriers to the uptake of such programmes; and suggest recommendations for making such programmes effective, meaningful and appropriate for the participants.

The methodology involved the use of 'Photovoice'[3] which allows participants to take photos illustrating their emotions/ family situations which then form the basis for interviews, as part of a Participatory Research paradigm often used with marginalised or disempowered societal groups. Troy approached various criminal justice, social work and third sector agencies to recruit participants, and after an introductory meeting, individual interviews were conducted in a variety of settings using the participant-generated photographs. Giving an overview of the findings, Troy noted that the mothers reported mental health issues, substance abuse, relationship problems, housing issues, poverty, trauma, stress, domestic abuse, self-criticism and self-harm. Asked whether they felt that support programmes addressed their needs, they said that many were based on a crisis management model whereby the support was perceived as being 'too little, too late'. Moreover, findings suggested it was more 'surveillance than support'; that the mothers had no power in decision-making; that the programmes did not address the underlying causes of their problems, e.g. alcohol abuse; and that they weren't listened to. In conclusion, these findings identified barriers and facilitators which could be incorporated into future research and support programmes to make them more socially just for the participants.

Following Troy's presentation, it was asked how this could be achieved. One answer might lie in more active engagement of practitioners and policy makers, e.g. appropriate training for social workers. Another detrimental aspect was felt to be the 'tick-box' nature of many programmes which did not suit the needs of individual participants, e.g. if the latter felt that reducing their drinking would help to reduce their dependence, then they should be supported in doing that, rather than become completely abstinent if that was not what they wanted. It was noted in this context that minimum unit pricing of alcohol will help the most socially disadvantaged harmful drinkers and can therefore be viewed as a socially just intervention, whilst not being coercive.

2 Troy, V., McPherson, K.E., Emslie, C., & Gilchrist, E. (2018). *The feasibility, Appropriateness, Meaningfulness, and Effectiveness of Parenting and Family Support Programs Delivered in the Criminal Justice System: A Systematic Review.* Journal of Child and Family Studies.

3 Wang & Burris, 1994. *Empowerment through photo novella: portraits of participation.*

Other factors that work against support programmes being regarded as appropriate were lack of time, and trust, given the power dynamics between clients and agencies. Other barriers to socially just research were named as ethics committees, gatekeepers and the uses to which research might eventually be put – not necessarily in the interests of the mothers and children. In conclusion, Troy noted that the system doesn't support the philosophy we would like to underpin research: often the system tries to fix the people, rather than the problems which caused them to lose control over their lives. The language we use and how we frame the issues is crucial if we are to conduct socially just research.

Alcohol harm reduction through a social justice lens: lessons from Canada

Professor Bernie Pauly, Canadian Institute for Substance Use Research, University of Victoria, British Columbia

Monday, 12th March 2018

Professor Bernie Pauly

Introducing herself, Professor Pauly noted that her nursing background helped her to see the addiction problems of indigenous populations in Thunder Bay, British Columbia, where communities are ravaged by the harms of addictions as a result of displacement. Severe alcohol dependence among homeless, male populations is found to be between 8 and 58%, whereas the global figure is 3-4%. As wealth inequality increases, so do the harms homeless people experience: poisonings, stigma, assault, violence, injuries, weather exposure and death. They are even literally 'left out in the cold', so that when two homeless males died 'freezing deaths' in Toronto in 1998, the coroner directed that programmes should be set up to prevent this in future.

Pauly explained that she carried out the Canadian Managed Alcohol Program Study (CMAPS) with a team of researchers from the University of Victoria's Canadian Institute for Substance Use Research, to assess Managed Alcohol Programs (MAPs) in Canada. The purpose of the research was to rigorously evaluate these programmes with a focus on outcomes and process; and to answer the question whether such programmes reduce consumption, alcohol-related harms, improve housing tenure, health and quality of life and reduce economic costs.

The methodology comprised of quantitative surveys, both monthly (28 days) or longer-term (6 months), analysing programme participants who were either new to the programme, long-term participants or controls; qualitative work consisting of 13 case studies with interviews; and site visits to describe existing MAPs. Eligible clients were those who had a history of binges, chronic homelessness, and high levels of contacts with police and the criminal justice system. She noted that prior to 2016 there was no research in this area with multiple programmes or control groups.

