A Qualitative Study of the Views of Alcohol Frequent Attenders at Royal Alexandra Hospital, Renfrewshire

Ken Barrie, Dr Mathis Heydtmann & Richard McKean

UNIVERSITY OF THE WEST of SCOTLAND UWS

Renfrewshire Health & Social Care Partnership

NHS Greater Glasgow and Clyde

SHAAP

SCOTTISH HEALTH ACTION ON ALCOHOL PROBLEMS

www.shaap.org.uk

A Qualitative Study of the Views of Alcohol Frequent Attenders at Royal Alexandra Hospital, Renfrewshire

Ken Barrie, Senior Lecturer, University of the West of Scotland (UWS)

Dr Mathis Heydtmann, Consultant Hepatologist, formerly at
Royal Alexandra Hospital,
NHS Greater Glasgow and Clyde (NHSGG&C), now at NHS Dumfries & Galloway

Richard McKean, Research Assistant, UWS.
Clinical Nurse Specialist, East CAMHS, NHS GG&C.

March 2023

Acknowledgements

For participation:

The time and effort given by the study participants in sharing their experiences and their opinions on services, is greatly appreciated.

For significant effort in assisting with participant recruitment:

Ashley Barclay, RMN, Specialist Addiction Outreach Nurse. Alcohol Liver Frequent Attenders Service.

Katie Ettles, RGN, Specialist Addiction Outreach Nurse. Alcohol Liver Frequent Attenders Service.

Royal Alexandra Hospital. NHS Greater Glasgow & Clyde.

For transcribing:

Alison Fitzpatrick, School Executive Assistant, School of Education & Social Sciences

University of the West of Scotland.

For funding and feedback:

Scottish Health Action on Alcohol Problems (SHAAP)

Contents

Executive Summary **5**

Background **8**

Rationale **11**

Methodology **11**

Participant Recruitment **12**

Ethics **13**

Procedure **13**

Data Analysis **13**

Results

Demographic findings **14**

Qualitative findings **18**

Overarching themes:

A. Gender **19**

B. Harmful and dependent drinking **20**

C. Motivation, self-efficacy and locus of control **21**

D. Mental health **21**

E. Physical health **23**

F. Family and relationships **24**

G. Livelihood and employment **25**

H. Justice system **26**

I. Service perspectives **26**

Discussion **29**

Limitations **35**

Recommendations **35**

Conclusions **38**

References **40**

Appendices **48**

4

Executive Summary

Introduction

Conducting this study in the West of Scotland was relevant given the significant impact of alcohol consumption, the level of health inequalities and the distinct nature of the population compared to other similar studies. The study was informed by inclusivity, patients' voices and service enhancement agendas.

Around 20% of those hospitalised consume alcohol to excess, half of whom are alcohol dependent, representing a major challenge to the NHS. Men predominate in this population, but the experiences of women are significantly different and require consideration. Close to these studies into people who are known as "Alcohol Frequent Attenders" (AFAs) in academic literature, are those studies which investigate alcohol related deaths. Studies on wholly-attributable alcohol related deaths suggest a similar profile to AFA. The implication therefore is that effective responses to AFA may reduce alcohol related harms and in turn impact on wholly-attributable deaths.

Methods

Twenty alcohol frequent attenders (AFAs) (seven female, thirteen male) were interviewed using a semi-structured interview (SSI) schedule to gather information about their alcohol-related problems, their reasons for attending hospital services, and to gain their views on their use of services.

A thematic analysis was conducted on recorded and transcribed participant interviews, and the over-arching themes, which affected most participants, were identified. In addition, a content thematic analysis was conducted for gender.

AFA was defined as people who made at least ten Emergency Department (ED) attendances in the previous year or three hospital admissions in the previous three months. Participants were purposefully recruited from the Alcohol Liver Frequent Attender (ALFA) nurse project of the Renfrewshire Health and Social Care Partnership (HSCP) in collaboration with the NHS Greater Glasgow and Clyde Royal Alexandra Hospital (RAH) Paisley, Scotland. Data were collected during COVID-19 restrictions in 2021.

Findings

Demographic data suggested that participants appeared to be relatively stable compared to those reported in other UK studies on alcohol frequent attenders. Consistent with local demographics, none reported current homelessness although levels of unemployment were relatively high. Alcohol dependence levels were measured using the Leeds Dependence Questionnaire (20% high, 50% medium, 30% low dependence), which, for some, implied active use of behaviour change processes and engagement with support services.

Over-arching themes, identified from thematic analysis, were:

- Gender
- Harmful and dependent drinking
- Motivation, self-efficacy and locus of control
- Mental health
- Physical health
- Family and relationships
- Livelihood and employment
- Justice system
- Service perspectives

Recommendations:

Gender

Careful analysis of the role of gender in this study identified that, within AFAs, two distinct populations were identified, which were broadly divided on gender lines. Women reported drinking in the context of a mental health crisis and men reported physical deterioration, through chronic drinking problems.

Mental health

All participants referred to the impact of their mental health on their alcohol consumption. Women, in particular, spoke of negative experiences of out-of-hours mental health assessment, describing being sent to places of emergency assessment only to be turned away, leading to frustration. Given the strong association with mental health crisis in this study, services should review their provision, particularly for women with alcohol problems who are in crisis.

Family

Study participants indicated that the negative impact of problem drinking in families was significant across generations. However, participants noted the support of families and significant others in their recovery. Development of family/significant others' support and information services are recommended.

Mutual Aid

Recovery communities and mutual aid form a significant dimension of recovery from alcohol related problems, often in the absence of formal treatment. Based on a significant body of supporting evidence (Tonigan et al,. 2018), and reports from a substantial proportion of study participants, dependent drinkers should be informed of, and encouraged to consider mutual aid/Alcoholics Anonymous participation.

Alcohol-related Liver Disease

Study findings supported SHAAP (2018) "Alcohol-related liver disease: Guidance for good practice", particularly in relation to the need for follow-up to prevent frequent re-attendance, and to develop services for people who decline engagement with the usual services.

Service Design

AFAs represent a population of long-term, harmful and dependent drinkers, who present with wide-ranging and complex needs, sometimes in crisis. Their impact on both ED and hospital admissions is very significant (Blackwood et al., 2021). In light of these findings, it is recommended that consideration be given to designing a dedicated service effectively for the complex needs of AFAs and to support recovery. Such services should take account of study findings particularly with reference to gender, mental health and trauma.

Service network

Service signposting might assist AFAs to access services other than the NHS, particularly if hospital attendance is not in the best interests of the person. Therefore, better links between services, and help to navigate these, should be considered by the Alcohol and Drug Partnership (ADP) to help frequent attenders.

Many participants have missed the opportunity to access what can be regarded as ‘social prescribing’, which would have helped them in their recovery, and the COVID-19 pandemic has been a significant barrier to accessing such interventions. It is evident that for many people in recovery, social interaction with their peers in non-drinking environments was valued. For this very vulnerable group online replacements of interactions were very unpopular.

Research recommendations

Continuing evaluation of NHS records to identify AFAs in real time and their follow up through the health and care systems has previously been recommended (Blackwood et al.2021).

Participant numbers were appropriate for this qualitative study. However, a larger cohort study and further participant follow-up would add to knowledge about this group. The findings of this study were broadly consistent with similar studies on AFA populations in the UK.

As women spoke more about disengagement from the Community Mental Health Team (CMHT), further research could specifically examine support for women with alcohol problems and mental health issues (Jemberie et al., 2022).

Given the variety in definitions (Black & Gill, 2016; Blackwood et al., 2021; Dargan 2013; Neale et al., 2016), care must be taken to clarify the AFA group concerned and the implied relevant interventions. Such definitions imply differing characteristics, particularly in relation to age, gender, homelessness and the potential variety of substances used. It is concluded that a consensus on a very reactive definition of frequent attenders will be important for future research.

The change to telephone interviews because of COVID-19 restrictions in this study is relevant and the future of addiction research may be shaped by the pandemic. As a result, remote methods for interview and assessment could be used more often, which will enable access to different populations (Englund et al., 2022).

In this qualitative study the Alcohol Liver Frequent Attenders (ALFA), project, at RAH, has not been evaluated with regard to its service objectives.

Background

Hospital Admissions

A systematic review/meta-analysis of the impact of alcohol on NHS England concluded that 20% of those hospitalised were drinking to excess and that 10% were alcohol dependent (Roberts et al., 2019). The Scottish Public Health Observatory (ScotPHO, 2018) reported that, in 2015, over 41,000 adults aged over 16 were admitted to hospital in Scotland at least once, with a wholly or partially alcohol-attributable condition: men outnumbered women by 2:1.

In a cohort study using routine administrative data, based on the England national data set for the NHS, Blackwood et al. (2021) concluded that people with repeated admissions for alcohol-related problems, appeared to be a “high-cost, high-need, complex group of patients” that made up more than a quarter of England’s alcohol admissions. Measures, from administrative records, showed a higher number of admissions, occupied bed days, average length of stay and total admission costs over a five-year period, among AFAs, (with wholly attributable alcohol related diagnoses), when compared to non-alcohol and non-frequent admissions. In addition, costs did not account for mental health in-patient, community health, ambulance, outpatient or accident and emergency care associated with AFAs.

Emergency Department (ED)

A service improvement project at the Glasgow Royal Infirmary ED showed that the top eighty frequent attenders (of almost 100,000 attendances) accounted for 1.95% of total attendances and comprised many individuals with experience of substance misuse, alcohol misuse, mental health issues and homelessness (Kyle et al., 2021). In England, Neale et al. (2016) conducted qualitative research with frequent attenders (ten or more attendances in one year) at ED (gender ratio: 1.5:1 male-female). They concluded that those attending for alcohol-related reasons, “tend to experience alcohol dependence associated with multiple and complex needs, but also report diverse patterns of drinking and other substance use, and varied health and social problems.” The need for help with practical issues regarding homelessness, accommodation and finance was identified. In the same series of studies, Parkman et al. (2017) reported both push and pull factors contributing to frequent ED attendance: “push” factors related to individual level problems and limitations of community-based services, whilst “pull” factors were associated with positive experiences of, and beliefs about, ED care.

Health professionals report that responding effectively to AFAs is difficult: Neale et al. (2016) proposed service improvements in the form of assertive outreach and discussed this in staff focus groups. This was supported by the staff participants of these focus groups, as a solution to a particularly challenging set of patients and circumstances, with which ED staff felt ill-equipped to deal. This was further developed by Drummond et al. (2018) who proposed “assertive outreach for high-need, high-cost alcohol related frequent NHS hospital attenders”.

Stigma is a significant aspect of this patient group's presentation. In particular, liver disease patients, drug injectors, as well as problem drinkers, experience significant stigma and inequity in accessing appropriate care (Manns et al., 2018).

Alcohol-related Deaths

In 2020, rates of alcohol-specific deaths in Scotland were 2.7 times higher than in 1981. In 2020, 1,190 people in Scotland died from a cause wholly attributable to alcohol. This equates to an age-sex standardised alcohol-specific death rate of 22.0 deaths per 100,000 population. In 2020, the alcohol-specific death rate for men was more than twice that for women (31.3 deaths per 100,000 population for men compared with 12.7 deaths per 100,000 population for women). Rates vary with age, the highest being in the 55–64-year age group (53.2 deaths per 100,000 population): the rate in this group was more than 30% higher than the rate for any other age group. In addition, in 2020, rates of alcohol-specific deaths were nearly five times higher in the 10% most deprived areas in Scotland than in the 10% least deprived areas. Alcohol-specific death rates are consistently higher in Scotland than in England and Wales, (Public Health Scotland, 2022).

In Glasgow, Dargan (2013) studied a random selection of fifty-six alcohol-related deaths (out of 189 in the study area in one year). Almost all of the cohort was "White Scottish" (gender ratio 3:1 male-female) and over one-third of those who died were aged between 45 and 54; 86% of the sample lived at home. Alcohol problems were recorded in 96% of case records and dependence was recorded for 56% of the cohort, over 40 % had a close relative with an alcohol problem, 55% had been prescribed anti-depressants and more than 70% were unemployed at the time of death. In the Edinburgh "ill drinkers" study (Black & Gill, 2016), subjects were drawn from both acute and specialist alcohol services and there was a 16% mortality rate in the cohort over the two-year duration of the study. The mean age at death was 51 years; however, the mean age of death for women was lower, but not statistically significant. The gender ratio was 3:1 male-female). Regional differences with regard to levels of alcohol/drug use and self-reported mental health conditions when comparing Glasgow and Edinburgh were noted. Women in Glasgow reported significantly more mental health conditions than men (Black & Gill, 2016).

