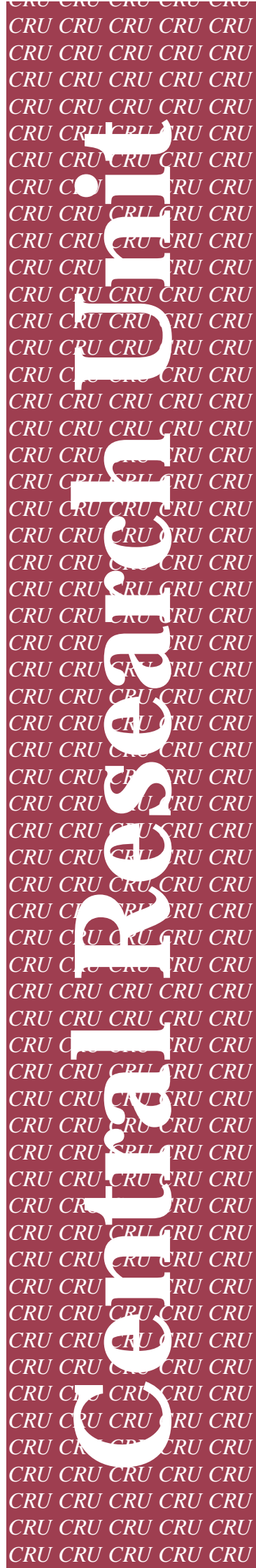


ATTITUDES TOWARDS ALCOHOL:

Views of the General Public, Problem Drinkers, Alcohol Service Users and their Families and Friends



SCOTTISH EXECUTIVE



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**Views of the General Public, Problem Drinkers, Alcohol
Service Users and their Families and Friends**

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NFO System Three Social Research**

**Scottish Executive Central Research Unit
2002**

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EXECUTIVE SUMMARY

Introduction

The Scottish Executive Health Department has recently undertaken a public consultation exercise and commissioned various pieces of research to explore issues around alcohol and alcohol misuse in Scottish society. Overall, the consultation and research programme aimed to examine the main concerns about the drinking of alcohol in Scotland, establish views about what is being done and what needs to be done, and establish how various bodies can contribute to the Plan for Action.

A key component of this large-scale exercise involved a research project carried out by NFO System Three to explore the views of specific groups towards alcohol use and misuse and services associated with these behaviours. The research focused on the perceptions and experiences of ‘drinkers’, current and past alcohol service users, as well as those close to them (i.e. family and friends). The research explored general views and experiences regarding alcohol and alcohol-related services, but also focused on perceptions of how far needs are being met and what other provision might be considered necessary and/or desirable.

Methodology

Because the research was exploratory in nature and focused on potentially complex attitudes, experiences and perceptions, the main component of the research was qualitative consisting of a mixture of focus groups and face-to-face in-depth interviews. There was also a separate quantitative survey that aimed to establish attitudes towards alcohol in Scotland, awareness of and contact with alcohol services among the general population and strategies for tackling alcohol misuse. A representative sample (consisting of 1,061 adults) of the Scottish population was interviewed using Computer Assisted Personal Interviewing.

Summary of findings from the quantitative component

Awareness of and contact with alcohol services

In terms of alcohol-related services, respondents appeared to be confident about finding and contacting a service should they or someone they know experience problems with alcohol. However, the survey did not ask how they would find a contact name or address nor whom they would contact. The qualitative interviews suggest that the high levels of confidence may reflect very general ideas about contact – such as using a telephone book or contacting a local doctor – rather than actually knowing about specific services.

Attitudes towards alcohol misuse

The survey found many people feel that most violent crime is alcohol-related and that alcohol misuse is increasing among young people. While traditionally men have been perceived to be the major consumers of alcohol - and are perhaps the most likely to have alcohol-related problems - the survey suggests that this is no longer perceived to be the case

Tackling alcohol misuse in Scotland

Tackling alcohol misuse in Scotland is a major task and the survey found clear public support for stricter enforcement of existing laws, improving services for people with alcohol problems and providing more information or education about the dangers of drinking. There was no consensus on what should be done about the current opening hours of licensed premises.

Summary of findings from the qualitative component

Views and experiences of alcohol in Scotland

The research highlighted the pivotal role that alcohol plays in Scottish society with many people identifying alcohol as the main focus of their social life. There was a perception that drinking behaviour in Scotland differs greatly from other European cultures but is similar to the rest of the United Kingdom. Many people felt that media representation of Scottish people as '*big drinkers*' were unfair, but at the same time many of the same people contradicted this by embracing elements of the same stereotype image.

While alcohol was seen as being associated with enjoyment, socialising, relaxing and gaining confidence, there was also a perception that it was easy for the negative aspects of alcohol to develop out of these. For example, the 'positive' use of alcohol for the relief of stress and for forgetting about problems was seen to be dangerous. The main negative aspects of alcohol identified by participants related to the detrimental effect on other aspects of their lives – personal relationships, aggression and violence, financial problems and loss of control. The negative impact of alcohol on physical health was not highlighted to any great extent, except by alcohol misusers and those close to them. This latter group was, as expected, more aware of the negative aspects than others.

Understanding(s) of terminology associated with 'alcohol misuse'

The first point to note about the term 'alcohol misuse' is that it is not used in everyday parlance. When asked specifically about it, there was some evidence of people associating the term with the inappropriate use of alcohol, such as binge-drinking or drinking out of habit if not dependency. However, for most people the term was difficult to comprehend.

‘Alcohol problems’ were often seen to refer to the point at which alcohol begins to impinge on other aspects of the user’s life - for example by impairing their ability to function normally in a work, domestic or social environment.

‘Alcoholism’, a term which was commonly used, was most often seen as the point at which alcohol not only impinges on but takes control of everyday life and the point at which people ‘need’ to drink alcohol. For some ‘alcoholism’ was a disease, while others saw it as having different causes, such as socialisation and life crises.

While we can summarise these definitions in this way, it should be noted that these were the most common understandings to emerge but by no means the *only* understandings. There was a high degree of confusion and disagreement in relation to all three terms.

While exploration of how people define and understand alcohol problems proved an interesting part of the research in itself, it should not be viewed in isolation. Definitions of alcohol misuse are strongly linked to alcohol-related behaviours, cultural attitudes to alcohol and the likelihood of people contacting and accessing services.

Views on what leads people to problem drinking

Participants drew on a range of potential causes including illness, addiction, allergy, genetic pre-disposition and socialisation. In most cases, the explanations offered did not focus on one single reason but rather a combination of factors from across the range of discourses.

A number of alcohol service users saw alcohol misuse as the result of a disease, allergy, illness or genetic pre-disposition that simply meant they could not drink alcohol in the ‘normal’ way. Other explanations located the problem with the addictive qualities of alcohol itself rather than with any characteristic of individuals. It was also noted that multiple alcohol problems experienced within families might result from socialisation rather than genetic determinism. For some service users, the transition from drinking to developing a problem with alcohol was clearly marked by some kind of traumatic life event. Others described more of a gradual descent into alcoholism through prolonged and everyday use.

There was a widespread consensus that problems of alcohol misuse can affect anyone regardless of age, sex or social background. However, certain groups were seen to be more at risk than others. The current generation of young people was seen as at greater risk of developing problems with alcohol. Loneliness and boredom were also seen as factors increasing risk for groups such as the unemployed, divorced or widowed people and those living in rural areas.

Awareness and perceptions of alcohol-related services

The research found that there were low levels of awareness of organisations providing help or advice for people with alcohol-related problems. This was the case across all the different participant groups, although those who had had some contact with a service displayed higher levels of awareness than those who had not. In the majority of cases, once contact had been made with a service, awareness and knowledge of other service providers appeared to increase.

The local doctor was most commonly identified as a potential source of advice or help, primarily because of a lack of knowledge about other service providers. Most participants were aware of Alcoholics Anonymous. A small number of non-service users were able to name other specific services, but most of the services mentioned were more generic, such as ‘counselling’, ‘the doctor’ and ‘psychologists’.

Levels of awareness of services for friends and families of those with an alcohol problem were generally even lower, not only among ‘drinkers’ but also among current alcohol service users and the friends and family service user target groups.

Regardless of participants’ levels of knowledge of available services, there was a widespread consensus that alcohol services are not publicised widely enough.

Views of and contact with services

The discussions with all participant types highlighted a recognised need for alcohol-related services for problem drinkers and this support was confirmed in the findings of the survey of the general public. There was also support for increasing the provision of services for families and friends of alcohol misusers.

Alcohol services tend to be seen as providing help and support to the most ‘desperate’ people. This again links back to our discussions of terminology – services tend to be seen as being for ‘alcoholics’ (that is, as defined by research participants, people whose lives are falling apart) not for alcohol misusers.

There was a widespread view that a large number of barriers that might prevent people from making contact with alcohol-related service providers existed. The most fundamental barrier was identified as getting people to admit to themselves, and then to others, that they had a problem. Reluctance to admit to a problem was again linked to perspectives on what constitutes alcohol misuse and alcoholism. Until this barrier is overcome it was felt unlikely that people would be more willing to approach services for help. However, even if a person recognises the need for help there still appears to be a number of significant factors preventing contact being made with a service. These fell into two main categories – psychological and practical. The psychological barriers were primarily based around what other people would think – for example, fear of shame, embarrassment and stigmatisation. Fear of the possible impact on careers and employment were of particular concern to some respondents. On a more practical level, caring responsibilities were perhaps the single most common barrier. Perceived problems with some processes of referral to alcohol services were also mentioned, particularly in relation to GPs. While some general practitioners were knowledgeable and informed, others appeared to have little awareness of how to deal with the issue or knowledge of other services that could help.

Perceptions of what works

Participants saw some characteristics as essential requirements of any kind of alcohol-related service provision. Confidentiality was considered to be a crucial element of any service provision and this was generally framed in terms of the fear of the stigma surrounding alcohol misuse.

Several issues relating to the accessibility of services arose in the research. Participants felt that services should be free, easy to get to, and available at the times when they were most needed (which is often during evenings and weekends) and provide childcare facilities. There was also some concern about waiting lists – a service needs to be able to respond immediately.

There was a widespread belief that a holistic, positive and practical approach was required. Alcohol problems need to be examined within the broader context of people's lives and services should consider the potential causes of the alcohol problem. Moreover, help should be provided to enable service users to fill the gap in their lives left by not drinking alcohol (or drinking less alcohol). Participants also felt that service provision should be on-going rather than time-limited and that follow-up services were crucial to prevent the alcohol problem recurring.

There were mixed views about which types of alcohol services actually work. In particular, there were different views relating to the approach that alcohol services should take in relation to a 'no drinking' or a 'controlled drinking' model. There was, however, a widespread consensus that there is a need for a range of services – with different methods for different people and at different stages in their treatment. Perhaps the most important point to note in relation to perceptions of what kind of alcohol services work is that alcohol services need to be tailored to the individual needs of the alcohol service users and be revised during the process of service contact.

Although participants disagreed on the relative merits of different services, it was generally felt that the mix of service provision should comprise of detoxification programmes; medication; day or drop-in centres; group counselling; individual counselling; follow-up support and advice (practical and psychological); and, finally, support and advice for family and friends.

The way forward

Overall, participants clearly felt that alcohol misuse is a problem in Scottish society that needs tackling. There were, however, mixed opinions about how this should be done and a strong feeling that this would be a very difficult, if not impossible, task. Calls were made for more information, education and advertising on both sensible drinking and the harmful effects of drinking. Participants also felt that health promotion activity currently prioritised smoking and illegal drug use at the expense of alcohol. It was widely agreed that the main barrier to tackling alcohol misuse consists of the prevailing cultural attitudes to alcohol in Scotland and a fundamental shift is required before any change in alcohol-related behaviour will occur.

Conclusions

In conclusion, there is no doubt that alcohol plays a central role in Scottish society. While there are many positive aspects associated with alcohol consumption - such as supporting social networks and relaxation – it is clear that there are also many negative aspects. Many of the negative factors discussed – such as relationship breakdowns, the impact on physical,

mental and sexual health, and withdrawal effects - are perhaps aspects that members of the wider general public may not commonly associate with alcohol. In this sense, it seems that there may be limited awareness of the potential dangers of alcohol. This, coupled with experiences of alcohol problems 'creeping up' on people, suggests that education about the impact of alcohol on the individual and those around them is of crucial importance. Although most people participating in the research agreed that alcohol was a problem in Scotland, few people translated their definitions of alcohol misuse into their own behaviour. This is linked to the prevalence and acceptance of excessive drinking, which allows people to think there is always someone who is drinking more than they are and, therefore, that they do not have a problem with alcohol.

The challenge facing policy-makers is how to get people to realise that alcohol misuse is not the same as alcoholism. Any attempt to tackle problems with alcohol must pay considerable attention to the terminology applied. The issue of definitions is crucial to that of service provision. If people see an alcohol problem as only the most extreme type of drinking behaviour then services are identified as an appropriate option for only a small group of people, and as having curative rather than preventative aims. Until people recognise that problems with alcohol begin much earlier on than the stage at which somebody is totally dependent on alcohol and their life is falling apart, it is unlikely that services will be used by anyone other than by those with the most severe problems.

While the confusion around definitions of alcohol misuse is perhaps the main barrier to people accessing services, the research identified a number of other important obstacles. First, there was limited awareness among all participants of what kind of help is available for people with alcohol problems and who provides it. Because of this lack of awareness, most people felt their doctor would be their first point of contact, primarily because they would not or did not know where else to go. This clearly suggests that doctors need to be equipped to deal with such consultations and be aware of services available, as they will often be the first, and in some ways, most important contact made.

In addition to the problems of self-admission and the lack of awareness about the existence and purpose of alcohol-related services, the research identified a large number of both psychological and practical barriers to people contacting services. Perhaps some of the biggest obstacles to be overcome are the fear of stigmatisation, feelings of embarrassment, and confidentiality and anonymity concerns. The first two of these barriers are strongly intertwined with cultural attitudes towards alcohol.