Homeless addiction services comprise of three different types in the shelters: 'Dry', where abstinence is required; 'Tolerant', where drinking is allowed, but not managed; and MAPs, where clients are provided with alcohol in a managed way.

Pauly offered the following definition for MAP: 'A harm reduction program offering regularly dispensed and/or administered sources of beverage alcohol alongside accommodation and other programming to prevent alcohol related harms by reducing consumption of non-beverage alcohol, binge drinking, and public intoxication'[1].

In 2009, a strategy was initiated across Canada whereby alcohol was given to addicts to help them control their lives and prevent harms. Today, there are 22 managed alcohol programmes in 13 Canadian cities, from Toronto to Vancouver; CMAPS covers 10 projects in seven cities. The four pillars of MAPs are:

1 Provide a safe source of alcohol and regular, dosed amounts to clients, including food; and use of protocols to assess intoxication and outside drinking

2 Provide safe settings which are supportive, transitional and can be on an emergency basis, providing security to clients

3 Monitoring health of clients through primary care and access to social services

4 Aiding social and cultural reconnect, e.g. community or native population elders may be present.

The pilot studies compared two centres: the Kwae Kii Win Centre in Thunder Bay with 18 indigenous males and females; and Station Street, Vancouver (7 participants). Outcomes demonstrated that safety was very important to the participants who said that "MAPs was safer than being on the street, in jail or shelters". They associated housing with home and hope, and in Kwae Kii Win Centre, clients reported 43% fewer police contacts, 47% fewer hospital admissions, a 70% reduction in the use of detox services and an end to social isolation. In both centres, non-beverage alcohol drinking was reduced and drinks were consumed in safer settings; however, in Vancouver for some participants, alcohol consumption went up over six months and liver function deteriorated for most clients, whereas in Thunder Bay, consumption results were mixed but liver function improved for most indicators over the same period.

Overall, research carried out by Pauly and Tim Stockwell found that for every Canadian dollar invested in MAPs, between $1.09 and $1.21 was saved in terms of the costs of addressing health, social and criminal justice harms.

From the studies, Pauly noted that the harm reduction goals of MAPs had largely been met and self-reported data showed that MAP participants experienced fewer physical and social harms than those not on the programme; they had fewer hospital and police contacts and drank on more days but less overall. At six months, 90% were still being followed up. Recommendations for future interventions included: clear eligibility criteria; chronic harms, e.g. liver function tests, could be monitored; and the potential risks of heavy drinking explained to participants with the amounts administered adapted to take account of this – or prevent the worst harms.

In the ensuing Q&A session, the issue of 'unintended consequences' of minimum unit pricing (in Canada and Scotland) was discussed, whereby Pauly said that the lives saved through these programmes will still outweigh the negative impacts. She regarded as weaknesses of MAPs that there was no 'social context' attached to them and very little gendered data. Asked about the reaction of local communities

1 Pauly et al., 2018. *Community managed alcohol programs in Canada: Overview of key dimensions and implementation.*

and the media to such programmes, Pauly said that the media reaction had been broadly ‘favourable’ and the public were not necessarily aware of the programmes. In a broader societal context, she pointed out that the Justin Trudeau government elected in 2015 had overseen a ‘culture shift’ in policy towards harm reduction, e.g. with drugs, the introduction of supervised injection sites and the legalisation of cannabis. She also noted the impact of MAPs on drinkers’ families, where some centres encouraged family visits and phone calls, in re-establishing the family connection.

In conclusion Pauly noted that future evaluations of these programmes would look at what is most effective, and develop programmes in conjunction with users who have previously been told ‘just to stop’.

Accounting for harms: the role of qualitative sociology in social justice approaches to alcohol and suicide

Dr Amy Chandler, Chancellor's Fellow in Health, through Arts, Design and Humanities, School of Health in Social Science, University of Edinburgh

Monday, 23rd April 2018

Dr Amy Chandler

Introducing her study, which was funded by Alcohol Research UK (ARUK), Chandler outlined the themes that she would cover in her presentation:

1 How does social justice impact on alcohol and suicide?

2 Silences re qualitative work – lack of research into alcohol use and suicide

3 Alcohol stories – case studies

4 Epistemic injustice.

Chandler explained that the link between alcohol use and suicide was well-established: according to the Samaritans (2014) suicide is eight times more likely if alcohol abuse is involved, partly because it reduces inhibitions and increases impulsive behaviour, mood swings and depression; and studies show that the links are more prevalent in deprived areas. Regarding the social justice aspect, the increased prevalence of inequities is socially patterned (Whitehead 2007; Smith, 2017), i.e. there are more hospital admissions in SIMD 5 (most deprived) areas, meaning that suicides are potentially avoidable. Self-poisoning by alcohol is the second most likely cause of suicide.