Puddephatt et al. (2022) noted associations between common mental disorders and alcohol use in the adult general population. People with common mental disorders (depression, anxiety and phobia) were twice as likely to report an alcohol use disorder as people without common mental disorders. Mental health issues are a characteristic of alcohol frequent attenders at both ED and hospital admissions (Black & Gill, 2016; Neale et al., 2016: Kyle et el., 2021). In a Swedish study of 1,741 people (28% female), aged over fifty, at risk of recurrent hospitalisation, because of problem alcohol use and multiple needs, an integrated focus on substance use and mental health was recommended (Jemberie et al., 2022).

Gender

In the general population, male alcohol consumption is greater than that of women both in terms of frequency and amount consumed, per drinking session. In the Scottish Health Survey (2019) drinking more than fourteen units a week was reported by 32% of men and 16% of women. Men drank an average of 15.5 units of alcohol a week, and women drank an average of 8.8 units a week. This is reflected in a wide range of alcohol service settings, including studies on alcohol related mortality, where male-female gender ratios commonly range between 2:1 and 3:1, (Black & Gill, 2016; Dargan, 2013; Neale et al., 2016). In 2020, in Scotland, women died from a cause wholly attributable to alcohol at half the rate of men. The consistent gender ratio across settings requires that consideration be given to both female and male AFA perspectives.

"Gender matters at every level from the intimate and highly personalized to the broad cultural." Campbell and Herzberg (2017, p251).

Definitions of an Alcohol Frequent Attender

The definition of an AFA in this study is someone who has made at least ten ED attendances or three hospital admissions in the previous three months. In contrast, Neale et al. (2016) defined an AFA as ten or more ED attendances in the last year. In a study of hospital records Blackwood et al. (2021) defined alcohol-related frequent attenders as having had more than three hospital admissions during a Hospital Episode Statistics year for NHS England. In addition, in a proposed randomised controlled study of high-need, high-cost, alcohol-related frequent attendees, in comparing assertive outreach with treatment as usual, AFA is defined as follows:

> "Two or more admissions in any of the participating NHS trusts for at least one wholly attributable alcohol diagnoses within a 1 year period, **OR**; has had at least ten presentations to an emergency department in any of the participating NHS trusts within a 1 year period, **OR**; has had at least four presentations to an emergency department in any of the participating NHS trusts within a month, **OR**; has been admitted at least once for a wholly attributable alcohol diagnosis and had at least four presentations to an emergency department in any of the participating NHS trusts within a 1 year period" (Blackwood et al., 2020).

These study samples are comparable, but with some contrasting characteristics, with the AFA population defined in this study. These will be relevant differences in the interpretation of the studies, but also because of different categorisation of, for example, acute admissions units, wards, and coding of emergency /urgent admissions; therefore, cohort/sample definitions may have distinct implications for service design.

Alcohol Liver Frequent Attenders Project: Royal Alexandra Hospital (RAH), Paisley

This innovative project was started in January 2021 in the Renfrewshire HSCP in collaboration with RAH, Paisley, part of NHS Greater Glasgow and Clyde. Patients' frequent attendances were identified using a NHS Micro-strategy approach (an automated list generated from hospital data). Frequent attendance was defined as three or more ED attendances in the previous four

weeks, or three or more inpatient admissions in the previous twelve weeks. This service methodology was chosen to capture the 'tip of the iceberg' of frequent attenders. The advantage of this approach was that it was more reactive than other, retrospective definitions (attendances over one year) and was chosen because research (e.g., Kyle et al., 2021) showed that frequent hospital attendance and admissions can fluctuate or be a temporary issue for people. The aim was to immediately identify and then treat, support and direct individuals to appropriate services thereby reducing ED attendances and hospitalizations. The project was staffed by two nurses (See Appendix C). The service is broadly consistent with the service needs suggested by Drummond et al. (2018).

Rationale

In considering both ED attendance and hospital admissions in relation to multiple attendances where alcohol-related issues feature, pressure is brought upon hospital services (Barrie & Scriven, 2014). At the same time, resource allocation is stretched and it remains unclear whether an alternative approach may be more effective in relation to both patient care and efficient allocation of resources.

This study sought to ascertain the experiences and views of twenty AFAs (as defined for this study) and identified from NHS records by the nurse-led ALFA team in real time in relation to both ED attendance and hospital admission at the RAH. In addition, the study sought to identify participants' views, taking account of gender differences, which may contribute to service enhancement at both hospital and community levels without prejudice to any response or service. The interviews were conducted within a short period of time following admission or attendance, and this was considered optimal for avoiding reductions in participants as a result of alcohol-related mortality and to promote effective co-design of service enhancement. The study was informed by the principles of inclusivity, patient voice and quality improvement agendas.

Methodology

The aim of the study was to maximise understanding of the views and opinions of AFAs as identified in real time through the local NHS Micro-strategy and cared for by the ALFA nursing team. Demographic data were collected in the study referral form and some were obtained in interviews, including education, gender and ethnicity. Alcohol dependence was measured using the Leeds Dependence Questionnaire (LDQ), which is a validated, ten-item multiple-choice tool designed to rate levels of dependence on a range of psychoactive substances by reflecting on the "last four weeks", with scores ranging from 0 to 20 (Raistrick et al., 1994). The interview method is based on Grounded Theory (Bowling, 2002; Glaser & Strauss 2017) and used a semi-structured interview (SSI) schedule to elicit participants' views using motivational interviewing techniques. It contains questions consistent with problem solving/solution focused approaches to identify participants' views in relation to their personal experiences, service use and enhancement (See Appendix B). The method is, therefore, inductive in that themes were

enabled to emerge from participants, rather than being pre-formed. A thematic analysis was conducted on qualitative interview data for all twenty participants. With regard to examining gender differences, a thematic content analysis was conducted on the transcripts of all female participants (n 7) and n7 (of 13) randomly selected male participants, (King et al., 2018). It was important that women's themes were generated from a corpus in their own right and that men were parsed against those themes, and the same iterative process applied for men. Parhoo (2006) promotes the importance of reflexivity in qualitative research and the authors recognise the potential bias of their social privileges (McIntosh, 1989) in analysing women's experiences.

The methodology was prospective in design, identifying patients in real-time thereby maximising recruitment potential and minimising the influence of the mortality rate, identified in a follow-up study of a similar population (Black & Gill, 2016). A supermarket voucher for £25 was offered to each completing participant, as an incentive for a 'difficult to reach' population.

Participant Recruitment

Original participant recruitment strategy

All frequent attenders were to be identified through the weekly run of the automated NHS Micro-Strategy. Using hospital coding based on alcohol issues including Fast Alcohol Screening Tests (FAST) on ED attendance or hospitalization by medical staff at the RAH, frequent attenders with significant alcohol issues (AFA) were to be identified. GPs would have been informed of frequent attenders by way of hospital ED and discharge letter. All AFA patients would have received intensive assertive outreach through the ALFA service, and all were to be considered for referral to the research team for this study. All patients stable enough for interview were to be referred until the pre-defined case number of twenty was reached. Using Scottish CHI numbers alongside medical and psychiatric electronic records (TrackCare and EMIS data), hospital records were to be reviewed with regards to attendances/admissions, and brief patient histories were to be re-assessed by the research assistant in order to confirm inclusion criteria and establish suitability for the study.

Revised participant recruitment in response to COVID-19 pandemic

Account was taken of Scottish Government guidance on COVID-19, namely the need to maintain 'social distancing', and initial contact was always remote for consent and interviews were carried out by telephone. Given the inaccessibility of hospitals and GP surgeries, the ALFA nursing team became the sole source of referrals. The ALFA nurses referred into the study after gaining provisional informed consent; thereafter the research interviewer contacted candidates by telephone to discuss the project (Participant Information Sheet, PIS), confirm consent, assess capacity and conduct the SSI.

Ethics

Ethical approval was given by the School of Education and Social Sciences, UWS, 21 November 2019. The UWS Ethics Committee stipulated that it was to be made clear that the voucher was not to be spent on alcohol. An amendment was submitted in respect of COVID-19 and the need to use remote interview methods. In addition, it was confirmed by the NHS ethical lead that formal approval was not required because the study was considered to be a service evaluation.

Procedure

Following referral by the ALFA service, the interviewer contacted participants by phone, confirmed their informed consent and arranged an interview date (though many participants agreed to interview on first call). A hard copy of the PIS and the shopping voucher was sent to participants following completion of the interview.

Capacity and Risk

Capacity and risk were addressed by ensuring each respondent was orientated to time and place and could relay what they were consenting to. Risk was managed through debriefing with respondents at the end and following standard mental health risk assessment protocols.

Technical Process

Audio recordings were obtained with consent and made using a simple analogue splitter linked to a digital recorder. Exact call lengths have not been analysed, but completed interviews lasted approximately between forty-five minutes and one hour. Sound files were all optimized for sound quality using Waves L3 (multiband limiter) within Reaper v6.26 and stored on the secure UWS OneDrive, and thereafter shared securely with the transcriber. Recordings and transcriptions are indexed to a chronological referral number. Quantitative/demographic data were gathered in real time into an anonymised excel spreadsheet on the UWS OneDrive.

Data Analysis

Recorded interviews and their transcriptions were both used to code qualitative data by the principal investigator and the research assistant independently to minimise bias (Church et al., 2019). Data was analysed using Iterative Categorisation (IC), a rigorous and transparent technique for analysing textual data used to support the analysis of recorded and transcribed interview data (Neale, 2016). Consistent with this approach, recorded interviews/data were transcribed, read and re-read to ensure familiarisation. Transcriptions (20) were anonymised and indexed by referral numbers in the chronological order of referrals: 02 – 021. One referred patient (male participant 1) was not interviewed. One recording file (Female Participant 16) was

lost because of a technological failure and limited thematic data were drawn from interview notes.

First, a Descriptive Analysis (DA) was carried out, producing coded themes. Secondly, an Interpretive Analysis was carried out which consisted of the following activities:

- Differentiation: identification of similarities and differences and overlaps in themes.
- Abductive conceptualisation: reading relevant literature to find concepts/frameworks which best fit the data. This approach is particularly relevant to applied research.
- Externalisation or transferability: links made between findings and established bodies of knowledge in cognate fields (Neale, 2016).

Thematic analysis consisted of two elements: a grounded theory approach facilitated the emergence of a "bottom up" account of participants' experiences and opinions (Glazer & Strauss, 2017). In addition, as the participant group was sufficiently large, and there were responses to themes by most respondents, an overarching template coding structure was applied to the data (King et al., 2019). This was based on the theoretical and practical concerns of the study and reflected in the SSI (Appendix A). A thematic content analysis (King et al., 2018) was conducted in order to identify gender differences.

The over-arching template is set out below:

Applied Coding Structure: Overarching Themes

- Gender: female and male differences in reporting their experiences
- Harmful drinking and dependence: harms and dependence on alcohol
- Motivation, self-efficacy and locus of control: drivers for change
- Mental Health: mental health issues either preceding or consequent upon alcohol use
- Physical Health: health issues including those associated with alcohol use
- Family and relationships: family and relationship issues associated with alcohol use
- Livelihood and employment: income and employment issues associated with alcohol use
- Justice system: criminal justice issues associated with alcohol use
- Service Perspectives: experiences of alcohol problem services and evaluative opinion.

Results

Demographic findings

Demographic findings and contextual information:

Participants (n=21) were drawn from the caseload of the ALFA service, which was purposively screened to the study via the NHS Micro-strategy starting in January 2021. Certain demographic data were obtained from all twenty-one referrals beginning on 22nd March 2021 and the study closed to referrals on 11th December 2021 with twenty patient interviews completed (one patient had consented to referral and interview but could not participate because of

incarceration). Qualitative data and Leeds Dependence Questionnaires (see below) were based on the 20 who completed.

Gender

Fourteen of the twenty-one recruits identified as male and seven as female. The gender ratio was 1.9:1 (male: female) for those who completed the interview.

Age

The mean age of the twenty one recruits was 43.2 years (SD 13.33). The mean age of the females was 41.42 (SD 13.15), age range 33-51 years and the mean age of males was 41.00 years (SD 16.21), age range 19 –68.

On average, participants in this study were younger in comparison to other relevant studies: Interviewees in the larger "Edinburgh Ill Drinkers" study including inpatients in medical or alcohol services, as well as outpatients, had a mean age of 47 years (age range 21–80, mean age of 47 for the 67% males and age 46 for the 32% females) (Black & Gill, 2016). People of the Dargan's Glasgow cohort study of alcohol related deaths (2013) were older at 54 years (males 54 years, and 51 years for females, almost 40% of those who died were in the 45-54 age range).