A very important point to note for the Plan for Action on Alcohol Misuse about perceptions of what kind of alcohol services work is that there is a clear need for a range of services – with different methods for different people and at different stages in their treatment. Essentially, alcohol services need to be tailored to the individual needs of the alcohol service users and be revised during the process of service contact. In many cases, participants had tried a range of services and approaches before finding one that suited their particular problem or personality. Given the perceived barriers to contacting services, it is particularly important that once people do make contact with a service, they are made aware that there are a range of different service approaches and options.

The research has highlighted some important issues surrounding the role alcohol plays in society, perceptions of what constitutes problem drinking and awareness of and attitudes towards services. In addition, it explored issues surrounding perceptions of 'what works'. However, an additional element of the research, and one that will also feed into the Plan for

Action on Alcohol Misuse, explored perceptions of how alcohol misuse in Scotland should be tackled.

In general, participants felt that health promotion campaigns currently prioritised the issues of illegal drugs and smoking and there were low levels of awareness of any information or advertising warning against the dangers of excessive alcohol consumption. While there was clearly support for the increased use of advertising and information on safe levels of drinking *and* the dangers of excessive drinking, many felt that these would be of limited use in facilitating behavioural change. Again, this appeared to result from a view that alcohol is deeply ingrained in Scottish culture. In this sense it was felt that education about alcohol was crucial, particularly at an early age - for example, primary school level. There was, then, widespread recognition of a need for a cultural shift in attitudes to drinking.

A problem for policy-makers is the questionable compatibility of strategies to, on the one hand, stress that 'getting legless' is not normal or socially acceptable, while on the other, trying to reduce stigmatisation associated with alcohol problems so as to encourage people to seek help through services.

CHAPTER ONE: INTRODUCTION

BACKGROUND

It is widely acknowledged that levels of alcohol use and misuse in Scotland are high relative to other countries.¹ Previous research has found a significant minority of adults exceeds the recommended weekly limit for alcohol consumption. Moreover, ‘binge drinking’ appears to be a particular social problem among young people.² This combination – the *amount* of alcohol consumed and the *way* in which it is consumed – has been a cause of concern for some time.

The vast majority of Scottish adults drink alcohol – whether it is a small amount on an irregular basis or large amounts frequently. The 1998 Scottish Health Survey³ (SHS) found evidence to suggest that ‘excessive’ drinking is indeed a problem in Scotland, with 33% of adult males exceeding the recommended maximum consumption level of 21 units of alcohol a week. Similarly, 15% of women were found to exceed the recommended maximum alcohol consumption level for females (that is, 14 units).

The 1998 SHS also found that over half of men (51%) and almost a third (31%) of women reported having been ‘drunk’ at any time in the last three months. While a fifth (20%) of males and a tenth (9%) of females reported having been ‘drunk once a week on average in the past 3 months’, the survey also found evidence of ‘problem drinking’ (based on answers to six questions forming part of the ‘CAGE’ questionnaire). Over one in ten (12%) of men were defined as ‘problem drinkers’, as were 5% of women. In general, the likelihood of problem drinking decreased with age, with those adults in the 16-24 age group being the most likely to be ‘problem drinkers’. Importantly, the survey found that there has been an upward trend in alcohol consumption among women of all ages, particularly in the 16-24 age range. In light of these findings, and information from other sources, such as the medical profession and criminal justice field, it is clear that alcohol consumption behaviour is a challenge to policy-makers.

The Scottish Executive Health Department recently conducted a public consultation exercise and commissioned various pieces of research to explore issues around alcohol and alcohol misuse in Scottish society. Overall, the consultation and research programme examined the main concerns about alcohol use in Scotland, explored views about what is being done and what needs to be done, and how various bodies can contribute to the Plan for Action on Alcohol Misuse.⁴

¹ Overview of National Alcohol Policies in the 15 countries of the EU. Prepared by French Society of Public Health and European Commission DGV (1998).

² E. Goddard (1996), *Teenage Drinking in 1994*. London: HMSO.

³ Scottish Health Survey 1998, Volume One, Scottish Executive Department of Health, Edited by Andrew Shaw, Ann McMunn and Julia Field.

⁴ Consultation Paper on Plan for Action on Alcohol Misuse.

While a significant part of the exercise involved consultation with professionals in fields such as health, criminal justice, business, academia and local authorities, the Department was also aware of the importance of including members of the general public in the consultation and, more specifically, those who have experienced problems with alcohol (either directly or indirectly) and those who use or have used alcohol-related services. It was recognised that a public consultation with the general public would not generate views from these specific groups; as well as being ‘hard to reach’, such groups are unlikely to feel comfortable divulging sensitive and personal information in a public setting. Therefore, the Executive commissioned a number of separate research projects to fill the gaps that would have been left if only a general public consultation exercise were undertaken.

A key component of this large-scale exercise involved a research project carried out by NFO System Three to explore the views of specific groups towards alcohol use and misuse and services associated with these behaviours. Two separate research exercises were carried out, the first involving a quantitative survey of the general public and the second, a qualitative study of drinkers, alcohol services users and their family and friends. The report presents the main findings from both research components.

AIMS AND OBJECTIVES OF THE RESEARCH

The main aim of this research was to explore views about alcohol, alcohol misuse and alcohol-related services. While a more detailed discussion of the methodology is presented in Chapter Two, it is worth considering the contributions of both research components at this stage.

Research with problem drinkers and their friends and families: qualitative component

The research involved focus groups and in-depth interviews, the specific objectives of which were to:

- explore cultural attitudes to drinking alcohol and the role it plays in Scottish society
- explore levels and frequency of alcohol consumption
- ascertain factors which are perceived to lead to alcohol misuse
- assess the impact of alcohol misuse on both the ‘misuser’ and those close to them
- explore ‘at risk’ behaviours associated with alcohol misuse
- assess levels of awareness of alcohol-related services
- explore cultural attitudes to alcohol-related services and perceived barriers to contacting these services
- explore awareness and experience of different types of services, strategies and therapies
- explore perceptions about ‘what works’ in alcohol-related services.

Three key ‘hard to reach’ groups were covered, namely:

- adult alcohol misusers who use or have used a service to help people with alcohol-related problems
- friends and family members of adults who misuse alcohol, both service users and non-service users
- drinkers.⁵

Research with the general public: quantitative component

A second component of the research consisted of a survey of 1,061 adult members of the general public. This aimed to provide some baseline information about the prevalence of contact with alcohol-related services and to establish attitudes towards alcohol in Scotland and how the problem of alcohol misuse can be tackled.

STRUCTURE OF THE REPORT

The report is primarily structured on the basis of the main headings used in the topic guides and interview schedules, although it has also tried to accommodate some of the consultation questions. Chapter Two provides a discussion of the methodology adopted for the study and the reasons for our approach.

The main findings of the research are presented in Chapters Three to Ten. The first of these - Chapter Three - reports the findings from the survey of the general public and provides graphical representations of some of the main issues to emerge. Chapters Four to Ten are based on the data generated through the interviews and focus groups with drinkers, service users and their friends and families.

Chapter Four provides detailed discussion of views and experiences of alcohol. More specifically, it looks at perceptions of the role alcohol plays in Scottish society and positive and negative aspects of alcohol use. Chapter Five presents a discussion of perceptions of terms commonly used to describe alcohol misuse, such as ‘alcohol problems, alcoholism as well as ‘alcohol misuse’ itself. Chapter Six provides a brief discussion of perceptions of what is thought to lead people to problem drinking.

Chapters Seven to Nine focus on alcohol-related services. The first of these explores levels of awareness of alcohol-related services, both for people with alcohol problems and their families and friends and Chapter Eight discusses participants’ views of alcohol-related services, perceived barriers to contact and what prompts people to make contact. Chapter Nine focuses on perceptions of ‘what works’ in terms of service provisions.

In addition to views and experiences of alcohol use, misuse and services, participants were asked to discuss how they think alcohol misuse would be best tackled. Chapter Ten presents a discussion of the many approaches suggested by participants.

⁵ See Chapter 2 for a definition of ‘drinkers’.

Finally, Chapter Eleven presents the main conclusions to be drawn from the research, and highlights those findings relevant to some of the main questions raised as part of the public consultation.

In some Chapters findings from the different participant groups are presented in a combined manner due to the similarity in the views expressed. In other Chapters the findings are presented separately for each of the participant types, meaning that there is necessarily some repetition in certain sections. Generally, there were high levels of consensus among the different participant groups but any clear differences between groups on the basis of respondent characteristics, such as sex and socio-economic group, are outlined in the report.

Consultation questions

This specific piece of research was commissioned to contribute towards the Plan for Action on Alcohol Misuse. The public consultation aims to address eleven key questions, some of which were explored in this research. However, many of the issues are discussed in a slightly different way and, because of the focus of the research, others were not addressed at all.

The consultation questions addressed, at least in part, are outlined below and guidance is provided as to where the discussion appears in this research report. In some cases, the link between the question and Chapter is only partial (i.e. it is an issue addressed, perhaps in as a sub-section of a Chapter), and not necessarily in exactly the same terms as the consultation question posed.

- How should we define alcohol misuse? (Chapter Five)
- What concerns you most about patterns and trends? (Chapters Four, Five and Six)
- Are there priority groups or individuals whose drinking we should try to influence in the Plan for Action? (Chapter Six)
- What specific objectives and activities designed to achieve these, would you like to see in the National Plan for Action? (Chapters Seven to Ten).
- Would you like to see changes in aspects of the law relevant to misuse of alcohol? (Chapters Three and Ten)
- What gaps to do you identify in action that is currently being taken? (Chapter Ten)

CHAPTER TWO: METHODOLOGY

As noted in Chapter One, the research consisted of two main components: a survey of the general public and focus groups/ interviews with specific groups. Before each of these is discussed in detail, it is necessary to provide some definitions of the 5 respondent types included in the research, namely:

- General public
- Current alcohol-related service users
- Previous alcohol-related service users
- Family members and friends of alcohol-related service users
- Family members and friends of alcohol-related non-service users
- ‘Drinkers’

General public

In the quantitative survey, the ‘general public’ refers to a representative sample of adults aged 16 and over.

Current alcohol-related service users

Current service users were defined as anybody receiving care, counselling, advice and support etc. from a statutory, voluntary or private service aimed at people with alcohol-related problems.

Previous alcohol-related service users

Previous service users were defined as people who had received care, counselling, advice and support etc from a service aimed at people with alcohol related problems but were no longer officially a ‘client’. The extent of contact they maintained with the service was dependent on the type of service received in the first place. Some previous users still visited the service for informal discussions and support, whereas others had broken all ties with the service.

Family members and friends of alcohol-related service users

Family and friends of alcohol-related service users were defined in two ways. First, those whose close friend or relation receives care, counselling, advice and support etc from a service aimed at people with alcohol related problems. And, second, those who attend a service aimed specifically at close friends and relatives of people with alcohol problems. Again, these definitions covered users of statutory, voluntary or private services.

Family members and friends of non-service users

Family and friends of non-service users were defined as a member of the general public who had any close friends or family members whose drinking has caused a problems for them or other members of their family and, as far as they were aware, had never had contact with any services for people concerned about their drinking habits.

‘Drinkers’

‘Drinkers’ were defined as someone who had indicated on a questionnaire that in their own view, they had drunk more than they should have done four times or more in the last 6 months *and* they had had any of six particular alcohol-related experiences. (See Appendix B for more detail).

It was felt important that this type of person be included in the research as they could be categorised – as could anybody who drinks alcohol – as a potential user of services. Therefore, their perspective is likely to reflect what might have been the view of the problem drinker before they reached that stage.

QUALITATIVE DATA COLLECTION

The qualitative component of the research was conducted using a mix of focus groups (7-9 participants), mini-focus groups (3-6 participants) and individual, face-to-face in-depth interviews. Because these methods are more flexible than a structured questionnaire, the researcher can probe deeper and more easily build a rapport with and secure co-operation from respondents. Such techniques are particularly useful when working with marginalised groups - such as alcohol misusers - because they provide an opportunity for them to express their views in their own terms. Qualitative research provides a means of ‘getting beneath the surface’ of attitudes and opinions and of exploring complex or sensitive areas.

Sample selection

At the outset, it was emphasised that the qualitative component of the research project would have to be approached with some degree of flexibility. While, in general, it was possible to complete most of the work in the way originally proposed, the approach required slight amendments to take account of, for example, patterns of service delivery, respondents’ wishes, particular local situations and unwillingness to participate, which could not have been accounted for at the outset of the research.

In terms of alcohol-related services, the researchers planned to include a mix of NHS, social work, voluntary and private-based providers. While not intending to be representative in a statistical sense, it was hoped that services could be selected to provide a broad geographical spread and include both rural and urban areas. However, three of the rural services invited to take part in the research declined to do so – one NHS and two voluntary alcohol-related services. This has meant that the work conducted with alcohol service users is, therefore, primarily, though not entirely, urban-based. Nevertheless, the research with ‘drinkers’ and

family and friends of alcohol misusers who had not used services did take fuller account of the urban/rural dimension. The urban focus of the study is not problematic, as this has been compensated for by other parts of the consultation process.⁶

The following table provides a summary of fieldwork conducted during June and July 2001.

Table 2.1: Summary of fieldwork conducted

Type of respondent	Service provider	Interviews	Groups	Respondents (n)
Current service users	Private	-	1	6
	Voluntary	5	1	10
	Social work	-	1	9
	NHS	2	1	9
Previous service users	Private	1	1	5
	Voluntary	2	-	2
	Social work	-	-	-
	NHS	1		1
Families/ friends of service users	Private	-	1	3
	Voluntary	3	-	3
	Social work	-	1	4
Families/friends of non-service users.	-	6	-	6
Drinkers	-	-	4	20
TOTALS	-	19	12	78

It was originally proposed that 11 mini-groups/ focus groups and 24 in-depth interviews would be conducted. As a number of services withdrew from the research and because of the modes of service delivery and respondents' wishes, the final combination of interviews and groups was slightly different. For example, groups rather than in-depth interviews were originally proposed for the voluntary sector work in the Borders but this proved impossible because the organisations selected did not operate on a group basis.