Mark Button (2016) argues that alcohol abuse and suicide can be seen as a 'solitary' answer to an undignified, inhumane existence. Sociological work on intersectionality (Collins & Bilge, 2016), e.g. gender, ethnicity and nationality, considers that alcohol and suicide are the effect of and response to structural inequalities and oppressions – e.g. black women experience more discrimination and income inequality than others. Research by Darwishi et al (2015) looks at suicide ideation, attempt and completion and finds strong evidence for the role played by alcohol, even when controlling for other social factors. Kaplan et al (2016) examine the link with alcohol in more depth, and note a rise in male suicide rates after the US financial crash of 2008. It seems that women may have more resilience; the control group showed no

higher use of alcohol than those who died, but with men, the relationship with alcohol is much more significant. Norström & Rossow (2016) conducted quantitative research into gender differences and cultural variation, but more empirical evidence for a cause/effect is needed in Chandler's view.

Bagge et al published research in 2015 which identifies that alcohol is used to disinhibit people wishing to commit suicide, and to facilitate the act. Chandler presented some 'alcohol stories' from case studies assembled by ARUK from ten males, aged 38-61 years who had self-harmed and had suicidal thoughts, from semi-rural, ex-mining communities, some of whom had been in touch with mental health and/or primary care services. These men corroborate the research from their own experience, or that of people they know, saying alcohol … "lowered that inhibition" and gave them "the courage to do it"; and "alcohol would certainly help" because… "it's the doing it that's the problem". Regarding alcohol and self-harm, one said "when you take the drink, you feel that bit braver".

Finally Chandler talked about 'epistemic' injustice, documented by Miranda Fricker in her 2007 book (OUP) *Epistemic injustice: power and the ethics of knowing*. This comprises both 'testimonial injustice', meaning that the accounts of individuals inhabiting particular social identities are not heard or even sought, i.e. they don't have a 'voice' and are therefore not supported properly in their specific needs; and 'hermeneutic injustice', i.e. the language does not exist or is not made available for certain groups such as women, BAME and LGBTQ+ people, to express their experiences. Chandler argued that better qualitative research is required to enable these voices to be heard in a meaningful and non-judgmental way. Research by Saunders et al (2012) has revealed, for example, negative attitudes among A&E staff towards self-harming patients where alcohol is involved. Sometimes, patients' accounts are deemed 'untrustworthy' or taken 'at face value', and not followed up with further in-depth probing.

In conclusion, Chandler reiterated that alcohol use and suicide is a matter of social justice, for which there is a huge amount of evidence; and the type of research used is also a matter of social justice. Such research must be multi-disciplinary, using a range of methodologies and methods.

In the ensuing discussion, it was noted that finding out where these people are is essential to understanding their context and supporting them better. It is therefore important that agencies/researchers build trust with them, so that they feel able to talk about their experience and then these conversations will form a basis for better qualitative research. It is important not to 'dehumanise' or 'institutionalise' these people, especially if they are in hospitals or prisons; are they 'hard to reach' or are the services which should help them, hard to reach? The point was also raised in this context of the lack of 'joined up services'. Eric Carlin, SHAAP Director, noted that SHAAP was currently conducting a small piece of qualitative research into the lived experience of harmful alcohol users which reveals that this group has a clear need to talk about these issues in a safe and non-judgmental environment and to express themselves in their own language. Concluding the session, Chandler noted that this is social capital, which all researchers, support services and harm reduction advocates have a responsibility to identify and preserve.