Ethnicity and nationality

All twenty-one recruits identified as "white", and the twenty actual participants were of UK nationality, of which fifteen identified as Scottish, four British, and one English. The one recruit who did not complete was Eastern European. This study's sample is similar to Dargan (2013) where approximately 75% of the sample was predominately "White Scottish" and different to the London study from Neale et al (2016), where greater ethnic diversity was recorded, reflecting differences in the local populations.

Location, accommodation and deprivation

All twenty one study recruits had a form of residency in the RAH catchment area. No participants reported being homeless or living in hostel accommodation at the time of the interview. However, one mentioned recently moving out of temporary homeless accommodation.

ScotPHO Tool (2021) reports that deprived areas have 115% more hospital admissions than the overall average, and National Records Scotland (NRS) (2021) reported that in 2020 people within the most deprived areas were 4.3 times more likely to have an alcohol-related death compared to the least deprived areas.

The Scottish Index of Multiple Deprivation (SIMD) is the Scottish Government's (2021) statistical map of levels of multiple deprivation indexed by exact postcodes. To avoid 'jigsaw identification', exact SIMD/postcode data for study participants will not be published. SIMD's finest measure is vigintiles (20ths), and 47.3% of recruits to this study live in the top three vigintiles of deprivation in Scotland. Therefore, while severe deprivation is represented, the

SIMD ranks also reflect that the sample includes people from more privileged backgrounds, which is furthermore evidenced in employment and education data.

Table 1: Scottish Index of Multiple Deprivation: SIMD Brackets by Participant Numbers

SIMD Brackets	Participants	% of Sample
in 1st quintile	10	47.62
in 1st decile	6	28.57
in decile 1-3	11	52.38
in 1st vigintile	3	14.29
in vigintiles 1-3	10	47.62

Education and employment

One fifth (20%) of the sample had no educational qualifications, (one person had received special needs education) compared to the Renfrewshire average of 4.6%, the Scottish average of 8.1% and the UK average of 6.4%. However, 22% report qualifications equal to, or exceeding NVQ5 (degree level and post-graduate) which is similar to the local area where "Almost one-quarter of people have degree-level qualifications in Renfrewshire" (Renfrewshire Council, 2015).

Of the twenty study participants interviewed, 70% (14) were unemployed, 15% (3) retired and 15% (3) were in employment. The Office for National Statistics (ONS)/NOMIS (official labour market statistics) data for 2020-2021 reports that employment is less in Renfrewshire (75.4%) than Scotland (76.1%) which in turn is lower than the rest of the UK (78.5%). Unemployment in Renfrewshire (4.2%) is similar to the rest of Scotland (4.2%) and lower than the UK rate of 4.8%. Numbers for those retired in Renfrewshire are 18.6%, which is higher than the Scottish rate of 14.6% and the UK rate of 13.6%. Therefore the sample has a disproportionately high number of people who are unemployed compared to the general Scottish population.

Alcohol dependence: The Leeds Dependence Questionnaire (LDQ)

Table 2 shows participants' scores: 20% scored as high dependence, 50% scored as medium, 30% scored as low. The mean dependence score is 15.45 (SD 9.62). Mean dependence scores for males (15.54, SD 9.47) are comparable to females (15.29, SD 10.24). The proportion of females scoring high for dependence was higher when compared to males (28.6% to 15.4%), but this difference was not statistically significant (Chi-square test).

Table 2: Leeds Dependence Questionnaire (LDQ) Scores

Gender	Low LDQ score (0-9) (%)	Medium LDQ score (10-22) (%)	High LDQ score (23-30) (%)
Female (7)	2	3	2
Male (13)	4	7	2
Total (20)	6 (30%)	10 (50%)	4 (20%)

The small number of high-dependency drinkers (LDQ score 23-30) might suggest a bias towards people actively engaging in services who are "ready to change", though this construct was not measured. It was evident that some participants were reporting their drinking prior to the four-week period specified in LDQ (during which they would have experienced the assertive outreach from the ALFA service) and often had to be prompted to consider the immediate four-week window. Failure to consider their recent drinking might have led to higher scores at a time prior to starting assertive outreach. In response to the LDQ questions on substance use some participants asserted that they did not "take (*illegal*) drugs".

Summary of demographic and LDQ data

Data were collected from twenty interviewees of whom 65% were male and 35% were female, which is consistent with populations of alcohol problem studies. The frequent attenders had possibly lower levels of employment and educational achievement compared to the host community. The study participants were similar in age to other AFA studies, although there was a wide age range, particularly in the males. The study population is predominantly "White Scottish" with the rest being "White British" or "White English" and appear to be settled in local accommodation with no reports of current homelessness. Only 20% indicated high levels of dependence at the time of interview as measured by the LDQ. This might imply active changes to drinking behaviour. There was also little mention of substance use other than alcohol.

Qualitative Findings

Table 3. shows the overarching themes and their respective subthemes. Overarching themes and the related sub-themes are elaborated, including gender differences.

Table 3: Thematic Analysis: Overarching themes and sub-themes

CODE	Over-arching themes	Sub-themes
A	Gender	
B	Harmful/dependent drinking	
C	Motivation, self-efficacy and locus of control	
D	Mental health	D1. Co-morbidity of mental illness
		D2. Impact of COVID-19 on mental health
		D3. Trauma
E	Physical health	
F	Family and relationships	F1. Family history of substance use/dependence (See also Legal over-arching theme)
		F2. The impact of the drinker on other family members
		F3. Child welfare and protection
		F4. Abusive and coercive relationships, including domestic violence.
		F5. Legal issues associated with family
G	Livelihood and Employment	Unemployment
H	Justice system	Offending: criminal justice system (see also Family sub-theme F5)
I	Service perspectives	Participants' perspectives on services used

Sub-themes are distinct but linked to the over-arching theme. Overlap between these and sub-themes is common, given the definition of an overarching theme i.e., most participants responded in ways consistent with the over-arching theme. For example, "domestic violence" and "child welfare and protection" sub-themes are linked to both Justice and Family over-

arching themes. Similarly, there are clear overlaps between these themes: Mental Health, Trauma and Harmful/Dependent drinking.

Overarching theme A. Gender

"[…] A recent episode was about a fortnight ago and it was really bad and I didn't actually realise myself that I had taken a whole week's worth of my anti-depressants in the one go, which caused me severe hallucinations, and that was a danger to myself. […] It's a mixture, the mental health brought the alcohol on, so now they're not treating me for alcohol related problems just now, because you know I've not even bothered about a drink, I don't crave for it. It's been hellish but now I'm dealing with it and I think my main problem was I was always too scared to talk about things", (Female Participant 6).

"I suppose like there are other ways to sort of deal with low mood, low self-esteem, self-hatred, all those kinds of things. There's other ways, kind of positive or negative to deal with those other than alcohol. Quite often alcohol's just been easier or more available or I used to think it worked and those kinds of things. If I combine the two it's just absolute carnage and a downward spiral I suppose", (Female Participant 11).

"To get Valium. When I come off alcohol to get rid of the shakes and the sweats and just to, so I would get my breakfast, lunch and dinner and didn't have to worry about anything. I just felt safe in the hospital, but mainly to get Valium to get me on my feet again. Just to get sober and fit again", (Male Participant 13).

A Comparative Content Analysis (King et al., 2018) was conducted on all seven female and seven randomly selected male participants' interviews. Gender differences identified are also presented in each of the over-arching themes below.

Men presented as suffering the physical effects of chronic alcohol misuse (7/7 men: 5/7 women) and women presented as drinking in the context of crisis and drinking to cope with poor mental health (7/7 women versus 5/7 men). Women (3/7 versus 0/7 men) reported being disengaged from mental health services. Women were more likely to reflect on beliefs about recovery compared to men (5/7 women versus 0/7 men). Men spoke factually about physical deterioration and managing alcohol withdrawal (7/7 men versus 5/7 women). Women emphasised the negative social consequences associated with drinking more so than men: all female participants and almost half of male participants (3/7) reported experiencing isolation. Both women and men spoke of feelings of abandonment and rejection (6/7 women and 5/7 men), both in social circles and by professionals. Almost half of the female participants (3/7) spoke at length, of experiencing stigma, unlike men (0/7). 4/7 women express feelings of guilt, unlike male participants (1/7).

In some of the overarching themes identified, the numbers of male and female responses appeared similar, but these numbers do not convey the qualitative differences in the focus of the narrative. The manner and volume of how men and women addressed certain subjects were different; women spoke expansively about mental health crises and impact on relationships. Men spoke more expansively around details of physical, and sometimes mental

health deterioration, and to a lesser degree of mental health crises and referred to social relationships only in passing.

Unlike most male participants, all females demonstrated insight into how alcohol consumption made mental health much worse. A small number of women viewed mental health as their primary problem, believing it to be central to their recovery; however, most women reported disengagement from mental health services.

Male participants, more commonly than female, reported legal problems, specifically in relation to offending and contact with the criminal justice system.

Over-arching theme: B. Harmful and dependent drinking

"Just basically it was a case of having a couple of drinks and then it was a case of wakening up during the night, and if there was drink left, I was like I'll just keep on drinking that and then get back to sleep. The next day you'd always have the shakes and stuff and I'd be like Oh I need to get another drink to kind of calm me down, kind of thing"... "Aye, the moderation thing doesn't come into it for me" (Female Participant 10).

"It's the psychological and mental addiction" (Male Participant 08).

"I'm drinking far too much. I had a period of sobriety, five years then I had a relationship breakdown, lost my job, lost my driving license, lost my home, so I picked up the drink again" (Male Participant 02).

All participants indicated that they had, at various times, received treatment for alcohol withdrawal and, in turn, alcohol dependence. Most of the classic physical symptoms of alcohol dependence were reported: withdrawal symptoms, seizures, nausea, tremor, and delirium tremens.

Psychological aspects of dependence were also apparent, e.g., perceived "loss of control", the subjective experience of craving, and relapse. Participants expanded upon consequences associated with physical health, mental health, family, employment and the law. Most consequences of alcohol consumption were also reported as relapse precipitants for alcohol consumption.

Treatment for alcohol dependence varied depending on the agency providing support, including NHS inpatient and outpatient care, and access to community based Third Sector organisations, including the fellowships. Treatment was predominantly psychosocial in nature, with additional medical interventions, for some, to support withdrawal, abstinence or prevent relapse, including prescribing of medication e.g., acamprosate or disulfiram.

With regard to abstinence from alcohol, female and male participants referred to past periods of abstinence, while a much smaller number referred to current abstinence, which was confirmed by the range of LDQ scores. Psychological aspects of dependence were also apparent, e.g., perceived loss of control, craving, and relapse. Participants expanded upon consequences associated with health, mental health, family, employment and the law. Similar

to consequences precipitating relapse participants also reported that consequences also precipitated heavy drinking.

While hopes and beliefs around getting better were expressed, there was no explicit reference to treatment experiences in the context of “recovery”.

Overarching theme: C. Motivation, self-efficacy, and locus of control

“[Services] have been great but at the end of then it’s down to me” and “[…] “they are doing everything they can but it’s me that walks down the road to the shop” (Male Participant 02).

“I didn’t know how to help myself, stop myself, so I actually contacted the police, and they came and took me to hospital to try and get some help from the mental health team” (Female Participant 06).

“I’ve only got myself to blame, but that’s due to you know not getting, you know I was kind of self-medicating because I wasn’t getting the help that was kind of requested, with the alcohol” (Male Participant 05).

“One of my main character flaws is not dealing with issues head on or confrontation etc. […] I turned to drink instead” […] “I thought this is too much, but I was in too deep at that point and it was hard to break the cycle […] and again it was a decision on my part not to refuse it, not to do anything about it” (Male Participant 09).

These comments indicate how difficult it can be for individuals to make changes, seek help, or accept responsibility for their own actions. All participants outlined a wide range of personal, health (including mental health) and social problems, which maintained alcohol consumption. Extracts illustrate internal locus (Male Participants 02 and 09), external locus (Female Participant 06), but some expressed ambivalent and contradictory motivational stances (Male Participant 05). Evidently, participants’ motivation or readiness to change varied significantly; however, motivation or commitment to change was not formally measured.

Overarching theme: D. Mental health

Sub-theme: D1. Comorbidity with mental health

“...they [Psychiatry] said it [emotionally-unstable personality disorder] was likely due to past trauma” (Male Participant 20).