In terms of the services covered, the research included seven service providers – 3 voluntary, 2 NHS, 1 social work and 1 private service. The following table summarises the location of the services.

⁶ Issues affecting people in rural areas, and the need to address their concerns and requirements, emerged in responses to the written consultation, and are discussed in the final report which provides a summary of the evidence gathered.

Table 2.2: Services participating in the research by location and type of data collection

	Interviews				Groups			
	Borders	Fife	Edinburgh	Glasgow	Borders	Fife	Edinburgh	Glasgow
Voluntary	7	-	2	-	-	-	-	1
NHS	-	-	3	-	-	-	-	1
Social Work	-	-	-	-	-	-	-	2
Private	-	-	-	1	-	-	-	3

Table 2.3 refers to the location of the fieldwork with non-service users – that is, friends and families of non-service using alcohol misusers and ‘drinkers’.

Table 2.3: Interviews and groups with non-service users by location

	Interviews				Groups			
	Borders	Fife	Edinburgh	Glasgow	Borders	Fife	Edinburgh	Glasgow
F&F non-users	1	2	2	1	-	-	-	-
Drinkers	-	-	-	-	1	1	1	1

Recruitment methods

Participants for the research were recruited in two ways. First, current and previous alcohol service users and their friends and families were recruited directly through the co-operation of the services selected to take part in the research. Second, those defined for the purpose of the research as ‘drinkers’ and family and friends of alcohol misusers not in contact with services were recruited through door-to-door and on-street recruitment methods. Participants were asked a series of questions to establish their eligibility for inclusion and then asked if they would be willing to participate in the research. (Recruitment questionnaires can be found in Appendix A).

Participants recruited through services were offered £10 each, to cover any travel expenses. Those recruited through door-to-door and on-street recruitment were given £20 to cover any travel and childcare costs.

Analysis and presentation of data

With the consent of participants, and after emphasising the confidential nature of the exercise, interviews and focus groups were tape-recorded. Only on one occasion was an

interview not recorded and this was because of the inappropriate surroundings.⁷ All of the interviews and focus groups that were tape-recorded were then fully transcribed.

The analysis of the data was conducted using the ‘matrix approach’⁸, which examined the data thematically. The analysis has provided an immense amount of rich data and in reporting the findings, we have made extensive use of quotations to illustrate the main issues arising. Quotation marks (“ ”) are used to identify the start and end of a single quote or a series of quotes forming a conversation. When quoting a conversation between participants, asterisks are used to identify individual speakers – for example, person one is identified as ‘*’ and person two by ‘**’. When the interviewer or moderator is quoted, this is identified in the text. An anonymous reference to participant type is given after each individual excerpt.

SURVEY OF THE GENERAL PUBLIC

In conjunction with the Scottish Executive, the research team designed four questions to be included in the NFO System Three’s monthly omnibus survey, the ‘Scottish Opinion Survey’. These questions assessed attitudes towards alcohol misuse, knowledge of how to contact a service, levels of contact with organisations that provide help or advice about alcohol, and, finally, views on the effectiveness of various measures for tackling alcohol misuse in Scotland.

A representative sample of the Scottish population was interviewed using Computer Assisted Personal Interviewing. A sample of 1,061 adults aged 16 and over was interviewed in-home in 41 sampling points throughout Scotland over the period 21 – 27 June 2001. The sample was selected to be representative in terms of geographical location (North, East Central, West Central, South) and, to ensure that the sample was representative of the adult population in terms of age, sex and socio-economic group, the data were weighted to match population estimates from the National Readership Survey of April 1998 – March 1999. The achieved sample profile, both unweighted and weighted, is shown in Table 2.4.

The findings from the survey of the general public are presented in Chapter Three. The questions used and a full set of data tabulations can be found in Appendices C and E respectively.

⁷ This interview was with a young person whose father had an alcohol problem. The interview took place in a local café and it was felt that the use of a tape-recorded would arouse the curiosity of other customers and, therefore, create an atmosphere in which the respondent would be unwilling to speak openly.

⁸ The matrix approach involves the creation of a grid, in this case with the different respondents/groups down the side and the themes across the top. Each cell is completed when reading the transcripts, providing the researcher with the ability to identify patterns emerging across the different groups.

Table 2.4: Scottish Opinion Survey, achieved sample (n=1,061)

		Unweighted	Weighted
SEX:	Male	44%	48%
	Female	56%	52%
AGE:	16 – 24	11%	14%
	25 – 34	20%	19%
	35 – 44	18%	19%
	45 – 54	17%	15%
	55 – 64	13%	13%
	65+	22%	20%
SEG:	AB	16%	19%
	C1	28%	28%
	C2	22%	20%
	DE	33%	33%
Area	West	43%	42%
	East/ South	34%	34%
	North	24%	24%

Note: SEG = Socio-economic group.⁹

Percentages may not add up to 100% due to the effects of rounding.

⁹ **A** = Professionals, senior managers & top civil servants. **B** = Middle management in large organisations, principal officers in local government/civil service/top management & owners of small businesses, educational & service establishments. **C1** = Junior management & other non-manual. **C2** = Skilled manual workers & manual workers with management responsibilities. **D** = Semi-skilled & unskilled manual workers & apprentices & trainees to skilled workers. **E** = unemployed, benefit dependent & casual workers without regular income.

CHAPTER THREE: SURVEY OF THE GENERAL PUBLIC

The findings from the survey of Scottish adults, which asked four questions about attitudes, services and strategies to tackle alcohol misuse in Scotland, provide useful background and contextual information for the more focused study on the ‘hard to reach’ groups.

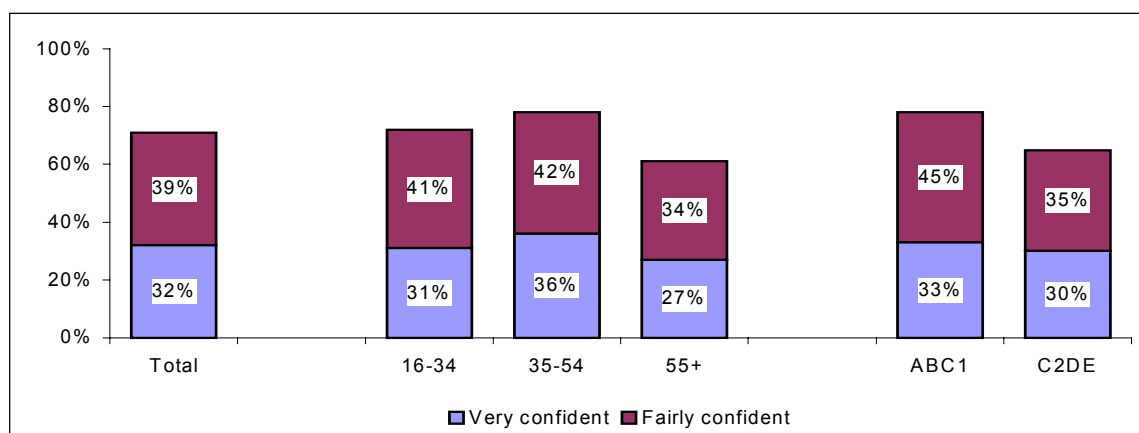
All differences reported between sub-groups (for example, between men and women) are statistically significant.

FINDING AND CONTACTING ALCOHOL-RELATED SERVICES

Finding out about services

Respondents were asked how confident they would be about finding and contacting a service providing help or advice should they, or someone they know, experience problems relating to alcohol misuse. Seven in ten respondents (71%) of all respondents reported that they were either very confident or fairly confident that they would be able to find and contact such a service.

Figure 3.1: Level of confidence about knowing how to find and contact alcohol-related services by age and socio-economic group (%)



Other categories available were ‘not very confident’, ‘not at all confident’ and ‘don’t know’.

Total (n =1,061). Age: 16-34 (n=325); 35-54 (n=372); 55+ (n=364). Socio-economic classification: ABC1 (n=474); C2DE (n=587)

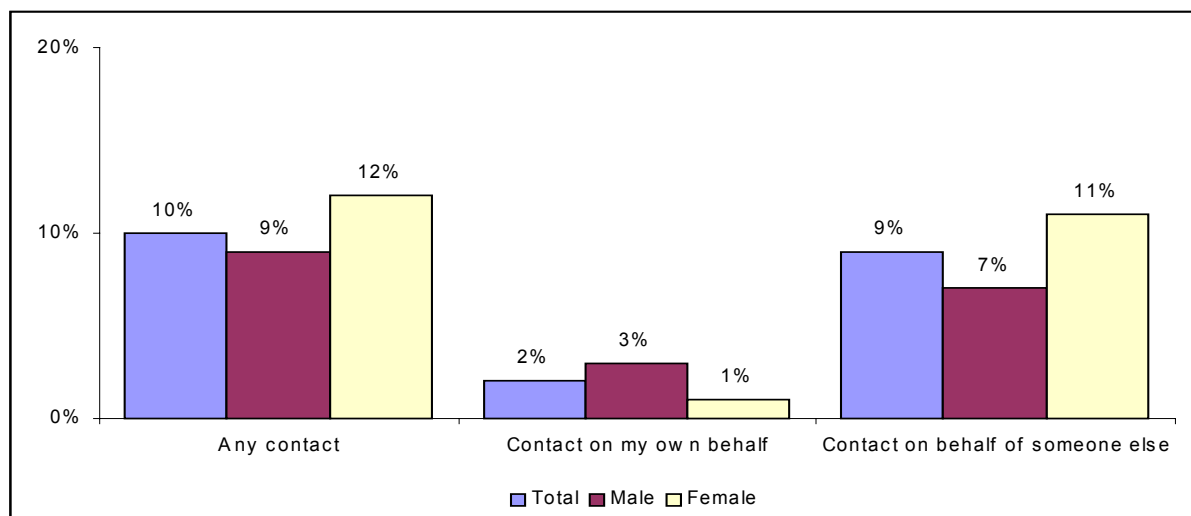
As shown in Figure 3.1, although responses did not vary significantly by sex, there was some variation by age, which suggests that those in the older age group (i.e. 55+) are the least likely to be confident of finding out and contacting services for people experiencing problems with alcohol. Around three quarters of those aged 16-34 and 35-54 (72% and 78% respectively) were confident of finding and contacting such services, whereas less than two-

thirds (61%) of those aged 55 or over were similarly confident. There was some evidence of levels of confidence varying by socio-economic group – while 78% of those in social class grouping ABC1 were either very or fairly confident about contacting these services, this fell to 65% of those categorised as C2DE.

Levels of contact with alcohol-related services

One in ten of all respondents said they had ever had contact with services or organisations that provide help or advice about alcohol. There was little evidence of any differences in level of contact on the basis of age, socio-economic group or geographic area. The only aspect on which a statistically significant difference was found was between men and women in relation to the type of contact they had had with a service. While a similar proportion of men and women had ever had any contact with a service or organisation that provides help or advice about alcohol (9% of men and 12% of women), men were more likely than women to have contact such a service on their own behalf (3% and 1% respectively) and women were more likely than men to have had contact on behalf of someone else (11% and 7% respectively). So it appears that whilst women were more likely to contact services than men, on many occasions this was on behalf of someone else.

Figure 3.2: Contact with service or organisation providing help or advice about alcohol, by sex (%)



Note: n=1,061

ATTITUDES TO ALCOHOL MISUSE

Respondents were presented with three attitude statements and asked to what extent they agreed or disagreed with each of them:

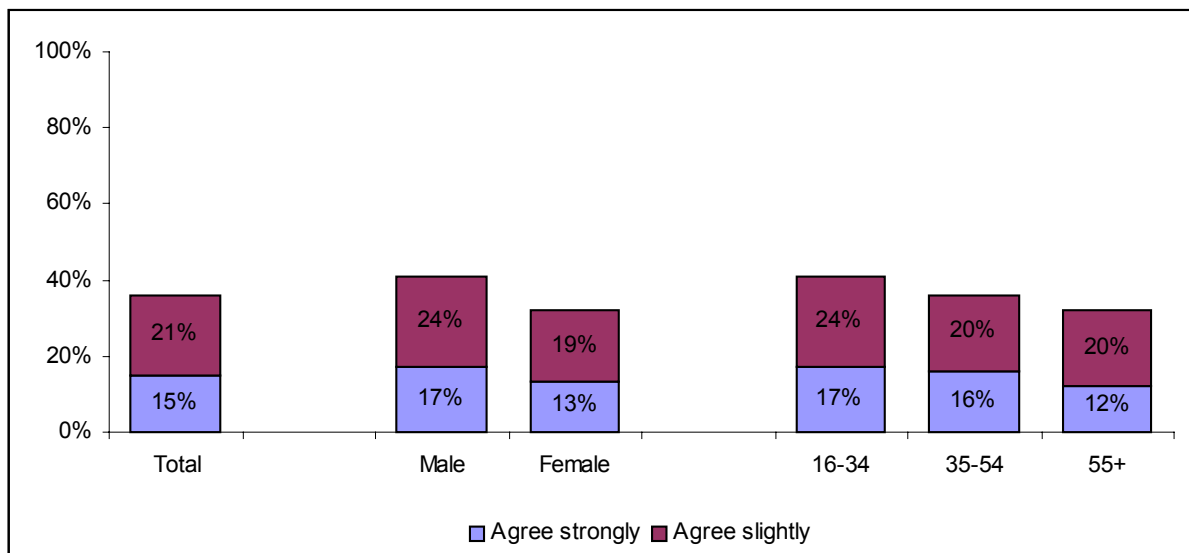
- Men are much more likely than women to experience problems with alcohol
- Alcohol misuse is increasing among young people in Scotland

- Most violent crime is alcohol-related

Statement 1: ‘Men are much more likely than women to experience problems with alcohol’

Roughly a third (36%) of all respondents agreed to some extent that men are much more likely than women to experience problems with alcohol. However, almost half (45%) disagreed - either slightly or strongly – with this statement. Interestingly, men were more likely than women to agree that men were more likely to experience problems with alcohol (41% and 32% respectively). The survey also found that the likelihood of agreeing with this statement decreased with age - while 41% of those aged 16-34 agreed that men were more likely than women to have a problem with alcohol, this fell to a third (32%) of those aged 55 or over. (See Figure 3.3).