Drunk and doubly deviant? Gender, intoxication and assault: An analysis of Crown Court sentencing practices in England and Wales

Dr Carly Lightowlers, Senior Lecturer, Department of Sociology, Social Policy and Criminology, University of Liverpool

Monday, 28th May 2018

Dr Carly Lightowlers

Underpinning Lightowlers' research is the contentious question of how alcohol and gender influence sentencing practices in England and Wales, and whether male and female defendants are treated equally where intoxication is involved in assault crimes. Given that alcohol-related violence is generally considered to be a 'male' crime, she wanted to find out whether female defendants were more likely to be given a harsher, or longer, sentence than males; and if this were true, how it could be squared with the notion of social justice.

Lightowlers noted that different legal systems deal differently with intoxication-related crimes and that the literature is traditionally focussed on sexual assault of women as victims, where societal assumptions about gendered behaviour in terms of blameworthiness come into play. The judiciary is largely male and middle class, and social norms around gender and intoxication are likely to influence sentencing decisions; female consumption of alcohol is often judged differently from that of males.

The data analysed by Lightowlers were provided by the CCSS (Crown Court Sentencing Survey), inaugurated in October 2010 and capturing information on over 30,000 assault sentences handed down between 2011 and 2014, of which 9.25% or 2,855 were dispensed to females. Monitoring operation and effect of sentencing, the outcomes noted whether a custodial sentence was handed down, and if so, for how long; and also what factors were taken into account when determining the sentences, i.e. the type of offence; whether the defendant pled guilty; previous violent offending; age; gender; and mitigating or aggravating circumstances. The methods Lightowlers used were binary logistic regression (this allows for an assessment of contributory factors that make a custodial sentence probable) and ordinal logistic regression (this allows for an assessment

of the factors which contribute to the severity of the sentence), controlling for the above factors. The models also allowed for consideration of the extent to which gender moderated the sentencing outcome with intoxication present.

The results showed that nearly one-quarter of all assault offences for both male and female defendants cited intoxication as an aggravating factor. 'Being under the influence' aggravates sentencing outcomes, in terms of the probability of a custody and lengthier sentences. Whereas in general, female defendants receive fewer and lower custodial sentences than men for assault crimes, her work shows that the 'uplift' is greater in the sentencing of female defendants compared to males where alcohol is involved. Where no intoxication is involved with Actual Bodily Harm offences, the probability of a more severe sentence for men increases by 49%, whereas for women it is 30%; however, once alcohol is involved, these rates rise to 55% for men whilst for women it rises to 43%, i.e. a 13% 'uplift' – or double that for their male counterparts, hence the 'doubly deviant' of Lightowlers' talk title.

Conclusions from Lightowlers' research include that intoxication remains a contested factor in sentencing; less leniency is afforded to females where intoxication aggravates the assault offence; more methodological precision is required in studies looking at how gender impacts on sentencing practices, especially where alcohol is involved. Looking forward, Lightowlers noted that the CCSS survey was discontinued in 2015; she argued that intoxication as a contentious sentencing factor requires more investigation as well as more in-depth, qualitative understanding of how gender and alcohol influence sentencing, and how sentencing decisions around these factors are arrived at (e.g. by judges, lawyers, pre-sentence reports) and what theories about alcohol and gender play into them.

In the ensuing discussion, many questions raised about sentencing practices elicited the response from Lightowlers that no data are collected about some specific, relevant factors. For example, data on whether female offenders are mothers with childcare responsibilities are not collected (although the responsibility as primary care-giver is cited in sentencing guidelines and captured in the CCSS) – which could influence sentencing from a social justice point of view, especially where custodial sentences are involved. Similarly, it would be useful to collect qualitative data on vulnerable women re-offending where intoxication is involved so that their complex needs could be addressed. Likewise, there are no data on whether medical or psychiatric reports are requested prior to sentencing, although this could be included on a checklist of factors to consider before deciding on the sentence. Other questions raised were about how judges' own attitudes feed into sentencing decisions where it is clear they have their moral systems about who is 'deserving' or not (are women 'troubled' or 'troubling'?). This is not monitored and does not translate into hard evidence, as 'interpretation' and 'discretion' are subjective concepts. Other issues raised concerned levels of intoxication (how drunk is drunk?), and whether age and socio-economic status of defendants are considered.

In summary, it was agreed that all these areas would benefit from much greater scrutiny and especially qualitative research, in order to achieve social justice in sentencing of defendants where assault offences are impacted by alcohol and gender.

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