“You are stuck in one part unless you deal with the trauma, which I never have. I’m a 46-year-old man that’s got a four-year old’s mind […] The two [siblings] that were abused, being me and my sister, both ended up alcoholics” (Male Participant 08).

“I’m kind of wondering what came first, the depression or the alcoholism” (Male Participant 09).

“I guess I was using [alcohol] as a kind of coping mechanism...” (Female Participant 15).

The mental disorders/symptoms reported were heavily skewed to the categories of low mood and anxiety, which were each reported by 12/20 (60%) participants respectively, with 9/20 (45%) experiencing both: the prevalence of depression is thirteen times higher in the study

sample than in the general population (4.5%), (NICE, 2021b). While 70% of participants reported themes of trauma, only 10% spoke of having post-traumatic stress disorder which is higher than the prevalence of PTSD in the general population (6-8%), (van der Kolk, 2009). Despite the frequency of reported mental health issues only a small proportion of the study group had received a specific diagnosis.

All participants mentioned mental health issues; however, female participants were more expansive than males. The emphasis of narrative for women was strongly about mental health crisis and more women expressed insight into alcohol having a negative effect on their mental health. All female, and most male, participants spoke of using alcohol to "cope", predominantly with mental health issues but also coping with withdrawal. Virtually all participants referred to past and/or current mental health issues, although females spoke more about mental health crises in the context of recent suicidal thought relapse precipitants. Only 30% (6/20) of participants mentioned previous engagement with a community mental health team (CMHT). Twice as many women spoke about outpatient mental health treatment compared to men: 2/7 female participants referred to mental health as a primary issue for them, unlike males.

Women expressed hopes for mental health treatment as a route to recovery more so than men. Some participants, particularly females, reported that their access to psychological therapy for trauma was hindered by their continued heavy drinking. The extracts above also highlight the indivisibility of themes of mental health and trauma where participants link their mental state and alcohol use to trauma.

Sub-theme: D2. Impact of COVID-19 on Mental Health

"I'm a wee bit depressed with lockdown and things being shut in Paisley, being shut in the house and being on my own" (Male Participant 13).

"I'm kind of in Limbo here; my work, my life, my wife, my life is essentially in …. and there's nothing I can do because of COVID[-19] etc." (Male Participant 9).

These extracts reflect the impact of COVID-19 restrictions on both mood and the way of life of participants.

This study opened for referrals in March 2021, just as the UK was going into its first lockdown and interviews were completed in November 2021 (Brown & Kirk-Wade 2021).

Social aspects of 'activities of daily living' have been recognised as essential to health and mental wellbeing (Goldberg et al., 2002) and correlating with mood/self-esteem: 13 of the 20 (65%) participants spoke of COVID-19 and the comments were predominately negative about their quality of life such as increased isolation, impact on employment, relationships and mental health. However only two participants explicitly expressed that their mental health had been impacted by COVID-19.

Sub-theme: D3. Trauma

"I lost a baby when I just about eight months pregnant […] which led to drink on and off" (Female Participant 06).

"The twins, their dad died about a year and a half ago. He had MS and basically, I looked after him for 20 years […] a big part is bereavement as well" (Female Participant 10).

"I lost my home, I lost my job, lost my car, my family" (Male Participant 02).

"I was sexually abused by a family friend when I was very young" (Male Participant 08).

13/20 (65%) participants described experiences, which they considered to be traumatic. These reports were predominately experiences of loss (including death, relationships and purpose) or abuse (sexual, physical, and emotional, in childhood and adulthood). 20% of participants reported the death of a child/miscarriage, 15% spoke of the death of a partner, the loss of relationships was reported by 75%, and childhood trauma was reported by 25% participants.

There was a gender distinction in that participants spoke of being affected by trauma with 100% of females reporting this and 45% of male participants. Three (3/13) men and four women (4/7) spoke about being an abuse survivor. Women also reported more experiences of being socially ostracised.

Overarching theme: E. Physical health

"I got told off by the Torley Unit (NHS alcohol problem service) to stop drinking, but I actually made myself ill with it couldn't even drink alcohol or wean myself off it, I couldn't keep anything down and I was just being violently ill. I just had to get into hospital because I couldn't keep any fluids down" (Male Participant 07).

"It's mainly to do with alcohol. Either coming off alcohol or alcohol injuries, but also a lot of the time... it's been a lot of mental health" (Male Participant 08).

"Due to alcohol and tremoring a lot, so had to get detoxed a few times. I took seizures through alcohol, and they hospitalised me every one time I done it. They kept me in hospital for two weeks" (Female Participant 04).

"I think maybe a couple of times it was alcohol related to mental health. Really, really struggling, couldn't cope and I think at one point, at my lowest ebb, being brutally honest with you I think I maybe drank for four days straight" (Female Participant 06).

It is no surprise that frequent hospital attenders reported at some length on their health problems. A wide range of health complaints were reported, covering accidents, injuries, long-standing health complaints and the physical consequences of alcohol dependence including alcohol withdrawal. Whilst liver disease, as a significant feature of harmful and dependent drinking, was commonly reported, it was not reported by all participants. Male participants referred to chronic physical health problems and physical deterioration and spoke more expansively on the topic compared to females.

Overarching theme F. Family relationships

“...looking at the way my family’s kind of dealt with stuff...and just following in their footsteps in like how they’ve dealt with it” (Male Participant 09).

“My father was an alcoholic, he used to abuse my mum, and that was a big thing for me” (Female Participant 06).

“I’ve got to weigh up what’s better for my life and I’m getting on a lot better with my family” (Male Participant 09).

“He chucked me out. Threw me out of the house” (Female Participant 04).

"[Alcohol is] contributing to the fact that my children are still away, obviously” (Female Participant 15).

This overarching theme comprised five sub-themes:

1. Family history of substance use/dependence
2. The impact of the drinker on other family members
3. Child welfare and protection
4. Abusive and coercive relationships including domestic violence
5. Legal issues associated with family

All female, and many male, participants spoke about having a protective relationship, commonly but not exclusively within a family. More men than women mentioned family, while some women spoke of the family being a negative factor with regard to being ostracised and feeling guilty, because of their alcohol consumption.

Sub-theme: F1. Family History of Substance use/Dependence

Participants commonly referred to a close relative as having an alcohol problem or being an alcoholic. This is in keeping with the research literature finding that both problem drinkers and problem drug users, who are engaged with addiction services, commonly report having a close family member who currently has, or had, an alcohol problem (Barrie & Scriven, 2014).

Sub-theme: F2. The Impact of the Drinker on other Family Members

Participants reported that their drinking had a negative impact on their family in a broad sense. Both female and male participants noted family conflict, breakdown and separation, which were attributed to alcohol consumption.

Sub-theme: F3. Child Welfare and Protection

Participants, particularly women, expressed concern for children, occasionally in circumstances where they had been separated for an indeterminate period. Childhood experiences of alcohol problems in the family were commonly reported.

Sub-theme: F4. Abusive and coercive relationships, including domestic violence

Both women and men considered that they had been the victim of abusive, coercive relationships. However only female participants indicated that they had been the victim of domestic violence. No-one acknowledged having been a perpetrator of domestic violence.

Sub-theme: F5. Legal issues associated with family matters

A range of family legal matters were reported including separation, divorce, and debt. Formal child welfare and protection procedures, including custody issues, were reported by a minority.

Overarching theme: G. Livelihood and employment

"I'd say from sort of my mid-twenties onwards […] by that point was unemployed. I couldn't leave the house and all that kind of thing […] I was just existing and at that point I knew I couldn't drink safely" (Female Participant 11).

Of the twenty study participants, most commented on their employment status and by implication their financial difficulties. Both in the past and present participants indicated that their drinking had had an impact on their working life, their ability to have a working life, to hold down a job, or they had lost a job because of their alcohol consumption. For some, drinking was an important aspect of the social context of work, particularly if working away from home. Almost 50% of female participants but no male participants spoke of current employment. Women also spoke, more than men, about being currently unemployed and viewed employment as an aspect of their recovery.

Overarching theme: H. Justice system

"I am on a Community Payback Order with two years supervision. I have been referred to a place that's literally near where I live […] it's funded by criminal justice" (Male participant 08).

"I've been in jail three times and it's because I've been drunk. I've never been in jail when I've been sober, but every time I'm always drunk" (Male Participant 18).

"...but then I started getting into bother with the police etc." (Male participant 05).

"...my partner was actually quite abusive towards me. She was a heavy drinker, it was a terrible break up, police and stuff got involved" (Male participant 09).

Most participants, particularly male, referred to their experiences of the criminal justice system, and described the centrality of their alcohol consumption in relation to their offending, indicating that the offences would never have occurred had they not consumed alcohol. Further, participants experienced a wide range of disposals from the criminal justice system reflecting the seriousness of their offences, or persistent offending over a lengthy period of time including fines, Community Payback and imprisonment for both male and female participants. Male participants predominated with regard to their experiences offending and the criminal justice system, compared to women.

A small number of women reported the police contact as being helpful, unlike men, specifically with regard to being escorted by police to hospital in crisis, involving alcohol and mental health

issues. Despite these contacts, charges were rarely brought, reflecting police reluctance to arrest and detain intoxicated individuals, potentially compromising health and safety. Two of the men spoke negatively about police involvement including allegations of excessive force.

Overarching theme I. Service perspectives

All participants had experience of health, alcohol problems and recovery services, in both the recent and distant past, including the Renfrewshire ALFA nurse project. Participants' experience was wide and varied with some recounting service contacts dating back over two decades, particularly in relation to NHS alcohol services in the West of Scotland. Most offered very positive comments, but also reported their reservations about services:

- Commonly based on personal prejudice or anxiety, particularly where they had decided not to attend a support service for the first occasion.
- Feeling that the service did not work for them, ranging from what was on offer in the way of support, including how they viewed the helper/professional, and their feelings of abandonment.
- Failed referrals, especially where the promise of a call from an agency did not materialise.
- Service access affected by COVID-19 restrictions.

NHS Emergency Department (ED)

"Because I was drinking every day and self-harming" (Male Participant 18).

All participants had attended ED, and a small number reported being escorted to ED, by police. Participants' experiences of ED were generally positive. This is consistent with the Neale study (2016) which was conducted exclusively on ED frequent attenders. In the same study series Parkman et al. (2017) reported both push and pull factors contributing to frequent ED attendance - push factors related to individual level problems and limitations of community-based services, whilst pull factors were associated with positive experiences of, and beliefs about, emergency department care.

NHS inpatient care

"It sounds silly, but when I'm actually in hospital, I just feel so relaxed and calm and looked after. Yeah, you just feel a bit nurtured […] yeah, you just feel nurtured and looked after" (Female participant 15).

A quarter of the study participants met the criteria of having been admitted to hospital three times in the previous three months for varying lengths of time and a further 60% (twelve) met the criteria for both hospital admission and ED. Participants spoke highly of the care they received whilst in hospital.

NHS substance use services: community and inpatient

"I was in the Kershaw Unit (inpatient detoxification service, Glasgow) but that was … probably about two years ago now, before the COVID […] Aye, it went fine. Aye it was alright" (Male participant 07).

"Dykebar (Paisley), when I was in Dykebar, they were absolutely brilliant with me. The guy I was seeing […] he was really good with me" (Male Participant 12).

Participants referred to having been patients of the Torley Unit (Paisley) and the Kershaw Unit; most had had outpatient contact, with a few being inpatient. Participants were prescribed withdrawal medication and offered support in changing their drinking behaviour. Most participants described treatment that indicated the standard inpatient Glasgow Modified Alcohol Withdrawal Scale (GMAWS): a benzodiazepine reducing regime for alcohol withdrawal syndrome plus intravenous Pabrinex (preventing vitamin B deficiency and Wernicke's encephalopathy). Some described community detox, although some mentioned detoxification support from their GP. As in Dargan's study (2013), only a small number of the cohort were recorded as having been prescribed relapse prevention medication (e.g., disulfiram or acamprosate).

The Alcohol-Liver Frequent Attenders (ALFA) service

"I think she (ALFA nurse) is going to do me alright. She's taken it out of my brother's hands, where he's not to prompt my medication […] and if I don't go to the chemist then the chemist's going to get in touch with her" (Female Participant 10).

All participants were recruited through ALFA and most had been in recent contact with that service, some currently. Perhaps, as a result of recent contact with the ALFA service, participants' responses about the service were always very positive.

NHS psychological services

Only a small number of participants referred to Psychological Services. Two female participants indicated that their continued consumption of alcohol resulted in their not receiving a service.