Figure 3.3: Proportion agreeing ‘Men are much more likely than women to experience problems with alcohol’ by sex and age group (%)

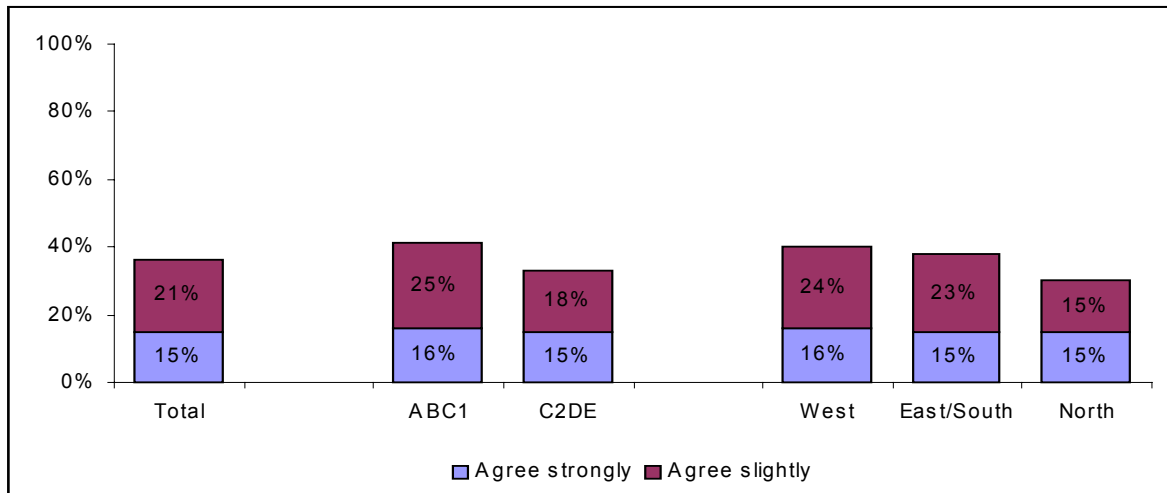


Other categories available were ‘neither agree nor disagree’, ‘disagree slightly’, ‘disagree strongly’ and ‘don’t know.’

Total (n =1,061). Sex: male (n=469); female (n=592). Age: 16-34 (n=325); 35-54 (n=372); 55+ (n=364).

The survey also found a difference in attitude on the basis of socio-economic groupings. Respondents in social class grouping ABC1 were more likely than those categorised as C2DE to agree that ‘men were more likely than women to experience problems with alcohol’ (41% and 33% respectively). Moreover, respondents in the North of Scotland were less likely than those in the West and East/ South to agree that men were more likely than women to experience problems with alcohol – while less than a third (30%) of respondents in the North agreed with this statement, this rose to 40% of those in the West. (See Figure 3.4).

Figure 3.4: Proportion of respondents agreeing ‘Men are much more likely than women to experience problems with alcohol’, by socio-economic group and geographic area (%)



Other categories available were ‘neither agree nor disagree’, ‘disagree slightly’, ‘disagree strongly’ and ‘don’t know.’

Total (n =1,061). Socio-economic classification: ABC1 (n=474); C2DE (n=587). Location: West (n=453); East/South (n=357); North (n=251).

Statement 2: ‘Alcohol misuse is increasing among young people in Scotland’

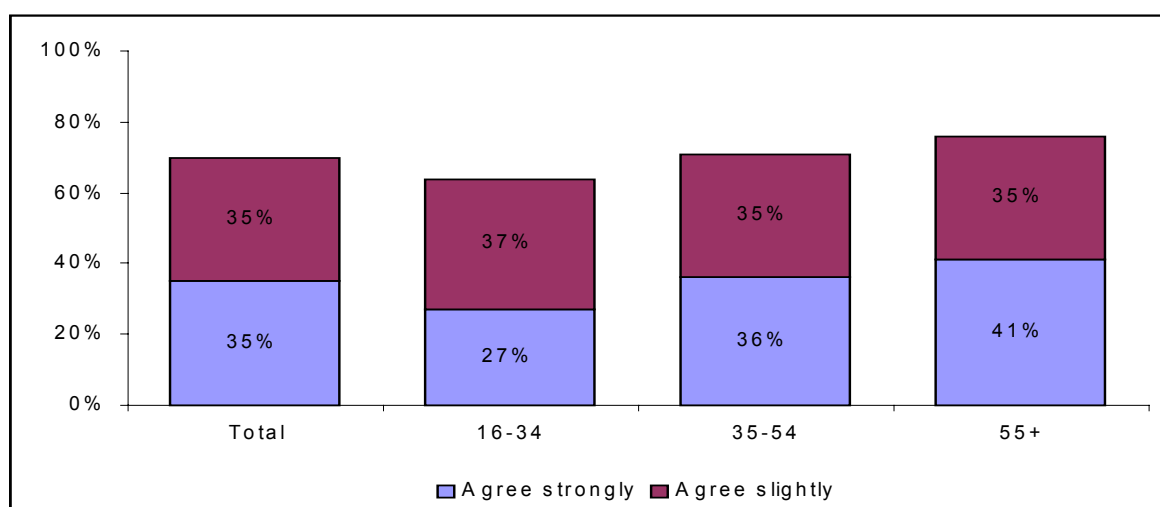
The vast majority (92%) of all respondents to the survey agreed that ‘alcohol misuse is increasing among young people in Scotland.’ Almost three-quarters of respondents (73%) strongly agreed with this statement, while a further 19% agreed slightly. Only 2% of all respondents disagreed that alcohol misuse is increasing among young people in Scotland. These findings were consistent across all sub-groups, with the expectation of age where those aged 35-54 were significantly less likely than those aged 55+ to think that alcohol misuse is increasing among young people in Scotland (91% and 95% respectively). Interestingly, those aged 16-34 did not differ significantly in their views from other age groups (with 93% agreeing).

Statement 3: ‘Most violent crime is alcohol-related’

In terms of the relationship between alcohol and violent crime, 70% of all respondents agreed with the statement ‘most violent crime is alcohol-related’, although a further 20% disagreed.

As shown in Figure 3.5, the respondents in the youngest age group were the least likely to agree with this statement, with just under two-thirds (64%) of those aged 16-34 agreeing with this statement. In contrast, 86% of those respondents aged 55 or over agreed that most violent crime was alcohol-related. The survey found no significant difference of opinion based on sex or socio-economic group.

Figure 3.5: Proportion of respondents agreeing ‘most violent crime is alcohol-related’ by age group (%)



Other categories available were ‘neither agree nor disagree’, ‘disagree slightly’, ‘disagree strongly’ and ‘don’t know.’

Total (n=1,061). Age: 16-34 (n=325); 35-54 (n=372); 55+ (n=364).

TACKLING ALCOHOL MISUSE IN SCOTLAND

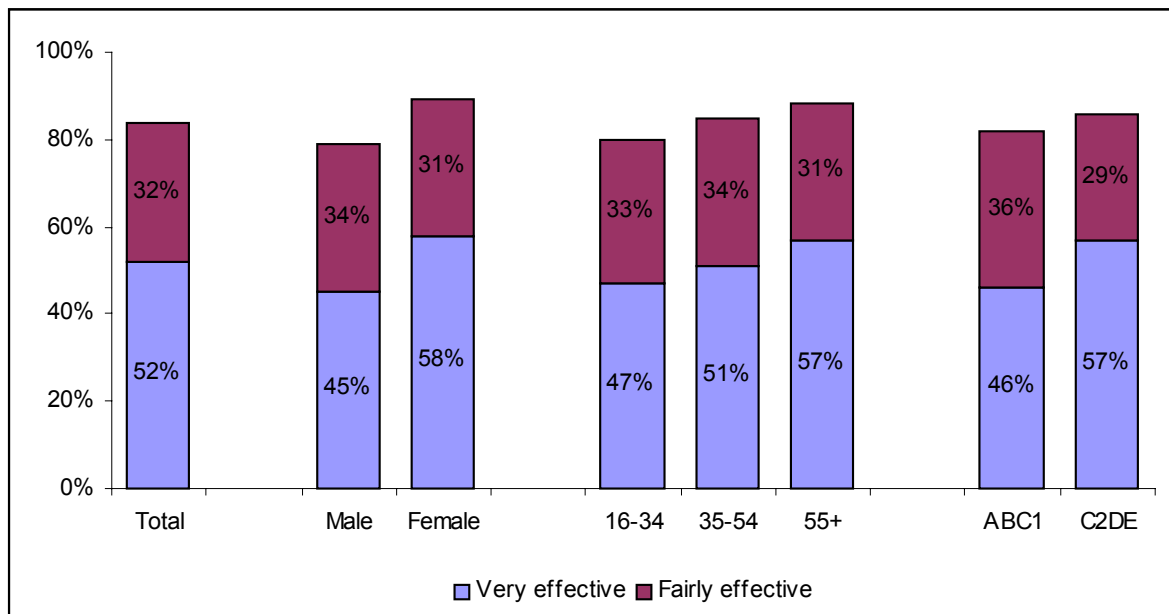
Respondents were presented with a list of 6 possible ways of tackling alcohol misuse in Scotland - some of the methods were mutually exclusive while others could be implemented alongside each other. Respondents were asked to state how effective each of the following would be in tackling the problem of alcohol misuse in Scotland:

- advertising campaigns on sensible drinking
- stricter enforcement of existing laws relating to, for example, drink-driving, street disorder, licensed premises and under-age drinking
- extending opening hours for licensed premises
- reducing opening hours for licensed premises
- providing more information/ education about the dangers of drinking
- improving services for people with alcohol problems

Overall, of the measures asked about, stricter enforcement of existing laws - for example those relating to drink-driving, street disorder, licensed premises, under-age drinking - was seen to be the most effective way of tackling alcohol misuse in Scotland. In total, 84% of respondents thought this might be effective (52% saying ‘very effective’ and 32% saying ‘fairly effective’), though this figure was higher among women than men (89% and 79%

respectively) and among older than younger people (80% of those aged 16-34 and 88% of those aged 55 and over). (see figure 3.6 below)

Figure 3.6: Effectiveness of stricter law enforcement in tackling alcohol misuse, by sex, age and socio-economic group (%)



Other categories available were 'not very effective', 'not at all effective' and 'don't know'.

Total (n=1,061). Sex: male (n=469); female (n=592). Age: 16-34 (n=325); 35-54 (n=372); 55+ (n=364). Socio-economic classification: ABC1 (n=474); C2DE (n=587)

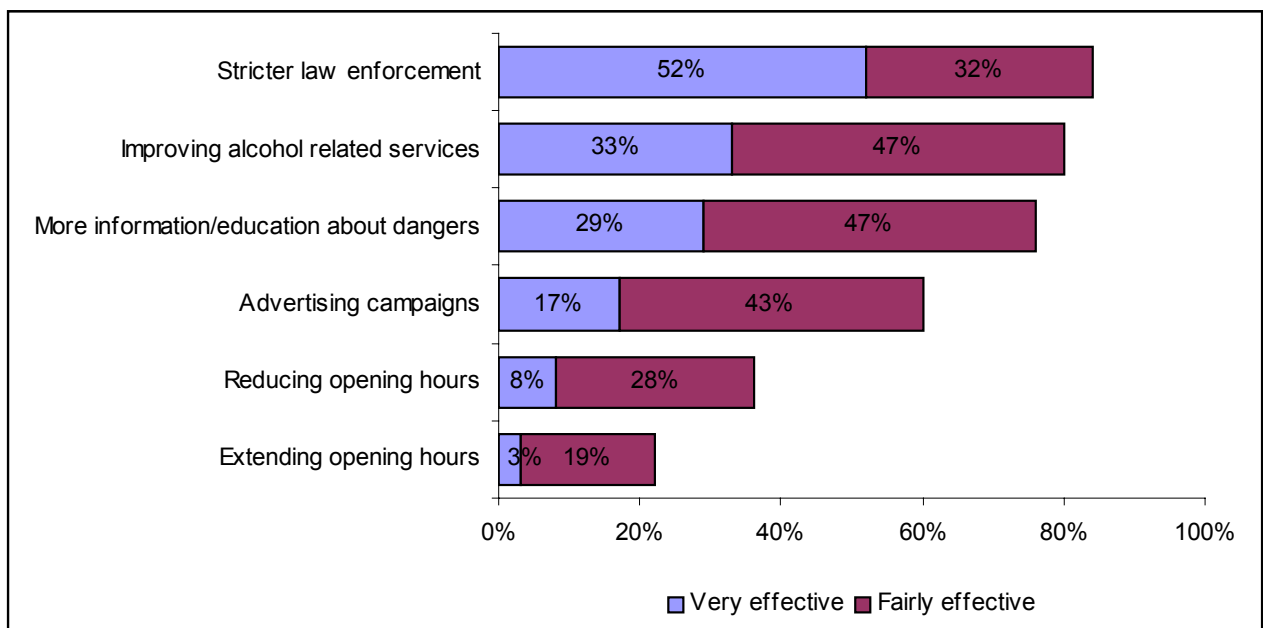
The measure perceived to be the next most effective strategy in tackling the problem of alcohol misuse in Scotland was improving services for people with alcohol problems (80%). A higher proportion of respondents thought this would be 'fairly effective' (47%) than 'very effective' (33%). Respondents in the North were the least likely to consider this an effective way of tackling alcohol misuse in Scotland (74%).