Local authority substance problem services

Two (of seven) female participants referred to social work addiction services, (in conjunction with Children and Families Social Work). They found this to be particularly helpful, in relation to practical support and access to resources. However, one felt "dropped" when a supervision order on her children expired following which she felt "left to get on with it" without support.

Third sector problem substance use and recovery services

*"RCA (*Renfrew Council on Alcohol*). It was really, really good. They never pushed you to talk, they would listen. That's the only way I can describe it" (Female participant 06).*

*"Just obviously RADAR (*Renfrewshire Adolescence Alcohol & Drug Resource*), but I've never heard of AA, but just like Cruse (*bereavement support service*) they're all phone consultations" (Male participant 05).*

Most participants knew of community-based voluntary/third sector bodies, particularly Renfrewshire Council on Alcohol. Only a small proportion reported that they had attended such services, commonly for short periods and not necessarily recently. Opinions were mixed as

to how helpful participants viewed services, often based on the study participant's perception of a counsellor's style and approach.

Mutual Aid: The Fellowship of Alcoholics Anonymous (AA)

"So, I was going down there and I've thought, right I'll go to the AA at night-time, kind of thing and then by the time I came in from the garage I was like, 'Nah I can't be bothered' [...] but I thought, 'Nah! Try and just go to the AA meetings'" (Female Participant 10).

"What did help initially was I started to go to AA, which I had to build up to mentally […] I would never have thought in a month of Sundays that it would've helped me […] my wife prodded and prodded and prodded me and I decided to go. I walked past the building about three or four times before I went in. […] Something made me go in and I went in and it actually helped" Male Participant 03).

All but one participant had heard of AA, although not all had attended. Of those who had attended, some found the Fellowship to be an invaluable source of support in their recovery. Others did not find it helpful.

Mental health services: NHS and Voluntary bodies

Access to mental health services was a common topic for participants. Despite participants' perceived need for these services, it was of particular note that continued drinking prevented some from accessing or continuing with NHS mental health services. A small number of female participants reported disengagement from mental health services associated with continued heavy drinking. Two participants reported historical engagement with RAMH (Renfrewshire Association for Mental Health). Mental Health Assessment Units received some negative comment where participants reported attending for a mental state examination, on occasion escorted by police, expecting to be treated, only to be turned away.

Statutory and voluntary drug services

Participants did not report problem drug service use. This is consistent with spontaneous comments made at the time of administration of the LDQ, where a significant number of participants emphasised that they did not use (illegal) drugs.

Summary of service perspectives

This study provides a clear indication from AFAs with regard to the wide range of services accessed, including specialist alcohol and mental health services, both within the NHS and the wider community, and that some services were accessed on multiple occasions.

Some participants offered views on services, which they may not have accessed for a significant period of time. Views on services ranged from dissatisfaction e.g., "abandonment" to great satisfaction e.g., "feeling nurtured".

Given the variety of problems associated with alcohol expressed in this study, it would be impossible for any particular service to be viewed as the "most effective" or "most popular". Rather, what emerges are the range and complexity of problems experienced. This suggests

that there is no service, or practitioner, that can cater for all preferences. This in turn gives rise to consideration of the nature of service provision required to respond to the high-need and complexity of this population.

Discussion

Demographic findings

People with frequent repeated admissions for alcohol-related problems accounted for more than a quarter of England's hospital admissions and appeared to be a high cost, high need, complex group of patients (Blackwood et al. 2021).

This study found that levels of unemployment were high (75%) consistent with research on other cohorts of people with severe alcohol problems. In this cohort only women (three) reported being in current employment: this represents almost half of the female population and 20% of the total sample. For those qualified to degree and beyond, alcohol consumption would appear to have impacted on their career. A small number of participants referred to alcohol consumption and their workplace culture. Levels of employment and unemployment were consistent with research on similar cohorts. Gender ratio was similar to other cohorts (Black & Gill, 2016; Dargan et al., 2013; Neale et al., 2016).

The study population was predominantly "White Scottish" and similar to Dargan (2013) and Black & Gill (2016) but distinct from Neale et al. (2016) where more diverse ethnic backgrounds were noted in a study conducted in London.

People in this current study differed from those in other studies:

- The frequent attenders in this study are younger than cohorts of mixed patients with alcohol problems or people who died because of alcohol (Black & Gill, 2016; Dargan, 2013). Mortality in these frequent attenders would be expected to be high.
- Alcohol was the only substance used problematically. This was emphasised by participants, who made no reference to accessing services for drug problems.
- Study participants appeared settled in local accommodation with no reports of current homelessness.
- This study is distinct from other studies with regard to the identification of different levels of alcohol dependence: 30% scored "low" on dependence, 50% "medium" and 20% "high", on LDQ (Raistrick et al., 1994). The lower levels of dependence, and abstinence in some, might be because of a commitment to change, reduced consumption, or abstinence, which was not further analysed. It is possible that this is a positive effect of the assertive outreach by the ALFA service. However, population or methodological differences which might explain different levels of dependence are not excluded.

Dargan's study (2013) of an alcohol-related deaths cohort noted alcohol dependence in 56% of patients and "alcohol problems" in 96%, drawn from NHS notes. Consequently, there is a broad

similarity between this and other relevant studies where alcohol dependence is recorded (Black & Gill, 2016; Dargan et al., 2013; Neale et al., 2016).

Thematic Analysis: Over-arching themes

What emerges from the thematic analysis is evidence of wide-ranging influences on drinking behaviour as well as significant complex and enduring problems which mirror the findings of other UK studies on alcohol-related frequent attenders (Black et al., 2011; Dargan 2013; Neale et al., 2016; Parkman et al. 2016). This AFA study sample consists of participants with significant problems related to alcohol, reflected in all over-arching themes.

Gender

The gender ratio of 1.9:1 male to female in this study is consistent with many studies on substance problem populations and services (Dargan 2013; Neale et al., 2016: Black and Gill 2016). Gender was associated with a strikingly different narrative and focus. Men and women sought support from services for different reasons. Men presented as suffering the physical effects of chronic alcohol misuse and women presented as drinking in the context of crisis. Women were more disengaged from mental health services and more concerned over the impact and backlash of their drinking at a social level and more likely to consider options for recovery. Men tended to speak more factually about physical deterioration and managing alcohol withdrawal. Women reported that they presented at services in crisis, using alcohol to cope with mental health issues.

All the female participants, and almost half of the male participants, reported experiencing isolation and they all spoke of feelings of abandonment and rejection, both in social circles and by professionals. Half of the female participants, but no men, spoke, at length, of experiencing stigma and feelings of guilt. Women emphasised the negative social consequences associated with drinking, more so than men, including stigma. Men reported, more than women, on their experiences with the criminal justice system.

The findings of this study are consistent with perspectives on gender studies and addiction (Campbell & Herzberg, 2017) and are relevant for service design for frequent attenders with alcohol problems.

Recovery and treatment

All participants had both historic and recent contact with alcohol treatment and recovery services in the NHS, local authority and the third sector, including fellowships. However, only a small number of participants referred directly to “recovery”. This is perhaps surprising given its prominence in Scottish policy and ambition of services (Scottish Government, 2018). This might reflect a lack of change/ recovery mindset in this population or a failure in policy and practice to effectively communicate a recovery perspective.

Alcohol treatment has often been seen within the concept of sobriety and recovery (rather than harm reduction). It has been subject to debate and may be defined as “a dynamic process of behaviour change in which improvements in biopsychosocial functioning and life satisfaction are fundamental” (Tucker and Witkiewitz 2022, p14). It consists of sobriety (harm-free drinking

or abstinence), general health and wellbeing and active community engagement (Best et al., 2022). As part of a recovery journey an individual may develop skills in dealing with alcohol issues, physical and or mental health, relationships, accommodation, finance and employment, peer support - all of which were mentioned frequently by participants in this study. Recovery may be conceived as an individualised journey in which recovery capital, for example in the form of personal resources, is required to sustain progress. Treatment of alcohol problems may play a part in the recovery process for some, but not for all, people with alcohol issues.

Some linked successful recovery directly with abstinence (Tucker & Witkiewitz, 2022). However, a large long-term study of people dependent on alcohol described the condition as a fluctuating disorder with differing types of remission including "controlled drinking". This challenged abstention as the only type of recovery for alcoholics (Polich Armor & Braiker, 1981). In a meta-analysis of twenty-two studies on abstinent versus non-abstinent treatment goals, the authors conclude that: "available evidence does not support abstinence as the only approach in the treatment of alcohol use disorder. Controlled drinking, particularly if supported by specific therapy, appears to be a viable option where an abstinence-oriented approach is not applicable." (Henssler et al., 2021, p1973). Recovery from problem drinking tends to involve control over alcohol, including abstinence, and is often associated with a significant change in sources of reinforcement e.g., new relationships, non-drinking social groups and employment (Tucker & Witkiewitz, 2022; Vaillant, 1983).

Analysis of different psycho-social interventions for alcohol problems by the Project Match (Matching Alcohol Treatment to Client Heterogeneity) compared 12 Step Facilitation (TSF by AA), Cognitive Behavioural Therapy (CBT) and Motivational Enhancement Therapy (MET). Outcomes did not differ between interventions with few "matches" found between interventions and subject characteristics. TSF best suited heavily dependent people lacking a supportive non-drinking social network and was less useful in people with significant psychopathology, (Babor & Del Boca, 2003). The United Kingdom Alcohol Treatment Trial supported these findings (Heather, 2008). Where AA has been evaluated, it is as effective as other, professionally delivered interventions and improvement in drinking outcomes correlates with attendance. (Gossop et al., 2003)

Therefore, the type of psychosocial intervention may be less important than identifying the needs of a service user and developing an effective therapeutic relationship as the ALFA nurses aim to do.

The key to self-help groups, including twelve step fellowships such as AA, is that the membership perceives themselves to share a common problem and, as a result, members support each other in the process of resolving the identified problem. AA promulgates the view that "alcoholism" is a disease and that abstinence, as a means of arresting the disease, is required.

Motivation, self-efficacy and locus of control

Alcohol consumption is motivated behaviour, which persists if reinforced. Change may occur when perceived benefits of drinking are outweighed by negative consequences. This involves the person mentally connecting consumption to consequence and deciding to make changes (Barrie & Scriven 2014). In terms of “motivational interviewing” or MET (Heather, 2008) exploration of “current concerns” are used as a means of enhancing “commitment to change”. MET showed equivalent outcomes when compared to TSF and CBT (Babor & Del Boca, 2003).

Self-efficacy describes an individual’s confidence in performing a specific behaviour, highlighting the prominence of self-efficacy in models of addiction (Bandura, 1977; DiClemente, 2018). It may be that self-efficacy moderates levels of relapse or recovery. This includes the concept of ‘locus of control’, ranging from people seeing themselves as the engine of change, i.e., ‘internal locus’ to change coming from other sources, i.e., “external loci” (Rotter, 1954).

A motivational perspective, based on individual current concerns or needs of the service user could be beneficial. However, the need to support self-efficacy is central to such an approach.

Mental health

The study participants, almost entirely, referred to mental health issues associated with their drinking being a means of coping with emotional stress and drinking preceding the emergence of mental health issues. Female, more than male, participants considered that drinking made their mental health worse and demonstrated greater insight into their situation.

Women, compared to men, expressed hopes for mental health treatment as a route to recovery and reported that access to psychological therapy for trauma was hindered by their continued heavy drinking. Participants highlighted the indivisibility of themes of mental health and trauma where participants link their mental state and alcohol use to their trauma. This corresponds with Charzynska, et al. (2011) who found a comorbid mental disorder in 31% of people with substance use disorder. Despite the frequency of reported mental health issues, only a small proportion of the study group had received a formal mental health diagnosis.

Participants reported that the COVID-19 pandemic and lockdown had affected mood, boredom and their lifestyles. The pandemic and suspension of many NHS services (Scottish Government 2020) limited access to helping services and this vulnerable patient group was particularly affected.

Mental health issues as a barrier to recovery (Ashford, 2022) and access to mental health services, was an issue for many respondents and this requires a commensurate response in the development of services for alcohol frequent attenders.

Female participants (4/7), in particular, demonstrated greater insight into how drinking made their mental health worse than males (0/7).

Women (4/7) expressed hopes for mental health treatment as a route to recovery, unlike men (0/7) and 2/7 reported that access to psychological therapy for trauma was hindered by their continued heavy drinking compared to 0/7 for men.

With regard to the fellowship of AA, in a meta-analytic review, Tonigan et al. (2022) reported that in many cases dual diagnosis patients who attended AA reported higher rates of abstinence from alcohol compared to dual diagnosis patients who were non-attenders.

Trauma

Psychological trauma can be defined in different ways (Weathers & Keane, 2007) and many authors talk about single or multiple experiences of overwhelming stress leading to significant impairment to emotional functioning (van der Kolk, 2009). Most people have resilience to developing psychopathology after potentially traumatic events (Galatzer-Levy et al., 2018). In this cohort, most (13/20) participants also describe having a mental illness/disorder which will influence their reaction to stress and a significant trauma history was found in 40% of a similar cohort (McKean, unpublished).

More women than men spoke of childhood mental health issues. Childhood trauma and adverse childhood experiences (ACEs) double the risk of significant mental illness (Lewis et al, 2019) and are associated with early onset alcohol dependence (Magnusson et al., 2011). ACEs have also been associated with poorer outcomes for dependent drinkers (Zaorska & Jakubczyk, 2019) and are important factors in understanding treated alcoholics, especially with regard to comorbid phobic anxiety disorders, PTSD, and suicidality (Langeland et al., 2004).

The prevalence of reported trauma, both childhood and adulthood, requires a commensurate response in the development of services for the AFA population, specifically in relation to trauma informed practice.

Family and relationships

Virtually all study participants reported that alcohol problems were a feature of their family setting. This included harmful childhood experiences, leading to ACEs and trauma for some. Current and recent stress in the family involved conflict, aggression, domestic violence and separation/divorce. Impact was also noted on, and concern expressed for children's safety and wellbeing. Women, more commonly than men, raised concerns about their children, even when the children concerned no longer lived with them. Problem drinkers and problem drug users who are engaged in "addiction" services commonly report having a close family member with an active or previous alcohol problem. Problem drinkers often acknowledge harm or problems that others cause through their own drinking. However, they are not as aware of their own behaviour, when intoxicated behaviour results in harm to others (Laslett et al., 2019) and this can lead to reduced quality of life, poor health and reduced family contacts. Harm can range from noise and fear to physical abuse, sexual coercion and social isolation, and is associated with reduced quality of life, poor health and contact with family members by heavy drinkers (Caswell et al., 2011; Laslett, 2011).

With regard to domestic abuse and violence, alcohol consumption is neither a necessary nor sufficient explanation, but is often a present and contributing factor. Perpetrators commonly use alcohol intoxication as an excuse and, in turn, survivors commonly blame alcohol rather than the perpetrator, with over 60% of domestic abuse and violence cases in the UK involving alcohol and almost 1/2 of the perpetrators being alcohol dependent. Furthermore, heavy

drinking among male perpetrators resulted in more severe injuries to the survivor (Alcohol Concern, 2010; Hester, 2009). Women who experience domestic violence are more likely, than women in the general population, to misuse alcohol (Alcohol Concern, 2010).

Contrary to the view that the family simply suffered at the hands of the drinker, most participants (7 of 7 women and 5 of 7 men) cited their family and friends as a source of support in their recovery, often after a period of poor family relationships. The family is an important source of support and reinforcement with regard to the individual's recovery from problem drinking (Barrie and Scriven 2014). The nature and quality of family and marital relationships has a significant impact on outcomes, for better or worse, and is important for sustaining change and preventing relapse (Heather, 2008).

Justice system

The role of alcohol in relation to offending is complex. Alcohol is not criminogenic, given that only some people offend when under the influence, but alcohol may contribute to offending in the following ways:

- Carrying out a crime in order to access alcohol
- Alcohol problems produce a home environment conducive to crime
- Alcohol may facilitate low impulse control, inhibition or trigger aggression
- Victimisation of people under the influence of alcohol
- Alcohol consumption may be an excuse for unacceptable behaviour

Consideration of the individual, the drug and the environment provides an opportunity to understand factors contributing to the relationship between alcohol consumption and offending behaviour (Morgan & Ritson, 2010). Offences associated with alcohol consumption range from “nuisance” e.g., Breach of the Peace in Scotland, to “very serious”, including homicide.

The criminal justice system provides a number of evidence-based opportunities for offenders to address alcohol consumption. This includes arrest referral schemes (Blakeborough & Richardson, 2012), Alcohol Brief Interventions (McGovern et al., 2012), court directed treatment orders and addiction services within prisons (Macaskill et al., 2011).

Service use

Participants engaged with a wide range of substance use services, including mutual aid groups and fellowships, both in the catchment area and beyond. Services have responded, according to participants, based on the problems and needs presented. Comments were overwhelmingly positive about the services provided despite the enduring alcohol-related problems within the group. Participants' comments did not point to a best or favoured response because of the wide range of complex problems presented to different services. No single service suited every participant and differing opinions on services were common. Individual participants had a history of accessing several different alcohol services and mutual aid groups, commonly over a lengthy period.

With regard to mutual aid, all participants had heard of and most had attended AA.

Given the wide range of complex problems identified it was concluded that a dedicated service for AFAs needs be considered in acute hospitals. This is consistent with Drummond et al. (2018) who proposed "assertive outreach for high-need, high-cost alcohol related frequent NHS hospital attenders." Such a service should not focus on alcohol consumption to the exclusion of addressing the other issues, which may go beyond health, e.g., housing, family, benefits, which these individuals face. Such a service would require strong links with the wider service network.

Limitations

The limitations imposed by the COVID-19 pandemic made physical access to many NHS services impossible for patients and researchers. One-to-one interviews by telephone were carried out with limitations in paralinguistic cues. However, qualitative interviews can be conducted via telephone with particular attention paid to building rapport and the interviewer adapting to participants' content and it may even have advantages in engaging difficult-to-access populations. It was concluded that this methodology is highly effective in recruiting and interviewing the target number of participants (Drabble et al., 2016: King et al., 2018).

While the study research criteria were met, the timing of interviews when patients were stable enough may have skewed the sample towards drinkers in an active recovery phase (possibly evident in LDQ scores). Previous interviews of patients with Alcohol-related Liver Disease frequently admitted to the same hospital indicated that this sample represents a typical cohort of local AFAs rather than the study missing out a distinct type of frequent attender with alcohol issues (Heydtmann, unpublished; McKean, unpublished). There will always be difficulties in getting views of patients in a crisis requiring frequent emergency attendances or admissions. However, this study has shown that it is possible, with some effort, to include them in service development.

Findings from this qualitative study, in a single Scottish hospital, can be refined with regard to themes in larger study populations. In addition, other disadvantaged populations with alcohol problems not captured here and known for possible frequent attendance could form target study populations.

As a "snap-shot" of AFAs' views and experiences the current findings provide no indication of outcome for participants as a group. A different study design would be required.

Recommendations

Recommendations for services

Service Design

AFAs represent a population of long-term, harmful and dependent drinkers, who present with wide-ranging and complex needs, sometimes in crisis. Their impact on both ED and hospital admissions is very significant (Blackwood et al., 2021). In the light of these findings, it is

recommended that consideration be given to designing a dedicated service primarily for the complex needs of AFAs. Such a service should take account of these study findings particularly with reference to mental health and trauma. Particular consideration should be given to gender in service design, given the distinctly different experiences of women and men.

Service network

A significant number of help/support/recovery services in the area and adjacent in Glasgow were referred to by participants but, whilst participants knew of many of them, they had attended only a few.

Service signposting might assist AFAs to access services other than the NHS, particularly if hospital attendance is not in the best interest of the person. However, it is acknowledged that the participant's readiness to change would influence engagement with such information.

The service network, at least from the participants' perspective, appeared to be disconnected, particularly between statutory services (NHS and local authority) and third sector organisations. Some of these services benefit from peer support and people with "lived experience" who may become a significant part of the contribution to recovery for frequent attenders. Therefore, better links between services and help to navigate these, including the engagement of people with "lived experience", should be considered by the Alcohol and Drug Partnerships to help frequent attenders.

It is noted in this study that many have missed what can be regarded as 'social prescribing' which would have helped them in their recovery, and the COVID-19 pandemic has been a significant barrier to accessing such interventions. Community Alcohol Teams and specialist acute services such as Addiction Liaison and Liaison Psychiatry routinely promote and signpost these. It is evident that, for many people in recovery, social interaction with their peers in non-drinking environments is valued. For this very vulnerable group online replacements of interactions were very unpopular.

Gender

Within AFAs, two distinct populations were identified, which broadly divided on gender lines. Women reported drinking in the context of a mental health crisis and men reported physical deterioration, through chronic drinking. Account should be taken of these dimensions in service design.

Mental health

All participants referred to the impact of their mental health on their alcohol consumption. Women, in particular, spoke of negative experiences of out-of-hours mental health assessment, often describing being sent/brought to places of emergency assessment by statutory services only to be turned away, leading to frustration. Given the strong association with mental health crisis in this study, services should review provision, in particular for women with alcohol problems in crisis.

Family

Study participants indicated that the negative impact of problem drinking in families is significant across generations. However, families and significant others can also be a source of support in recovery so it is recommended that support is given to the work of Scottish Families Affected by Alcohol and Drugs and other organisations that provide support for families.

Mutual aid

Mutual aid forms a significant part of the overall responses to problem drinking. Based on a significant body of supporting evidence, on AA in particular (Tonigan et al., 2018), and reports from a substantial proportion of study participants, dependent drinkers should be informed of, and encouraged to consider mutual aid or AA attendance. “To its detractors, AA is unscientific, smacks of fundamentalist religion, excludes those who do not espouse its views and is not open to other forms of help for alcoholics. To its admirers AA is an organization made up of winners”, (Vaillant, 1983).

Alcohol-related Liver Disease

Scottish Health Action on Alcohol Problems (SHAAP) has produced a guidance document including a set of recommendations (2018): “Alcohol-related liver disease: Guidance for good practice”. This is based on current evidence and is relevant given the proportion of study participants, in this study, who reported a diagnosis of liver disease. These findings underline the SHAAP recommendations in particular on follow-up to prevent frequent re-attendance and to develop services for people who decline engagement with usual services.

Research recommendations

In this qualitative study the ALFA project has not been evaluated with regards to effectiveness to decrease readmission rates. The focus of research could also be levels of engagement; progression in the recovery pathway of patients; and engagement with the broader service network. Evaluation of the views of providers of services for these patients, including the nurses, ED staff and third sector workers would be useful. Further positive evaluations will strengthen the spread of this quality improvement activity to other NHS services.

Ongoing evaluation of NHS records to identify AFAs in real time and their follow up through the health and care systems is recommended and definitions of frequent attenders might need to be individualised, dependent on local circumstances and resources. (See Blackwood et al.’s study (2021) of ARFA and NHS records).

This study used a small group of participants, only seven of whom were female. Careful analysis of the role of gender in this study identified that, within AFAs, there may be two distinct populations, which broadly divide on gender lines, with women drinking in the context of a mental health crisis and men physically deteriorating through chronic drinking. Given the small sample of this study, it would require more rigorous investigation of larger cohorts to discern whether our findings are generalisable for AFAs in other contexts. Because women spoke more about disengagement from the CMHT, further research could examine specifically support for mental health issues for women with alcohol problems (See Jemberie et al., 2022).

The change to telephone interviews because of COVID-19 restrictions in this study is relevant and the future of addiction research may be shaped by the pandemic. As a result, remote methods for interview and assessment might be used more often, which would have an effect on access to different populations (Englund et al., 2022).

Participant numbers were appropriate for this qualitative study. However, a larger cohort study and further participant follow-up would add to the knowledge around AFAs. It would be feasible to design follow-up studies, and to test further interventions for this group.

Given the variety in definition (Black & Gill, 2016; Blackwood et al., 2021; Dargan 2013; Neale et al., 2016) care must be taken to clarify the AFA/ARFA group concerned and the implied relevant interventions. Such definitions imply differing characteristics, particularly in relation to age, gender, homelessness and the potential variety of substances used. It is concluded that a consensus on a very reactive definition of frequent attenders will be important for future research.

Conclusions

> “High-need, high-cost (HNHC) alcohol related frequent attenders (ARFAs) are a subgroup of all patients with alcohol-related hospital admissions and are characterised by having multiple hospital admissions or attendances caused by alcohol during a relatively short time period” (Drummond et al., 2018).