Three-quarters (76%) of all respondents thought providing more information or education about the dangers of drinking would be an effective way of tackling alcohol misuse in Scotland. Respondents in the socio-economic grouping C2DE were more likely than those from ABC1 to identify this as effective (85% and 78%). Again, respondents in the North were less likely than those in the West to consider this an effective way of tackling alcohol misuse (70% and 80% respectively).

Sixty percent of all respondents thought advertising campaigns on sensible drinking would be effective in tackling alcohol misuse in Scotland. While 70% of those living in the East/South area and 65% of those in the West considered this effective, only 52% of those living in the North did so.

Opinions regarding the alteration to the opening hours of licensed premises were mixed. Around a quarter of all respondents thought *reducing* opening hours for licensed premises (28%) or *extending* opening hours for licensed premises (22%) would be effective in helping to tackle the problem of alcohol misuse in Scotland. Females were less likely than males to consider the extension of hours to be an effective method of tackling alcohol misuse (17% and 28% respectively).

Figure 3.7: Summary of effectiveness of measures for helping tackle alcohol misuse in Scotland (%)



Other categories available were 'not very effective', 'not at all effective' and 'don't know'.

Total (n=1,061).

SUMMARY

In terms of alcohol-related services, respondents were generally confident about finding and contacting a service should they or someone they know experience problems with alcohol. However, the survey did not ask how they would find a contact name or address or whom they would contact. As shown later in the report through the qualitative findings, the high levels of confidence may reflect very general ideas about contact – such as using a telephone book or contacting a local doctor – rather than actually knowing about specific services. A small minority of respondents had been in contact with a service that provided help or advice for people with alcohol-related problems. The data generated from the focus groups and interviews (see following chapters) suggests that only a small proportion of those who need help actually make such a contact, so these figures are likely to greatly underestimate the potential demand for services.

Many people believe that most violent crime is alcohol-related and that alcohol misuse is increasing among young people. While traditionally men have been perceived to be the major consumers of alcohol –and are perhaps the most likely to have alcohol-related problems - the survey suggests that this is no longer the case and that women are perceived to be at as great a risk as men.

Tackling alcohol misuse in Scotland is a major task and the survey found clear public support for stricter enforcement of existing laws, improving services for people with alcohol problems and providing more information or education about the dangers of drinking.

CHAPTER FOUR: VIEWS AND EXPERIENCES OF ALCOHOL

At this point, we turn to the qualitative element of the research, which explored views of specific groups in the population - that is, alcohol service users (past and present), family and friends of those with alcohol-related problems and 'drinkers'. By way of background, and to inform the Plan for Action, the research explored cultural and personal attitudes to the role alcohol plays in society and perceptions of the positive and negative aspects of consuming alcohol. This discussion has important implications for later Chapters on definitions of alcohol misuse and alcohol-related services. As the main themes emerging from the discussions were common across all groups, the findings have been presented in a combined format, although where differences were identified these are reported.

This Chapter contributes towards the consultation question, 'What concerns you most about patterns and trends?'

'A WAY OF LIFE': VIEWS OF ALCOHOL IN SCOTTISH CULTURE AND SOCIETY

The first point to note is that alcohol use is universally seen as a 'normal' feature of Scottish society and as deeply embedded in social tradition.

"Drinking in Scotland has been accepted from the year dot. It is socially acceptable... it is just a way of life." (Social Work service user, Male, Glasgow)

"I think we live in a drinking culture, it is acceptable to go down to the pub and have a few beers. It is also acceptable to go out on a Friday and Saturday night and get absolutely legless." (Voluntary sector service user, Female, Borders)

The central focus and acceptance of alcohol was reflected in the key role of 'the pub' in the social lives of individuals and communities. While the research found evidence of people drinking at home, most alcohol was consumed in the public arena – the pub being identified as the main meeting point for most people.

"I think it is how you meet people, you go to the pub." (Friend of non-service user, Male, Fife)

Across all groups, alcohol consumption was seen as a primarily social activity and, for most people, was usually seen as an enjoyable and positive part of life.

"Scottish people are quite friendly people and it is always 'let's go for a drink'. It is always drink-oriented" (Drinker, female, Edinburgh)

This social aspect was emphasised by current and previous users of services for people with alcohol problems - many felt that their social life was now limited because of the central role alcohol had previously played.

“I mean I really miss the company of not drinking more than anything else. Apart from the fact that I like drinking, I miss the company even a couple of years down the track. I haven’t found out how to replace the way I spent my time.” (Voluntary sector previous service user, Male, Borders).

While the ‘pub’ is undoubtedly a common and valued meeting place, there was some concern that the increased availability of alcohol - for example, through supermarkets and local grocery stores and ‘special offers’ - was changing the role alcohol played in society. Drinking in the home was sometimes seen as being anti-social rather than social. Additionally, it was seen as encouraging more regular and casual consumption of alcohol.

“[It is drunk] casually, like having a cup of tea. It is no different.” (Partner of private alcohol service user, Female)

Because alcohol was seen to play such a central role in the social life of most adults and because of the media portrayal of the centrality of alcohol to Scottish life, participants expressed some concern about peer pressure to drink alcohol. There was a perception that people were considered to be ‘abnormal’, or must be ill or pregnant, if they went to a pub and drank a non-alcoholic beverage.

“You have been to places that folk have said to you ‘oh, come on, you can’t sit there without a drink’. I’ve done it myself and you eventually give in.” (Partner of Social Work service user, Female)

As a result of this pressure and the desire to conform to social norms, many people felt they often drank ‘for the sake of it’ - that is, both when they did not actually want to consume alcohol at all or drinking more than they really wanted to. Alcohol promotions and the new designer drinkers, such as alcopops, with high alcohol content were seen to be encouraging this type of behaviour.

“When they had the promotion on the Guinness, I just drank it even though I didn’t like it”. (Drinker, Female, Fife)

*“*A lot of places I go I have to get drunk to enjoy it.*

Moderator: Why is that?

**Because they are so bad.*

Moderator: So, why do you go?

**Because it is cheap drink...I tend to go to the [club] quite a lot because they do drinks promotions but it is not my kind of place. The only way to make it bearable is just to go a bit overboard.”*

(Drinker, Male, Glasgow)

In terms of the way in which alcohol is consumed, it was widely acknowledged that people often ‘drink to get drunk’, which was something perceived to be peculiar to the United Kingdom, not just Scotland. This was often a calculated decision, for example to ‘drown your sorrows’ (Female, Drinker, Fife) and to ‘get away from problems’ (Female, Drinker, Edinburgh) but sometimes it was, again, simply to get drunk for the sake of getting drunk. In

discussions around this topic, participants provided examples of their own behaviour or people they knew to highlight what they perceived to be typical attitudes in Scotland.

“I do go out to get pissed sometimes. If I have been working and I have the next day off, I say ‘OK tonight I’m going out to have lots of pints’”. (Drinker, Male, Glasgow)

“If it is 10 o’clock and I am still not getting anywhere I will go and buy an After Shock or something and start downing Sambas or tequilas just to get a quick hit”. (Drinker, Female, Fife)

It was generally agreed that people in Scotland drink a lot *but* it was strongly felt that the levels of alcohol consumption and the way in which it is drunk differed little from elsewhere in the United Kingdom.

*“*Every second person you either hear singing or staggering down the road or the pubs are always chock-a-block. Scotland is famous for their drinking.*

Moderator: Do you think it worse than anywhere else?

**Not really, drink is everywhere. It’s not as if Scotland is specifically worse for drink.” (Partner of non-service user, Female, Glasgow)*

Because of the perceived lack of difference in drinking patterns, there was clear resistance to the media images of ‘the drunken Scotsman’. However, it seems that while there was some feeling that media representations of the Scottish drinking culture are inaccurate or unfair, to some extent there was evidence of people attempting to sustain the image of Scotland as a country of ‘*big drinkers*’, as highlighted by the quotation below.

“It is depressing though for a Scotsman [not] to start drinking [until he’s] eighteen.”(Drinker, Male, Glasgow)

There was, however, some recognition that drinking patterns in the United Kingdom were unlike most other cultures, particularly those of European countries. While continental Europeans were seen to consume a lot of wine, for example, the way in which this was done differed from in the United Kingdom. So while they were seen to drink alcohol with their meals and in restaurants and cafes, this contrasted sharply with the image of the pub-based binge-drinking which takes in the United Kingdom.

“We consume alcohol in a different way from the continentals – in more of a binge type way. There is probably more alcoholism on the continent but there is more drunkenness in Britain” (Voluntary sector service user, Female, Borders).

“I think it is the attitude of drinking – it is different here in Scotland. You drink to get pissed, in Greece you drink to have fun, to relax” (Drinkers, males, Glasgow).

So, from the research it is possible to conclude that alcohol plays a pivotal role in Scottish society – with many people identifying alcohol as the main focus of their social contact. It also highlighted the perception that drinking behaviour in Scotland differs greatly from other European cultures but is similar, if not the same, as the rest of the United Kingdom.

Understandably, many people felt that media representation of Scottish people as ‘*big drinkers*’ were unfair but at the same time many of the same people contradicted this by embracing the image. Discussions of why so many people drink alcohol – either sensibly or dangerously - led to the disclosure of information regarding the positive aspects of alcohol, and this is the focus of the discussion in the following section of this Chapter.

POSITIVE ASPECTS OF ALCOHOL USE

On the surface, alcohol was seen as a positive part of life in Scotland. Some of the most commonly mentioned aspects were relaxation, gaining in confidence, ‘Dutch courage’, stress relief, bravery, enjoyment and, again, socialising. In general, however, there was a perception that positive aspects could, at a certain level, cross over into negative aspects of alcohol use (see below).

Social functions of alcohol

As shown above, alcohol was seen by participants to play a major role in socialising and this was identified as *the* most positive aspect of alcohol use. Alcohol was seen to play an important part in celebrations, such as Christmas, Hogmanay, birthdays and so on, but also on a more mundane level, for example, going to the pub for a mid-week pint. It was perceived by all participant groups to be a facilitator of social contact and source of enjoyment.

Interpersonal functions

A number of the positive aspects of alcohol use related to the impact it has on the individual and how it makes them relate to others. For example, respondents spoke about using alcohol to give them confidence to speak to people – both with strangers and more openly with their family and friends.

“It gives you confidence. If you are quite a shy person and my husband is, he’s very self-conscious but he can hide it well. If we ever went anywhere when we were young he would always need a couple of pints before he went in to give him that wee bit of confidence. It makes you feel good, it relaxes you, it makes you more amenable.” (Partner of Social Work service user, Female, Glasgow).

“It is like a socialising catalyst – you talk to people maybe you wouldn’t normally approach.” (Drinker, Male, Glasgow)

However, this confidence was also seen to have negative implications, with references being made to speaking out of turn, saying regrettable things and encouraging aggressive behaviour from others.

Stress relief

While some may interpret it as a negative aspect of alcohol, most people made positive references to the use of alcohol to forget problems and relieve stress and anxiety. Alcohol was often used as ‘medicine’ when people were feeling under strain. It was for many a primary source of escapism and, while this was seen as a positive aspect of alcohol consumption, participants acknowledged that it was only a short-term solution to most problems.

“It drowns your sorrows...because when I fall out with my man that is the first thing that I think about – I am going to drink.

(Drinker, Female, Fife)

“It’s a crutch for a lot of people. Work is so hard and people tend to turn to drink” (Voluntary sector service user, Female, Borders)

“Drinking for relaxation, thinking it will help a night’s sleep becomes drinking into oblivion.” (Private sector previous service user, Male, Glasgow)

However, as some of the above quotations indicate, there was recognition among participants that using alcohol for escapism could lead to serious problems. Some thought if the problem driving the drinking remains, or in fact gets worse, the individual may become progressively dependent on alcohol rather than recognising that they need help, both for the initial problem - be it a bereavement, financial worries etc - *and* the alcohol dependency. Some discussions with family members and friends of those with alcohol problems suggested that if help had been sought for the initial problem, alcohol would have not become the predominant feature of their life. The following example relates to the way in which a current service user dealt with a family tragedy:

“Self-medication, rather than going to the doctor and getting professional help, she just said ‘Well I will have another drink and the problem will go away’. Her brothers and sisters went to the doctor for sedatives but she tended to think, ‘I’ll have another drink and that will be easier...It was just a matter of ‘I will self-medicate with wine’ and it just seemed to go on from there.” (Partner of private service user, Female).

So, to summarise, discussions highlighted that alcohol was seen to play an important role in Scottish society. Not only was it central to celebrations of rites of passage and traditional festivals, it was also perceived to play an important role in day-to-day life, particularly as a social facilitator. Participants often spoke of alcohol increasing people’s confidence and promoting relaxation, stress relief and escapism. Nevertheless, all respondents recognised that alcohol was potentially harmful and the negative associations identified are the focus of the remainder of this Chapter.

NEGATIVE ASPECTS OF ALCOHOL USE

“I mean drink is fair enough in its own place but I can’t understand why they have to take so much that they don’t know what they are doing.” (Wife of non-service user, Female, Edinburgh)

Although those defined as ‘drinkers’ identified a number of negative aspects of alcohol use, those with direct or indirect experience of alcohol problems were more aware of the broader negative aspects of excessive alcohol consumption and, understandably, expressed much stronger views about the negative impact of alcohol. With exception of the financial impact of alcohol use (see below), negative aspects of alcohol consumption were associated with the consequences and impact of excessive drinking and more specifically, drunkenness.

For ‘drinkers’ the main negative aspects were to do with the immediate-term (i.e. at the point of excessive consumption). For example, the impact on their health was only considered in terms of vomiting and hangovers and references were made to arguing, becoming aggressive and ‘*making a fool [of oneself]*’ while under the influence of alcohol.

“I say really nasty things to [my boyfriend], then I know the next day that it was stuff I meant, but I didn’t want to say it”. (Drinker, Female, Fife)

“It was through alcohol [the fight]. That was all because of my mouth. I could have just walked out of there without a scratch. I wouldn’t have thought about [getting involved] if it wasn’t for alcohol.” (Drinker, Male, Borders)

Very few of these ‘drinkers’ thought about the potential long-term impact of drinking on, for example, their health, finances or personal relationships.

Those closely involved with alcohol problems (i.e. alcohol misusers themselves or friends and family members of misusers) identified a range of negative aspects of alcohol use, including the short-term factors noted above. The remainder of this Chapter focuses on the main issues to emerge from this group, namely –

- impact on personal relationships
- personality changes, including aggression and violence
- physical, mental and sexual health
- financial impact
- loss of control over life

Impact on personal relationships

Families and friends of those with alcohol problems and the alcohol misusers themselves obviously had a great deal of experience to draw on when discussing the negative aspects of alcohol use. Perhaps the most commonly discussed issue was the destructive impact drinking had on personal relationships. For some, the alcohol had become the major focus of their relationship.

“As I say, it was not all bad but [the alcohol] was a predominant thing in our marriage.” (Wife of non-service user, Edinburgh)

For those living with someone with an alcohol problem, the experience was often overwhelming – taking over their whole life as well as the life of the misuser. Some had had to give up work because their partner needed care, others were simply too afraid to leave the alcohol misuser alone. The restrictions it placed on their lives, the mental and sometimes

physical abuse suffered (see below) and level of care they needed to provide (for example, dressing and bathing) sometimes led to a severe dislike and/or resentment of their partner.

“I wanted somebody to understand because I was beginning to hate him, really hated him, and I was really wishing him dead. If he would just die we would have a great life.” (Partner of Social Work service users, Female, Glasgow)

However, these feelings often coincided with a deep-rooted loyalty towards their partner that meant they would not 'give in' – that is, they were determined to overcome the problems associated with the alcohol. For others, they felt they had no option but to stay. Nevertheless, the levels of despair that some people reached clearly identified a need for services to support family and friends of people with alcohol problems (see Chapter Seven for further discussion of service provision).

Personality changes

Much of the strain on relationships stemmed from the apparent personality changes the misuser underwent when drinking. Most people with an alcohol problem, or those who knew someone with an alcohol problem, felt that the personality change was always for the worse – for example, increased aggression, depression, disinterest and/or violence. For some, there appeared to be a correlation between the degree of personality change and the amount of alcohol consumed.

“When I first met him when he had a drink he was jolly – even when he came home he was jolly. The more the alcohol begins to affect them the more they change.” (Wife of non-service user, Edinburgh)

“He is more interested in drink, drink, drink when he is on these binges. Other than that he is great when he is not drinking. One minute he’s brand new and next minute it is full scale riots, it’s terrible...Jekyll and Hyde, that’s what I call him.” (Wife of non-service user, Glasgow)

The inconsistency of personality placed a great deal of strain on those around the problem drinker, many living in a state of fear, leaving them feeling confused and helpless about how to address the problem. Women tended to be particularly confused about what to do about their partners drinking if children were involved. While some respondents reported staying with their partner primarily out of loyalty, love and lack of alternative options, some spoke of children being the main reason they stayed. In contrast, others spoke of children as the main reason for seeking help or leaving the family unit. Despite this many felt guilty about 'destroying' the family unit.

“One time I did think I should do something and I felt the children – I mean they did not dislike their Dad – and I thought it was maybe selfish of me to do that cause I was doing it for me. But then you don’t know, maybe I have damaged them by staying”. (Wife of non-service user, Edinburgh)

On a practical level, the involvement of children often made it more difficult to leave or seek help. Because the problem drinker tended to be either out of the home drinking or in an unfit

state to provide childcare, partners were often left with sole responsibility for the children. Therefore, seeking external help was sometimes impossible practically and leaving home was considered too much of a risk. For older women, there was also a sense of inevitability about the situation they found themselves in.

“I think in my day you didn’t do anything, then you just sort of accepted it but now [women] don’t accept it. My daughter [whose husband has a drink problem] is just not having it. I had four children, where could I go? I went to my mother’s once but I mean she did not have room for me. I stayed a couple of weeks or something but I couldn’t do anything else other than come back again.” (Wife of non-service user, Edinburgh)

The presence of a person with an alcohol problem in the home poses all kinds of restrictions on other household members. The research highlighted numerous tales of people being too embarrassed to take friends home or invite their child’s friends to visit because of the uncertainty of the problem drinker’s behaviour. Family and friends of problem drinkers also spoke of how their embarrassment of the drinker’s behaviour, led them to try and hide the problem from others.

One of the main personality changes identified by both those close to people with alcohol problems and the misuser themselves, was the increasingly aggressive and violent behaviour associated with alcohol use. Many spoke of drinking ‘binges’ resulting in fights with strangers and/or domestic violence, usually against their partner but also sometimes against children. In fact, for some it was only once a person become aggressive and violent that it was recognised alcohol had become a problem that needed to be addressed.

“I didn’t find it a problem until he would get aggressive about it. It was the children as well. If they got up I would just go through to the room, don’t come in. I was worried about them because he did occasionally hit them, on and off. I was unhappy about that. If it had only been me I could have coped a bit better or differently anyway.” (Wife of non-service user, Edinburgh)

Physical, mental and sexual health

In terms of the impact on health, many people did not prioritise this as one of the most negative aspects of alcohol. With the exception of ‘hangovers’ – which were seen as socially acceptable – most people saw alcohol having health implications only for people with ‘extreme’ drinking behaviours. Similarly, problem drinkers themselves only appeared to acknowledge the health implications of excessive alcohol consumption when they actually suffered from something as serious as a seizure, pancreatitis or cirrhosis, for example.

“I mean I was at death’s door before I went into rehab. I was going to die. I was told if I carried on I was definitely going to die.” (Private sector previous service user, Male, Glasgow)

However, even when told of the serious health implications, it did not always alter the problem drinker’s behaviour:

“I was in hospital because I had pancreatitis...I went on a binge and refused to come off it. I had a couple of bad weeks and I went on the drink and I am ashamed of it, well I am not ashamed actually because I couldn't give a shit to tell you the truth. I ended up in the hospital, I had four days on a drip and I thought to myself well I have had the yellow card, I don't want the red. I have been warned here to stop it. That is only three percent what I am drinking just now, I just like the taste of it.” (Friend of non-service user, Male, Fife)¹⁰

Despite having been in hospital for pancreatitis, the same respondent went on to say that an abstinence approach to alcohol misuse was the wrong approach for him, although it might be *‘fair enough if you have a serious illness.’* Such contradictions were apparent in many of the issues discussed in the course of the research.

The ‘shakes’ were also mentioned by many of those close to those with alcohol problems. This was seen as a physical and practical problem for the person suffering from the ‘shakes’ but also as embarrassing for the person around them. One woman spoke of how her husband’s shakes became so uncontrollable that she had to buy him a sports bottle to drink from as he could no longer hold a cup. She would no longer take him out socially because of the embarrassment it caused her. Another woman described how her husband’s work colleagues teased him about the shakes, treating it as if it were not a serious matter.

Current and previous service users also emphasised the physical and mental health problems associated with stopping drinking or detoxification.

“You know how I come off it when I've been on for weeks. I am violently ill, sick and shaking” (Social Work service user, Male, Glasgow)

“I've seen me sitting here and the television's been on fire...and I 'phoned the fire brigade to come out and there's nothing there. And I've had water coming down these walls, phoned the people up the stairs ... and there's nothing there. And, then there's mosquitoes [that] sit on your face...and animals loping here and big snakes going across there...I never slept for three weeks and I didn't eat and I lost about two stone in weight. Of course, this was me coming off the drink...I sat there one night and I must have fallen asleep for about 2 seconds, I woke up and there's this big tarantula on my hand”. (NHS, previous service user, Male, Edinburgh)

However, it seems that unless people have experienced this themselves, they are likely to be unaware of the potential severity of the experience of stopping drinking or, even if aware, unlikely to believe it will happen to them.

Although the impact of alcohol on sexual health was only discussed in one group, it is likely that this is a result of its sensitive nature rather than it being irrelevant to others. These women spoke of how their partners were no longer capable of sexual intercourse because of their drinking and, as a result, they had become increasingly distant from the person they had chosen to be with. While the older women who discussed this issue felt this was maybe less

¹⁰ Even though this person was recruited as someone who has a friend or relative close to them with an alcohol problem, through the course of the interview it became apparent that he himself had an alcohol problem.

of a problem for them, they thought that many younger women would be deeply affected by this consequence of alcohol misuse.

*“*You haven’t got a sex life either.*

***It destroys all the nerve endings, he used to be quite a virile man. They are just not the same anymore. No wonder all these women have affairs. It doesn’t bother me now but if you were a lot younger and you had a young husband who was an alcoholic, you would leave.*

**I know girls that have left their husband...they are just fed up living with a drunk. Simple as that.”*

(Social Work families and friends of people with alcohol problem service user, Females, Glasgow)

There was less direct discussion of alcohol impacting on mental health – in fact, this was more commonly identified as a cause rather than result of problem drinking. The most direct result identified was memory loss. However, even if not labelled by the respondent as such, it was clear from discussions that alcohol problems had led to severe mental health problems. It seemed that those at the most extreme end, that is those who had lost their relationship, children and employment for example, began to suffer mentally as a consequence of all the practical and physical damage done through alcohol. A number of people involved in the research acknowledged that they had reached a point where they had become suicidal and this, in a few cases, had acted as the catalyst for recognising they had an alcohol problem.

“He took an overdose of those Panadol things...and ever since then he has accepted he is ill and he can see for himself now what he couldn’t see before – that drinking altered his state of mind, that he was a Doctor Hyde, you know, a Jekyll and Hyde character.” (Voluntary families and friends of people with alcohol problem service user, Borders)

Some relatives and friends of alcohol service users were concerned about whether this behaviour was genuine or whether it was an attempt to make others feel guilty.

“He slit his wrists and everything because I wouldn’t take him back. He was sitting drinking Budweiser. He broke the bottle and slashed all his wrists. I am just caught in a vicious circle.” (Partner of non-service user, Female, Glasgow)

Families and friends of those misusing alcohol spoke of the mental pressure placed on them by the misuser's behaviour. This was particularly the case when they felt they could no longer do anything to help and there was little support for them - *“Sometimes you think you are going crackers”*.

In general, most people who had experienced living with someone with an alcohol problem spoke of how alcohol misusers try to attribute blame, and therefore guilt, for their problem onto the carer. This occurred in a number of different ways, for example, the partner being the root cause of their drinking because of *“nagging”* or *“the kids”* or their failure to succeed in tackling their problem for them.

“He was obviously getting better but then he went back to drink again. Then he blamed me because I said that I would help him but [I said] ‘I can’t stop you buying a bottle and pouring it’. You’ve got to stop that yourself.” (Partner of non-service user, Female, Edinburgh)

“I got ‘It’s your fault I’m like this. If you hadn’t done that...’ I was told that was them putting the guilt on you. Do you not find that alcoholics pick at your weak faults? They make you feel bad.” (Partner of Social Work service user, Female, Glasgow)

Often the feeling of guilt was not only a consequence of the problem drinker attributing blame but also a subconscious reaction, related to a sense of helplessness. Some people felt that if they had “*stepped in sooner*” their partner would not be at the stage they were at. Although most people accepted the problem drinker had to take responsibility for their own behaviour, the research found an undercurrent of guilt among families and friends.

Financial impact

“I sometimes wonder how much the arguments about alcohol are about alcohol per se or are actually about the fact that there’s no money because somebody’s spent it on alcohol.” (Voluntary sector previous service user, Male, Borders)

Perhaps the only negative aspect about alcohol raised that was *not necessarily* related to excessive consumption, was the financial impact it had on people. As it is such an ingrained part of Scottish culture, many people spoke of ‘going out’ when they could not afford to.

*“*I don’t know how I managed it because I was on a lower wage and everything and working less hours and I was out all the time...*

***I have seen me going out before with a fiver, just to get out, and I have bought myself one drink.*

****I have done that as well...*

***When I was homeless I wouldn’t bother with money for food. It was the minute anybody gave me money I went straight for drink and I didn’t care.”*

(Drinkers, Female, Fife)

Moreover, for those with alcohol problems or living with such a person, the financial impact was often a major source of tension. The research found that many people were spending large quantities of money on alcohol, often having a profound impact on their lives and the people around them.

“It was just since his stroke [and he started drinking] that he has gone through every penny we had in the bank.” (Partner of voluntary sector service user, Borders)

“I was running two businesses at the time...I was putting money in the bank and he was just taking it out. The effect it had on my kids...I had to shut the businesses down because basically there was no money.” (Drinker, Female, Edinburgh)

“Don’t forget, an alcoholic will spend his last penny on getting drink and deprive the family of the livelihood.” (Voluntary sector service user, Male, Glasgow)

In general, participants felt that the impact of spending money on alcohol would be greatest on those with the fewest resources. The important factor was the proportion of disposable income being spent on alcohol. For those with low incomes, spending money on alcohol could very quickly cause financial problems in the household. Some service users from more affluent backgrounds felt that their favourable financial both protected them from some negative aspects of alcohol (such as debt) but also worsened the problem, as readily available funds allowed them to increase and prolong the drinking – *“if you’ve got money you can avoid the problem for longer” (Voluntary sector previous service user, Male, Borders)*

Overall, the research clearly found that the financial impact of alcohol misuse was not only felt by the misuser, but also by their family members, in fact sometimes affecting them most harshly.

“I can see a lot of things happening to me but if I want a drink I don’t care. I don’t care whether you need to sell watches or throw the wife out. I want a drink. It is selfishness. Nothing else matters” (Social Work service user, Male Glasgow)

Loss of control of life

While current and previous service users emphasised how alcohol had caused them to lose control over their lives and lose sight of what was important to them. In many cases, it was only *after* they had lost everything that they realised the extent of the problem.