Drummond et al.'s comments emphasise the importance of early identification of AFAs to develop an effective patient-centred service. In this study, participants who attended ED, or were admitted to hospital for a variety of health issues, including liver disease, were interviewed. The advantage of the early identification was to help them almost immediately through contact with alcohol services (ALFA service) and this will have affected some of the results. Participants demonstrated a wide range of dependence on alcohol: 20% high, 50% medium and 30 % scoring low dependence as measured by the LDQ. The proportion of participants scoring low dependence might be because of a positive effect of the interventions by the ALFA service and may imply a degree of commitment to change.

It is relevant that participants were recruited from the newly implemented ALFA project and telephone interviews were conducted, which will need to be considered in interpretation of the report.

Participants reported a wide range of complex problems, some of which promoted drinking and many of which were consequent upon their heavy drinking. Overarching themes, on which most if not all participants contributed, included physical and mental health, motivation, trauma, family, livelihood and legal problems. Gender differences were specifically analysed. Women spoke of concerns about acute mental health and how it was impacted by drinking. They also gave more consideration to recovery options than men, who tended to focus on the

physical deterioration associated with drinking and engagement with the criminal justice system.

Participants reported their views on a wide range of services but did not point to a favoured theoretical framework or approach. However, the range of services accessed underlined the high need and complexity of AFAs, which suggests that a dedicated service is of benefit, taking into account the findings presented here. An increased awareness of AFAs in the service network will alert all services to the vulnerability and special needs of this group of patients, many of whom were known to different agencies in the service network.

AFAs have a high alcohol-related mortality. Consequently, appropriately targeted interventions for this complex vulnerable group are important, and lifesaving.

References

Alcohol Concern (2010a). *Factsheet: information and statistical digest*. London.

Alcohol Concern (2010b). *Swept under the carpet: children affected by parental alcohol misuse*. Alcohol Concern. http://www.alcoholconcern.org.uk/assets/files/Publications/Swept%20under%20the%20carpet.pdf

Ashford, R. (2022). Recovery, Communities and the Organised Recovery Movement. In Tucker J, and Witkiewitz, K. (Eds) (2022) *Dynamic pathways to recovery from alcohol disorder: Meaning and Methods*. Cambridge University Press.

Babor, T., & Del Boca, F. (Eds.) (2003). *Treatment matching in alcoholism*. Cambridge University Press.

Barrie, K., & Scriven, A. (2014) *Alcohol misuse: A Public Health Mini-Guide*. Elsevier.

Bandura A. (1977). Self-efficacy: toward a unifying theory of behavioral change. *Psychological review*, *84*(2), 191–215. https://doi.org/10.1037//0033-295x.84.2.191

Best, D., Hargreaves, C., Hodgson, P., & Patton, D. (2022). Recovery Communities: Resources and Settings, in Tucker, J., & Witkiewitz, K. (Eds.) (2022). *Dynamic pathways to recovery from alcohol disorder: Meaning and Methods*. Cambridge University Press.

Black, H., & Gill, J. (2016). *Mortality among a cohort of heavy drinkers in Edinburgh and Glasgow*. Scottish Health Action on Alcohol Problems.

Blackwood, R., Lynskey M., & Drummond, C. (2021). Prevalence and patterns of hospital use for people with frequent alcohol related admissions, compared to non-alcohol and non-frequent admissions: a cohort study using routine administrative hospital data. *Addiction.* 116(7). https://doi.org/10.1111/add.15354

Blackwood, R., Wolstenholme, A., Kimergård, A., Fincham-Campbell, S., Khadjesari, Z., Coulton, S., Byford, S., Deluca, P., Jennings, S., Currell, E., Dunne, J., O'Toole, J., Winnington, J., Finch, E., &

Drummond, C. (2020). Assertive outreach treatment versus care as usual for the treatment of high-need, high-cost alcohol related frequent attenders: study protocol for a randomised controlled trial. *BMC public health*, *20*(1), 332. https://doi.org/10.1186/s12889-020-8437-y

Blakeborough, L. & Richardson, A. (2012). *Summary of findings from two evaluations of Home Office Arrest referral pilot schemes. Research Report 60*. Home Office.

Brown, J., & Kirk-Wade, E. (2021). *Coronavirus: A history of English lockdown laws*. House of Commons Library. https://researchbriefings.files.parliament.uk/documents/CBP-9068/CBP-9068.pdf

Bowling, A. (2002). *Research methods in health: investigating health and health services*. Open University.

Campbell, N., & Herzberg, D. (2017). Gender and critical drug studies: an introduction and an invitation.*ontemporary Drug Problems, 44*(4), 251-264. https://doi.org/10.1177%2F0091450917738075

Charzynska, K., Hyldager, E., Baldacchino, A., Greacen, T., Henderson, Z., Laijärvi, H., Hodges, C.L., Lack, C., Sieroslawski, J., & Baeck-Moller, K. (2011). Comorbidity patterns in dual diagnosis across seven European sites. *The European Journal of Psychiatry*, *25*(4), 179-191. https://dx.doi.org/10.4321/S0213-61632011000400001

Casswell, S., You, R. Q., & Huckle, T. (2011). Alcohol's harm to others: reduced wellbeing and health status for those with heavy drinkers in their lives. *Addiction*, *106*(6), 1087–1094. https://doi.org/10.1111/j.1360-0443.2011.03361.x

Dargan, S. (2013). *Alcohol-related deaths in Glasgow City: a cohort study 2013*. Glasgow City Alcohol and Drugs Partnership. https://www.nhsggc.org.uk/media/240118/alcohol_related_deaths_glasgow_city_cohort_2013.pdf

Di Clemente, C. (2018). *Addiction and Change: How addictions develop and addicted people recover* (2nd ed.) Guilford.

DiClemente, C.C., Fairhurst, S.K., & Piotrowski, N.A. (1995). Self-efficacy and addictive behaviors. In J. E. Maddux (Ed.), *Self-efficacy, adaptation, and adjustment: theory, research, and application,* 109–141. Plenum Press. https://doi.org/10.1007/978-1-4419-6868-5_4

Drabble, L., Trocki, K. F., Salcedo, B., Walker, P. C., & Korcha, R. A. (2016). Conducting qualitative interviews by telephone: Lessons learned from a study of alcohol use among sexual minority and heterosexual women. *Qualitative Social Work : Research and Practice*, *15*(1), 118–133. https://doi.org/10.1177/1473325015585613

Drummond, C., Wolstenholme, A., Blackwood, R., & Kimergard, A. (2018). *Assertive outreach for high-need, high-cost alcohol related frequent NHS hospital attenders*. National Institute for Health Research, NHS. https://www.clahrc-southlondon.nihr.ac.uk/files/Assertive%20outreach_May_2019.pdf

Edwards G. (2000). Natural recovery is the only recovery. *Addiction*, *95*(5), 747. https://doi.org/10.1046/j.1360-0443.2000.95574710.x

Englund, A., Sharman, S., Tas, B., & Strang, J. (2022). Could COVID expand the future of addiction research? Long-term implications in the pandemic era. *Addiction*, *117*(8), 2135–2140. https://doi.org/10.1111/add.15790

Galatzer-Levy, I.R., Huang, S.H. & Bonanno, G.A (2018). Trajectories of resilience and dysfunction following potential trauma: A review and statistical evaluation, *Clinical Psychology Review, 63*, 41-55 https://doi.org/10.1016/j.cpr.2018.05.008.

Glaser, B., & Strauss, A. (2017). *The Discovery of Grounded Theory: strategies for qualitative research.* Routledge.

Goldberg, B., Brintnell, E.S., & Goldberg, J. (2002). The Relationship Between Engagement in Meaningful Activities and Quality of Life in Persons Disabled by Mental Illness. *Occupational Therapy in Mental Health*, *18*(2), 17-44. DOI: 10.1300/J004v18n02_03

Gossop, M., Harris, J., Best, D., Man, L. H., Manning, V., Marshall, J., & Strang, J. (2003). Is attendance at Alcoholics Anonymous meetings after inpatient treatment related to improved outcomes? A 6-month follow-up study. *Alcohol and alcoholism*, *38*(5), 421–426. https://doi.org/10.1093/alcalc/agg104

Hayhurst, C., Smith, S., & Chambers, D. (2017). *Frequent Attenders in the Emergency Department: Best Practice Guideline*. Royal College of Emergency Medicine. https://rcem.ac.uk/wp-content/uploads/2021/10/Frequent_Attenders_in_the_ED_Aug2017.pdf

Heather, N., & UKATT Research Team. (2008). UK alcohol treatment trial: Client-treatment matching effects. *Addiction, 103*(2), 228–238. https://doi.org/10.1111/j.1360-0443.2007.02060.x

Henssler, J., Müller, M., Carreira, H., Bschor, T., Heinz, A., & Baethge, C. (2021). Controlled drinking-non-abstinent versus abstinent treatment goals in alcohol use disorder: a systematic review, meta-analysis and meta-regression. *Addiction*, *116*(8), 1973–1987. https://doi.org/10.1111/add.15329

Hester, M. (2009) *Who does what to whom? Gender and domestic violence perpetrators*, University of Bristol. www.nr-foundation.org.uk/.../uploads/2011/07/Who-Does-What-to-Whom.pdf

Hu, B., Guo, H., Zhou, P., & Shi, Z. L. (2021). Characteristics of SARS-CoV-2 and COVID-19. *Nature reviews. Microbiology*, *19*(3), 141–154. https://doi.org/10.1038/s41579-020-00459-7

ISD (2009) *Alcohol consumption in black and minority ethnic groups and recent immigrants in Scotland: current situation on available information*. https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Alcohol/Historic-Publications/_docs/bme_and_alcohol_report_final.pdf

Jemberie, WB., Padyab,M., McCarty, D., and Lundgren, L. (2022) Recurrent risk of hospitalization among older people with problematic alcohol use: a multiple failure-time analysis with a discontinuous risk model. Addiction 117 (9). https://doi:10.1111/add.15907

King, N., Horrocks, C. & Brooks, J. (2019). *Interviews in Qualitative Research.* (2nd Ed.). Sage.

Kyle, D., Shaw, M., Maguire, D., McMillan, D., Quasim, T., Leyland, A. H., & McPeake, J. (2021). The wider implications of the COVID-19 pandemic: Assessing the impact of accident and emergency use for frequent attenders. *International Emergency Nursing*, *56*, 100984. https://doi.org/10.1016/j.ienj.2021.100984

Langeland, W., Draijer, N., & van den Brink, W. (2004). Psychiatric Comorbidity in Treatment-Seeking Alcoholics: The Role of Childhood Trauma and Perceived Parental Dysfunction. Alcoholism: *Clinical and Experimental Research*, *28*, 441-447.https://doi.org/10.1097/01.ALC.0000117831.17383.72

common are psychotic disorders? https://cks.nice.org.uk/topics/psychosis-schizophrenia/background-information/prevalence/

National Institute for Health & Care Excellence (2021c). *Depression: How common is it?* https://cks.nice.org.uk/topics/depression/background-information/prevalence/

National Records Scotland (2021). *Alcohol-specific deaths 2020*. https://www.nrscotland.gov.uk/files//statistics/alcohol-deaths/2020/alcohol-specific-deaths-20-report.pdf

Neale, J., Parkman, T., Day, E. & Drummond, C. (2016). Frequent attenders to accident and emergency departments: a qualitative study of individuals who repeatedly present with alcohol related health conditions. *Alcohol Insight, 134*. https://alcoholchange.org.uk/publication/frequent-attenders-to-accident-and-emergency-departments-a-qualitative-study-of-individuals-who-repeatedly-present-with-alcohol-related-health-conditions

Neale J. (2016). Iterative categorization (IC): a systematic technique for analysing qualitative data. *Addiction*, *111*(6), 1096–1106. https://doi.org/10.1111/add.13314

NHS Health Scotland (2015). *Social Prescribing for Mental Health: Background Paper.* http://www.healthscotland.scot/media/2067/social-prescribing-for-mental-health-background-paper.pdf

NOMIS (2021). *Labour Market Profile – Renfrewshire*. https://www.nomisweb.co.uk/reports/lmp/la/1946157429/printable.aspx

Osborne, R., Albert, R. (2018). *Managing Frequent A&E Attenders in an East London Hospital: Evaluation of a 10-month pilot project*. East London NHS. NHS Foundation Trust. https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/psychiatric-liaison-services-plan/past-event-resources/plan-managing-frequent-aande-attenders.pdf?sfvrsn=f2b378ad_2

Parahoo, K. (2006). *Nursing Research: Principles, Process and Issues* (2nd Ed.). Palgrave Macmillan

Parkman, T., Neale, J., Day, E., & Drummond, C. (2017). Qualitative exploration of why people repeatedly attend emergency departments for alcohol-related reasons. *BMC Health Services Research*, *17*, 140. doi: 10.1186/s12913-017-2091-9. PMID: 28209195; PMCID: PMC5314470.