“After thirty years [of marriage] I got divorced through drink. I lost a lot”. (Social Work service user, Male Glasgow)

“For me, I became suicidal, the other thing was that I lost my family, my mother and that will not speak to me at all. They won’t even let me near the door. I lost my wife, my house and my car – everything. I lost it all through drink.” (NHS service user, Male, Glasgow)

Some participants mentioned that excessive alcohol consumption could lead not only to the loss of control over life but also to the loss of life itself. Some of those involved in the research who were ‘surrounded’ by alcohol-related problems, knew of people who had died as a result of these. The following excerpt from one of the group discussions highlighted this point:

*“*There is nothing worse than alcohol. I’ve been to ten funerals this year and they are all alcohol related. A whole family was wiped out – a mother, a father, a son, an uncle. Every one of them on booze.*

***My two brothers were found dead behind a door - different doors – but it was alcohol.” (Partner of social work sector service user, Glasgow)*

SUMMARY

On the surface, alcohol was seen as a positive part of life in Scotland. It was seen as being associated with enjoyment, socialising, relaxing and gaining confidence. There was, however, a perception that it was very easy for the negative aspects of alcohol to develop out of the positive ones. In particular, the ‘positive’ use of alcohol for the relief of stress and for forgetting about problems was seen to be dangerous. The main negative aspects identified by those with either direct or indirect experience of alcohol-related problems were of a more serious nature than those identified by most ‘drinkers’. While everyone spoke of, for example, hangovers and speaking out of turn, those with alcohol problems and the people close to them tended to focus more on the serious and long-term problems, such as the impact on personal relationships, violence, financial problems and general loss of control. These negative consequences were perceived to impact on both the misuser and those close to them.

CHAPTER FIVE: UNDERSTANDINGS OF ‘ALCOHOL MISUSE’

This Chapter presents a discussion of how people define and understand alcohol misuse, therefore addressing one of key questions of the consultation exercise. Three main terms were explored in the research – ‘alcohol misuse’, ‘alcohol problem’ and ‘alcoholism’. For some, there were clear distinctions between the different terms but for many the terminology was meaningless. As the discussion below highlights, the term ‘alcohol misuse’ was particularly difficult for people to interpret, and it is not considered part of common parlance. In contrast, while in the health profession the term ‘alcoholic’ is no longer favoured, the general public still commonly use it when talking about people with alcohol problems.

This Chapter contributes to the consultation question, ‘how should be define misuse?’. While an attempt has been made to structure this chapter around the three main terms discussed – alcohol misuse, alcohol problem and alcoholism – it is clear that the distinctions between this terms are, to some extent, artificial. Each term is discussed separately, highlighting both common interpretations and confusions. Following on from the discussion of these terms, the Chapter presents a brief discussion of how respondents defined their own behaviour in relation to these terms.

ALCOHOL MISUSE

The first point to be noted is that the term ‘alcohol misuse’ was not generally used by any of those participating in the research. It was only when pressed that people attempted to attach definitions to the phrase. For one group of ‘drinkers’ initial discussions of the term ‘misuse’ referred to ‘*drinking for the sake of it*’ and they recognised that while they may not have a ‘problem’, they may in fact misuse alcohol.

“I guess I probably do misuse use it... Whenever we’re thinking of going out or we’re not quite sure [about where to go], it is always ‘Let’s go and get pubbed up’, almost every night. I guess that is misuse.” (Drinker, Male, Glasgow)

Although the term alcohol misuse was of limited meaning for many, most people associated it with what be termed ‘low level excess’.

“I think that people who problem drink have got a lot of deep psychological problems. Alcohol misuse can be just going over what is healthy” (Voluntary sector service user, Female, Edinburgh)

However, for others the phrase was discussed in terms of what other people would consider to be ‘alcohol problems’ and ‘alcoholism’. For example, men in one group talked about alcohol misuse in terms of the damage it can do to your body – ‘*having too much so it damages your liver and kidneys*’ – and in terms of dependency. For some, the term alcohol misuse was synonymous with the definition of alcoholism.

Some participants close to someone with alcohol-related problems referred to binge-drinking alcohol misuse and felt this could be distinguished from an ‘alcohol problem’ or ‘alcoholism’

because it does not form part of “*habitual consumption*” or part of “*the routine*” (*Relative of non-service user, Male, Edinburgh*).

When considering the term ‘alcohol misuse’, some respondents thought that economic factors were important features of alcohol misuse. In this case participants described how they would choose to spend their money on alcohol when they should be prioritising their spending. For those from lower socio-economic backgrounds and among the students there was evidence that buying alcohol often occurred when people were not in a position to afford it - ‘*spending money you don’t really have*’ (*Drinker, Female, Edinburgh*). It should be stressed that this was not necessarily in relation to excessive drinking but also more common behaviours such as going for ‘a pint’. People knew they could not afford to do it, but the social benefits of alcohol often meant that this type of spending could be justified. While this type of behaviour was common, only a small number identified this as a factor of misuse.

“You can misuse alcohol...where you get your money and you are automatically buying a drink. I do that myself. To me I misuse alcohol. I am not an alcoholic but I misuse it. As soon as I have money I am straight to the bar.” (*Drinker, Male, Borders*)

References to binge-drinking and spending too much money on alcohol when you cannot afford it, suggests that the term ‘alcohol misuse’ could be attached to the behaviour of a significant proportion of the adult population in Scotland. But, as shown above, people do not tend to think in these terms and therefore the implications might be that people believe help or support is only needed when the person becomes dependent on alcohol and not at a stage prior to this. Services are, in this sense, seen as curative rather than preventative.

ALCOHOL PROBLEMS

While there was some disagreement among respondents about what constitutes an alcohol problem, there was a general view that this term refers to when alcohol begins to impinge of the user’s life – as one respondent stated, “*when it starts to take over*” (*Voluntary sector previous service user, Male, Borders*). Other respondents made similar comments, as shown below:

“When it sets a whole train of events in motion – it affects your work, relationships, family life, children, finances” (*Voluntary sector service user, Female, Borders*)

“I did become aware of scheduling the day as such to get drink later on. The car would go away from lunch time...I would schedule the day round drink rather than scheduling it the other way.” (*Private sector previous service user, Female, Glasgow*)

However, there was again a reluctance to label personal behaviour in this way. For example, some ‘drinkers’ thought this was because excessive drinking and binge-drinking was simply seen as a part of being young. Interestingly, some of the younger ‘drinkers’ felt that while

their current drinking behaviour was not ‘a problem’, they might have classified it as such if they were older.

“Moderator: When does drinking alcohol become a problem?”

**When you take it home and it starts to cause arguments.*

***It is fair enough to get totalled for two weeks but when it goes beyond that.*

****Before I had the bairn, when it came to Friday night I had to have a drink and on a Thursday I couldn’t wait ‘til the morning because you knew you were going out. If I never had my work I went on Thursday [too].*

Moderator: At that point, did you think you had a problem with alcohol?

****No, even when I was going out every night.”*

(Drinkers, Female, Fife)

However, the research found that older participants who still engaged in this type of behaviour showed a similar level of reluctance to identify themselves as having a problem.

While most people associated dependency with ‘alcoholism’ (see below), some identified this as the point at which they felt they has ‘a problem.’

“I used to sneak up at 3 or 4 in the morning, have a quick glug out of the bottle and go back to sleep again. That was when I realised I had a serious problem” (Male, service user, voluntary, Borders)

Alcohol was seen to become a problem at various different stages or in different ways. While it was often associated with excessive or frequent alcohol consumption, this was not always the case. In fact, many respondents had accepted excessive alcohol consumption as ‘normal’ for a number of years before recognising the problem.

*“*It becomes a problem when you can’t remember what you’ve done the night before...*

***I don’t agree with that because [my husband] has never been like that.*

****I’ve been like that plenty of times!*

Moderator: Would you say that you had an alcohol problem then?

****No, because I only drink once a week on a Friday night.*

**But your Friday night could become a Thursday night and then a Thursday night could become a Wednesday night. That’s what happened to [my husband].*

***That is what happens.*

****I think the problem is when it is affecting your everyday life, or when getting to work is a problem...When Monday morning is a problem. When they get up, they are ill and they are shaking.*

(Partners of Social Work service users, Female, Glasgow)

For some, an ‘alcohol problem’ was defined by the amount of time spent outwith the household, for others it was levels of aggression, while for others it was the discovery that that person was hiding their drinking. In this sense, an alcohol problem was not necessarily defined by the amount being consumed but by the impact it had on the lives of those around them.

ALCOHOLISM

Although some people spoke of dependency in relation to ‘alcohol problems’, most identified this more closely with the term ‘alcoholism’. For some this dependency was highlighted by the frequency of the drinking.

“Alcoholics are constant drinkers. Alcohol misuse is binge-drinkers, like they don’t know when to stop. I would say they are two different things. (Partner of non-service users, Female, Fife)

References to alcoholism often focused on dependency *coupled with* secrecy. Some participants felt that if someone drank excessively in public, they might be considered to have an ‘alcohol problem’, but it was only when they started hide their drinking that they were considered ‘alcoholic’.

While some people referred to ‘*drinking all the time*’ and ‘*begging for money*’ as alcohol misuse, most respondents thought this type of behaviour was more extreme than ‘misuse’ and, again, referred to this as ‘alcoholism’. There was a perception that when somebody had reached this stage, they could be seen as having an illness which they cannot control without some form of intervention.

*“These people [who beg for money and drink all the time] are alcoholics and they can’t help it. My Dad was like that, he really couldn’t help it though”.
(Drinker, Female, Edinburgh)*

The term ‘alcoholism’ was clearly associated, for most people, with the most excessive and severe alcohol-related problems. Because of this, the reluctance among some individuals to label their own behaviour and the behaviour of those close to them in this way was particularly strong, as highlighted in the following conversation:

“Moderator: How would you define an alcoholic?”

**Somebody that wakes up first thing in the morning and has another drink.*

***They need a drink.*

Moderator: Has anybody ever woken up and wanted a drink?

***I have done that one morning.*

**[Yes]. It’s a lager or a Budweiser, I couldn’t go back to drinking vodka if I had been drinking it the night before...I used to think if I had a Budweiser out of the fridge, because it was cold, I would feel better after it.*

Moderator: Some people might say that was a sign [of alcoholism]

**Not really because you are in control of yourself.”*

(Drinkers, Female, Fife)

Generally, alcoholism was seen as the extreme end of a continuum of drinking problems. The further along this continuum service users considered themselves to be, the more likely they were to consider themselves to be ‘alcoholics’.

It should be noted that some service users used the term ‘alcoholic’ differently to others, largely depending on the approach of the alcohol service they had used or were using and their perceptions of the causes of alcohol misuse. Those who believed that alcoholism is a disease and whose service providers adhered to this belief had no problem using the term ‘alcoholic’ and believed that it is an appropriate and accurate description of their illness. Among these participants, there was still a concern that the term ‘alcoholic’ was misused and misunderstood by non-alcoholics but that it was these misconceptions that should be challenged rather than the use of the word ‘alcoholic’.

Other service users, particularly those following a ‘controlled drinking’ model, were less comfortable with the term alcoholic and in some cases felt that using the term was harmful to recovery.

“I hate that word alcoholic, it is horrible. I would rather say I had a problem with drink which I suppose is the same thing” (Voluntary service user, Female, Edinburgh)

DEFINING RESPONDENTS DRINKING BEHAVIOUR

Discussions around respondents’ own drinking behaviour and that of their family and friends, and around definitions of ‘alcohol misuse’, ‘alcohol problem’ and ‘alcoholism’ highlighted some interesting issues. As noted above, the most striking fact was the reluctance of people to attach any of the labels to their own behaviour, while at the same time describing similar

behaviour among other people and describing them as having, for example, a problem with alcohol.

Much of the behaviour of those participating in the research as ‘drinkers’ could be described as problematic. Nevertheless, while a small number acknowledged they might have a problem, many did not, and very few referred to themselves as ‘alcoholic’. Yet at the same time, much of the behaviour they associated with people with an alcohol problem or suffering from alcoholism was exactly the type of behaviour that they themselves engaged in. Recognising that one has an alcohol problem is the key to people contacting alcohol services but this appears to be a fundamental barrier to increasing access to services.

In general, most of those participating in the ‘drinker’ groups were or had been ‘heavy drinkers’. Of the four groups, perhaps the only group that showed a slightly different pattern of drinking was that which took place in Glasgow. In many ways, this group represented ‘typical student drinkers’ – they did undoubtedly engage in excessive drinking and sometimes put themselves at risk, but in general their drinking was more controlled, less disruptive to their lives and to some extent seen as ‘a stage’ they were passing through. While it is also true that the discussions in the three other groups highlighted changes in both attitude and behaviour with age and increased responsibilities, their general experiences with alcohol tended to be more ‘extreme’ and more central to their lives. Unlike the Glasgow students, respondents in the Borders, Fife and Edinburgh seemed to be ‘surrounded’ by alcohol and alcohol-related problems through exposure to problems more widely. For those with problems, it is difficult to assess to what extent this reluctance to label themselves is due to a genuine lack of recognition of a problem because of the extent of alcohol misuse in the community in which they are living or a deliberate or subconscious attempt to ‘cover up’ the problem. The difficulty in accepting any type of problem is that there always appears to be somebody who has a bigger problem and therefore it allows people to justify their own behaviour - *“anyone who ever drinks is someone else.” (Voluntary sector previous service user, Male, Borders).*

Most service users were, of course, much more willing to label themselves – once in contact with a service - as having problems with alcohol but still had concerns about the precise terminology used and how this was perceived by the rest of society.

“Most people think an alcoholic is a guy who is sitting pishing himself. He is sitting there mumbling and he’s lost it.” (Social Work service user, Male, Glasgow)

For those who had contacted a service as a preventative measure – that is, to stop themselves developing further problems with alcohol – there was more reluctance to label themselves.