Pavkovic, B., Zaric, M., Markovic, M., Klacar, M., Huljic, A. & Caricic, A. (2018). Double screening for dual disorder, alcoholism and depression, *Psychiatry Research*, *270*, 483-489. https://doi.org/10.1016/j.psychres.2018.10.013.

Polich, M., Armor, D., & Braiker, H. (1981). *The Course of Alcoholism: Four Years After Treatment.* Wiley.

Ponce Hardy, V., & Giles, L. (2022). *Monitoring and Evaluating Scotland's Alcohol Strategy: Monitoring Report 2022. Public Health Scotland*. https://publichealthscotland.scot/publications/mesas-monitoring-report-2022

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change of smoking: toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51*(3), 390–395. https://doi.org/10.1037/0022-006X.51.3.390

Puddephatt, J. A., Irizar, P., Jones, A., Gage, S. H., & Goodwin, L. (2022). Associations of common mental disorder with alcohol use in the adult general population: a systematic review and meta-analysis. *Addiction*, *117*(6), 1543–1572. https://doi.org/10.1111/add.15735

Roberts, E., Morse, R., Epstein, S., Hotopf, M., Leon, D., & Drummond, C. (2019). The prevalence of wholly attributable alcohol conditions in the United Kingdom hospital system: a systematic review, meta-analysis and meta-regression. *Addiction*, *114*(10), 1726–1737. https://doi.org/10.1111/add.14642

Raistrick, D., Bradshaw, J., Tober, G., Weiner, J., Allison, J., & Healey, C. (1994). Development of the Leeds Dependence Questionnaire (LDQ): a questionnaire to measure alcohol and opiate dependence in the context of a treatment evaluation package. *Addiction*, *89*(5), 563–572. https://doi.org/10.1111/j.1360-0443.1994.tb03332.x

Renfrewshire Council (2015). *Renfrewshire- Local Authority Profile*. https://www.renfrewshire.gov.uk/media/2187/Renfrewshire-Profile/pdf/RenfLocalAuthorityProfile.pdf?m=1460462834767

Rotter, J. B. (1954). *Social learning and clinical psychology.* Prentice-Hall, Inc. https://doi.org/10.1037/10788-000

Scotland's Census (2011). *Education*. https://www.scotlandscensus.gov.uk/census-results/at-a-glance/education/

Scottish Government (2018). Rights*, respect and recovery: alcohol and drug treatment strategy*. https://www.gov.scot/publications/rights-respect-recovery/

Scottish Government (2020). *Next steps for NHS Scotland*. https://www.gov.scot/news/next-steps-for-nhs-scotland/

Scottish Government (2021) Scottish Index of Multiple Deprivation 2020. https://www.gov.scot/collections/scottish-index-of-multiple-deprivation-2020/

Scottish Health Action on Alcohol Problems (2016). *Alcohol-Related Liver Disease: Guidance for Good Practice*. SHAAP. https://www.shaap.org.uk/downloads/reports-and-briefings/41-ald-report-v2018-pdf.html

Scottish Public Health Observatory (2018). *Hospital Admissions, deaths and overall burden of disease attributable to alcohol consumption in Scotland*. NHS Health Scotland. https://www.scotpho.org.uk/publications/reports-and-papers/hospital-admissions-deaths-and-overall-burden-of-disease-attributable-to-alcohol-consumption-in-scotland

Scottish Public Health Observatory (2021). *Online Profiles Tool*. https://scotland.shinyapps.io/ScotPHO_profiles_tool/

Shaw, J., Hunt, I. M., Flynn, S., Amos, T., Meehan, J., Robinson, J., Bickley, H., Parsons, R., McCann, K., Burns, J., Kapur, N., & Appleby, L. (2006). The role of alcohol and drugs in homicides in England and Wales. *Addiction, 101*(8), 1117–1124. https://doi.org/10.1111/j.1360-0443.2006.01483.x

Tonigan, J., Pearson, M., Magill, M., Hagler, K., (2018) AA attendance and abstinence for dually diagnosed patients: a meta-analytic review. Addiction 116 (11), 1970-1981. https://doi:10.1111/add.14268

Tucker, J., and Witkiewitz, K. (Eds) (2022). *Dynamic pathways to recovery from alcohol disorder: Meaning and Methods.* Cambridge University Press.

Vaillant, G. (1983). *The natural history of alcoholism*. Harvard University Press.

Van der Kolk, B.A. (2009). Developmental Trauma Disorder- A new, rational diagnosis for children with complex trauma histories. *Praxis der Kinderpsychologie und Kinderpsychiatrie*, *58*(8), 572-86. https://doi: 10.13109/prkk.2009.58.8.572.

Wales, A., & Gillan, E. (2009). *Untold damage: children's account of living with harmful parental drinking. Scottish Health Action of Alcohol Problems*. SHAAP & ChildLine Scotland https://www.shaap.org.uk/images/UserFiles/File/Reports%20and%20Briefings/Untold%20Damage%20full%20report.pdf

Weathers, F. W., & Keane, T. M. (2007). The Criterion- a problem revisited: controversies and challenges in defining and measuring psychological trauma. *Journal of traumatic stress*, *20*(2), 107–121. https://doi.org/10.1002/jts.20210

Zaorska, J., & Jakubczyk, A. (2019). The Prevalence and Significance of Childhood Trauma in Alcohol-dependent Patients. *Alcohol Drug Addict*; *32*(2), 131-152. https://doi.org/10.5114/ain.2019.87628

Appendices

A. Impairment Check and Demographic Detail

B. Semi-structured Interview Schedule: AFA

C. Leeds Dependence Questionnaire

D. ALFA (Alcohol Liver Frequent Attenders) nurse outreach project: information sheet.

Appendix A. Impairment Check and Demographic Details

Impairment Check

Q. Name?

Q. Where you are at the moment?

Q. What year it is?

Q. Prime Minister?

Flow: if not orientated to self, time, place then bring to end and re-arrange another appointment. If 3rd attempt, thank for participation and let them know they will be removed from list.

Demographic details

Q. Gender:

Q. Age:

Q. Ethnicity:

Q. Employment status:

Q Highest educational attainment:

Q. Address & Postcode (for £25):

Q. Supermarket of choice: Asda, Morrisons, Aldi

Appendix B: Semi-structured Interview Schedule

Semi-Structured Interview Schedule: Alcohol Frequent Attenders

1. Can you tell me why you have attended hospital in the last year or so?
2. What health issues are you / have you experienced in the last year?
3. What factors have influenced your health?
4. In what ways might drinking alcohol be a factor?
5. How useful do you think helping services have been for you? Have you used many help services in the last 2 years?
6. What sort of help do you think would help you best, now and in the future?
7. Do you think your drinking/substance use contributes to your current situation? In what ways?
8. Do you think you need help with your drinking?
9. Have you attended specialist alcohol/addiction services? E.g., NHS, community based, 12 step groups.
10. Are there other sources of help, other than a hospital, which you could access? e.g., in your local community.

Appendix C: The Leeds Dependence Questionnaire

Leeds Dependence Questionnaire - LDQ

Here are some questions about the importance of alcohol or other drugs in your life. Think about the main substance you have been using over the **last 4 weeks** and tick the closest answer to how you see yourself

	Never 0	Sometimes 1	Often 2	Nearly Always 3
Do you find yourself thinking about when you will next be able to have another drink or take more drugs?	☐	☐	☐	☐
Is drinking or taking drugs more important than anything else you might do during the day?	☐	☐	☐	☐
Do you feel that your need for drink or drugs is too strong to control?	☐	☐	☐	☐
Do you plan your days around getting and taking drink or drugs?	☐	☐	☐	☐
Do you drink or take drugs in a particular way in order to increase the effect it gives you?	☐	☐	☐	☐
Do you drink or take drugs morning, afternoon and evening?	☐	☐	☐	☐
Do you feel you have to carry on drinking or taking drugs once you have started?	☐	☐	☐	☐
Is getting an effect more important than the particular drink or drug you use?	☐	☐	☐	☐
Do you want to take more drink or drugs when the effects start to wear off?	☐	☐	☐	☐
Do you find it difficult to cope with life without drink or drugs?	☐	☐	☐	☐

APPENDIX D: ALFA Project Information Sheet

ALFA Project Information Sheet

“Specialist Outreach Addictions Nurses” (also known as ALFA Nurses - “Alcohol and Liver Frequent Attender Nurses”)

I would herewith like to introduce X and Y our two new full-time addiction / liver trained nurses based at the Royal Alexandra Hospital. The aim of their work will be to provide care in the community for very frequent attenders who usually do not engage with other services, thereby preventing frequent attendances. They are aiming to help people with alcohol problems who find it difficult to engage with other services and only use the Royal Alexandra Hospital emergency services for treatment. Alcohol is a common cause of A&E frequent attendance and data on readmissions show that alcohol and liver illness are the second and third cause of re-admission at the Royal Alexandra Hospital Paisley. These people generally avoid GPs and don't attend any other alcohol services and do not attend outpatient appointments.

This project is funded by the Renfrewshire HSCP (Health and Social Care Partnership) through Renfrewshire ADP (Alcohol and Drug Partnership) and Renfrewshire Primary Care Transformation Fund (PCTF) from Scottish Government. The posts are a result of local work done to better understand frequent A&E attenders and people frequently admitted to medical wards of the RAH. The posts are secondments, initially for two years. The nurses will identify patients by their frequent attendance on a weekly basis using a “microstrategy” approach (automated list generated from hospital data). This will identify the most frequently attending people to the hospital (tip of the iceberg approach). This is currently defined as three or more A&E visits in the previous four weeks or three or more inpatient admissions in the past 12 weeks. Due to the microstrategy approach referral to the nurses is not necessary but the methodology will be regularly reviewed. The aim is to reach and treat people who are not being treated at present and thereby reduce A&E attendances and hospitalisations in the frequent attenders by caring for those for whom this is the only point of call when in crisis.

The nurses will contact people identified through the strategy (in the hospital or the community) to find out what matters to them and identify ways of improving their health and wellbeing outside the hospital. They will work with general practice, community addiction workers, social service, housing, their family

or people important to them, navigators and other relevant services in the community (including third sector) to support the people and signpost to relevant support. Their work will include to help of the patients to attend clinic appointments (virtual or face to face), encourage healthier lifestyles including dealing with alcohol and addiction and there will be no barrier in their support (people do not have to be abstinent for example and support is repeatedly offered even if they do not engage). Clinical supervision will be by Dr. Mathis Heydtmann, Consultant Hepatologist at the RAH in Paisley and Vice Chair of the Renfrewshire ADP and by Dr. Chris Johnstone, Associate Clinical Director for General Practice in Renfrewshire. Line management and support will be from the Renfrewshire HSCP addictions team.

X and Y will have access to a computer and desk at the Royal Alexandra Hospital where they will link with relevant services (psychiatry liaison, alcohol and addiction liaison, liver and other medical teams as necessary). It is expected that their office work in the RAH will be limited to a few (a couple of) hours per day likely mainly in the morning. However, their main work will be in the community where they will provide assertive outreach to support the patients, make connections with and work with district nurses, case workers and other care providers. They will have at least weekly case conferences with their supervisor discussing the people and they will have individual phones. The best way of contacting X and Y with regards to patients identified as very frequent attenders is via their e-mails. It is expected that the nurses significantly improve the care for these people and reduce requirement for hospitalisation and lead to significant improvement in efficiency. The work will be based on the needs of the patients and discussions at the case discussions at the supervisory meetings. This semi-autonomous way of working will enable the X and Y to work out ways of engaging these people effectively and allow them to mould the future of engaging with these people. Their work will be audited on an ongoing basis and it is expected to lead to continuation of this work after the 2 years.

Dr. Mathis Heydtmann, Consultant Hepatologist, RAH, Paisley.

Chris Johnstone, Associate Clinical Director for General Practice, Renfrewshire.

SHAAP - Scottish Health Action on Alcohol Problems
12 Queen Street
Edinburgh EH2 1JQ
Tel: +44 (0) 131 247 3667
Email: shaap@rcpe.ac.uk
www.shaap.org.uk

UNIVERSITY OF THE WEST *of* SCOTLAND
UWS

Renfrewshire
Health & Social Care
Partnership

NHS
Greater Glasgow and Clyde

SHAAP

SCOTTISH HEALTH ACTION ON ALCOHOL PROBLEMS

www.shaap.org.uk