“I wouldn’t classify myself as an alcoholic or anywhere near that.” (Voluntary sector previous service user, Male, Borders).

“I would say I had a problem with drink – alcoholics have more of a problem. They need drink all the time and they won’t admit they have a problem”. (Voluntary service user, Female, Borders)

SUMMARY

From this account of the ways in which the various groups understand and use terms relating to alcohol misuse we can establish a number of points. The first to note is that the term 'alcohol misuse' is not used in everyday parlance. When asked specifically about this, some people associated the term with the inappropriate use of alcohol, such as binge-drinking or drinking out of habit if not dependency. However, for most people the term was difficult to comprehend. 'Alcohol problems' were often seen to refer to the point at which alcohol begins to impinge on the user's life - for example by impairing their ability to function normally in a work, domestic or social environment. 'Alcoholism', a term which was commonly used, was most often seen as the point at which alcohol takes *control* of everyday life and the point at which people 'need' to drink alcohol. While we can summarise these definitions in this way, it should be noted that these were the most common understandings to emerge but by no means the *only* understandings. There was a high degree of confusion and disagreement in relation to all three terms.

The exploration of how people define and understand alcohol problems proved an interesting part of the research in itself, however, it should not be viewed in isolation. While there was no consensus of opinion on what definitions mean, what is clear from the research is that the terminology to be used in the Plan for Action and the subsequent activities emerging from it needs to be considered carefully. The terminology needs to be understandable and meaningful so that people can recognise problems within themselves and/or others. An example of the difficulty of terminology relates to the words 'alcoholic' and 'alcoholism' - both of which are commonly used and, in general, associated with the most severe alcohol-related problems. However, the result of this common perception is that people are reluctant to identify a problem with alcohol at a stage prior to this. Therefore, interpretation of terminology is directly related to perceptions of acceptable drinking behaviour and alcohol-related problems and, therefore, service use.

CHAPTER SIX: VIEWS ON WHAT LEADS PEOPLE INTO PROBLEM DRINKING

This Chapter focuses on participants' accounts of how and why the transition is made from drinking to 'problem drinking' or 'alcohol misuse'. Varying opinions and explanations were offered, including perceptions of illness, addiction, allergy, genetic pre-disposition and socialisation. Each of these is discussed below.

This Chapter contributes, albeit indirectly, towards the discussion of two of the consultation questions – what concerns people most about patterns and trends and whether there are any priority groups or individuals whose drinking should try to be influenced through the Plan for Action?

ILLNESS, ALLERGY AND DISEASE

A small number of alcohol service users saw alcohol misuse as the result of physical causes, such as a 'disease' 'allergy' or 'illness' that simply meant some people could not drink alcohol in the 'normal way'.

“Alcoholism is a disease which is discernible and treatable.” (Voluntary sector service user, Male, Glasgow)

Often, this was framed in terms of a genetic pre-disposition. Several of those interviewed had a history of 'alcoholism' in the family and there was a widespread perception that there might be a causal link.

“An alcoholic, the minute you take one drink, you trigger off a gene in your body that you cannot control.” (Private sector service user, Male, Glasgow)

SOCIALISATION

It was also recognised, however, that the perpetuation of alcohol misuse within families might result from socialisation rather than genetic determinism.

“I am sure there was a lot of mimicking in that because my father drank, my uncle drank, everyone drank.” (Voluntary sector service user, Male, Glasgow)

ADDICTIVE PROPERTIES OF ALCOHOL

Others located the causes of alcohol misuse on the addictive properties of alcohol itself, equating it to, for example Class A drugs. Moreover, there was a widespread view that those properties were not sufficiently understood or talked about.

*“*We know that if it was invented today it would be registered as a Class A drug. We know that. We understand that.*

***This is why I was upset because I was never told it was a drug. I didn't know it was a drug.”*

(Voluntary sector service users, Male, Glasgow)

“If I take something and jag my arm with it, I know what I'm doing. I drank wine with meals since I was 17 or 18. I drank wine safely all these years. If I'd have lifted a needle I would have known what I was doing. To drink wine, I just did the same as everybody else.” (Private sector previous service user, Female, Glasgow)

LIFE CRISES

For some current and previous service users, problematic life events had led to the development of alcohol problems. For example, bereavement, unemployment, health problems and relationship breakdowns were commonly identified as factors which 'triggered' their alcohol misuse.

“I think it all came down really to when I really started drinking hard when my father died” (Private sector service user, Male, Glasgow)

SUSTAINED DRINKING

Others described a more gradual descent into alcohol dependency through prolonged and every day use. Many of these people had drunk alcohol 'socially' and in what they considered a controlled (if sometimes excessive) manner for many years before they felt it became a problem – for these people the problem emerged from a general progression of alcohol consumption.

*“*I drank safely for thirty years. Totally and gradually, out of the blue I became addicted to the stuff...Why it happened I don't know, after thirty years.*

***No matter which alcoholic you talk to they can never tell you the moment they stepped over the line. We discussed this in a group and no-one can exactly pin-point the day they finished becoming a social drinker and becoming an alcoholic. You just don't know. Just one day it happened, you must have a drink.”*

(Private sector previous service users, Mixed Glasgow)

For others, the transition between beginning drinking and the development of a problem with alcohol had occurred over a relatively short time period. Several participants described how easily and quickly they had developed a dependency on alcohol.

“You start drinking socially and then it gets a hold of you and you can’t do without it.” (Voluntary sector service user, Female, Borders)

“People don’t understand unless you’ve been there and it has happened. A guy might go for a couple of pints on a Friday. He’ll say, ‘how do people get like that?’ but we all started somewhere. I started going out for a couple of pints” (Social Work service user, Male, Glasgow)

As mentioned above, as well as there being a wide range of specific explanations given for problem drinking, there was also a tendency for participants to refer to multiple reasons rather than focussing on one. For example, in some cases a traumatic life event was seen as the initial trigger for starting to misuse alcohol but then the addictive nature of alcohol or a genetic pre-disposition towards alcoholism was seen as being the cause for the continuation of the alcohol problem.

ARE CERTAIN GROUPS MORE AT RISK THAN OTHERS?

While everyone was seen as having the potential to develop problems in relation to alcohol, some groups of people were seen as more susceptible than others. Many of the groups identified were believed to have one thing in common – that is, boredom. For example, there was some feeling that ‘lonely’ people, such as those separated from their partners and widows/widowers, may be more at risk.

“I think it is to do with your circumstances, whether you have got family round about you or if you are on your own. When I first came up here I didn’t know anybody, not a single person, I had stayed in the same place for thirty years and that was a big upheaval for me. When you do maybe start drinking in the house I think that is where it leads to you getting depressed and then you think you will have another drink.” (Drinker, Female, Edinburgh)

Similarly, there was a view that unemployed people may be more at risk due to the amount of spare time they might have and that those living in rural areas because of lack of leisure facilities.

There was a feeling that the current generation of young people is at risk. This was partly linked to the overt targeting and marketing of alcoholic drinks but also in terms of a more fundamental cultural change.

“It is a different culture and they are going out to get a kick. Kids to me look forward to going out and getting drunk. It is a different pattern” (Voluntary sector service user, Glasgow)

“I hate what I’m going to see in another 10 years time, the way youngsters are drinking now ... they’re drinking far more, plus they’re mixing it with drugs and everything. There’s fighting in the street and everything you know. You see youngsters of 13 year old drinking. At least I waited until I was 15.” (NHS previous service user, Male, Edinburgh)

There were mixed views as to whether there were differences between the sexes in relation to the risk of developing alcohol problems. Some participants believed that men and women

were equally at risk but that the problem was simply more visible among men because of perceived differences in drinking behaviour, as illustrated in the quotations below.

“Females are every bit as bad as males, they are as prone to it as we are [but] they don’t need to go in to a pub, a bar, or anything like that. They get it in the store.” (Social Work service user, Male, Glasgow)

There was, however, a view that the level of alcohol misuse among women was increasing, or at least becoming more visible.

“Nowadays women go out more than they did years ago. Yes I do I think a lot more women drink now and a lot more women go out to have a good drink.” (Drinker, Female, Edinburgh)

Overall, however, there was a clear consensus across all groups that problems of alcohol misuse can affect anyone regardless of age, sex or social background. Alcohol misuse was seen to cross all boundaries.

“If you look at however many – 3 or 4 different classes of people from poverty on the street, to a poor working class area with a high rate of unemployment or middle class where people are working or professionals in the city – it touches all walks of life.” (Voluntary sector previous service user, Male, Borders)

SUMMARY

There was a wide range of views in relation to what leads people to problem drinking. Participants drew on a range of potential causes including the physical illness, addiction, allergy, genetic pre-disposition and socialisation. In most cases, the explanations offered did not focus on one single reason but rather a combination of factors.

A number of alcohol service users saw alcohol misuse as the result of a disease, allergy, illness or genetic pre-disposition that simply meant they could not drink alcohol in the ‘normal’ way. Other explanations located the problem with the addictive qualities of alcohol itself rather than with any characteristic of individuals. It was also noted that multiple familial alcohol problems might result from socialisation rather than genetic determinism. For some service users, the transition from drinking to developing a problem with alcohol was clearly marked by some kind of traumatic life event. Others described more of a gradual descent into alcoholism through prolonged and everyday use.

There was a widespread consensus that problems of alcohol misuse can affect anyone regardless of age, sex or social background. However, certain groups were seen to be more at risk than others. The current generation of young people was seen to be one group cited as at greater risk. Loneliness and boredom were also seen as factors increasing risk for groups such as the unemployed, divorced or widowed people and those living in rural areas.

CHAPTER SEVEN: AWARENESS AND PERCEPTIONS OF ALCOHOL-RELATED SERVICES

The interviews and focus groups explored participants' awareness and perceptions of services providing help and support for people affected by alcohol problems. This Chapter is divided into two main sections – the first presents a discussion of awareness of services for alcohol misusers and the second examines awareness of services for friends and families of alcohol misusers.

This chapter contributes to the consultation question- 'are there priority groups or individuals whose drinking we should try to influence in the Plan for Action?. It also contributes in part to the consultation question, 'what specific objectives and activities designed to achieve these, would you like to see included in the National Plan for Action?', although this is addressed more fully in subsequent chapters.

AWARENESS OF SERVICES FOR ALCOHOL MISUSERS

All respondents were asked to what extent they were aware of services for people with alcohol-related problems. Awareness of organisations providing help or advice for people with alcohol-related problems was, in general, low and, as might be expected, particularly so among 'drinkers'. Nevertheless a small number of 'drinkers' had had some contact with services, either for themselves or on behalf of someone else (see below) and consequently their levels of awareness were more comparable to some of the service users.

By definition, current and previous service users and families and friends of those who had been in contact with services had a certain level of awareness of alcohol-related services; at the very least, they were aware of the nature of the service they used. Nevertheless, before initial contact was made with any service, alcohol service users recalled having fairly limited understanding about available services, who the services were aimed at and what services actually offered. The extent of knowledge of services, other than the ones they had used, varied.

The only service that virtually all people – across all groups - could name was Alcoholics Anonymous (AA); even then there was limited knowledge about the type of provision or aims of this organisation, again particularly among 'drinkers'.

"Everyone knows the AA but you never see anything else do you?" (Drinker, Female, Edinburgh)

A small number of family and friend respondents had had contact with AA in an attempt to help someone they knew, whereas the others simply knew the name. Most knowledge of this service had been gained through the media.

Most of the other services mentioned were more generic, such as 'counselling', 'the doctor' and 'psychologists and that'. Across all groups, the 'doctors' was identified as the place most people would go to if they were seeking help for an alcohol related problem, although 'drinkers' said they would probably approach a family member first.

“There aren’t many things, just Alcoholics Anonymous I think, or your doctor I suppose.” (Daughter of non-service user, Female, Borders)

Although most people referred to General Practitioners (GPs) as the first point of contact, this was often simply because they did not know where else to go, rather than because they thought the doctor was equipped to deal with their specific problem. Alcohol service users who had approached doctors in the past expressed mixed views about the quality of information and advice offered by doctors. Although some respondents felt that their GPs had offered very positive and useful advice, others felt that their GPs were lacking in awareness of how to deal with the issue, and knowledge about available services. In some cases, people felt that their GP had failed to accept that there was an alcohol-related problem to be addressed and had, for example, diagnosed the problem as depression. This has important implications for planning services – if doctors are most commonly approached about alcohol-related problems, they need to be in a position to be able to act in an informed way.

Family and friends of people with alcohol problems also mentioned home visits (by local doctors and volunteers from AA), help-lines and hospital-based psychiatrists as services available for people with alcohol-related problems. Again these tended to be mentioned by those who had already had some form of contact. For example, during the course of an interview with a male friend of someone with an alcohol problem, it transpired that he himself had an alcohol problem and was currently visiting a psychiatrist, primarily for depression but also for his drinking.

Discussions with both service users (current and previous) and families and friends of people with alcohol-related problems suggested that awareness of services increases once involvement in the ‘system’ has been established. But, thinking retrospectively, most participants said that prior to the initial point of contact they had limited, if any, knowledge of services that might be able to help people with alcohol problems. In general, many of those with a long-term history of alcohol problems had experimented with different services and/or combinations of different services to find the one best suited to their individual requirements. Thus, as a group, they were the most informed about services available for people with alcohol-related problems.

Among all groups, including current alcohol service users, there was perception that alcohol services were not widely advertised and availability of information was limited. Many ‘drinkers’ felt that alcohol-related problems did not receive the same priority as drug issues when it came to service provision.

“There are not really very many [services] for alcoholics but for drugs and that there are loads.” (Drinker, Female, Edinburgh)

Service users generally gained much of their awareness through word-of-mouth, with other alcohol service users making a recommendation and through local doctors or information in doctors’ surgeries.

“I wouldn’t have known about this place. It was only through word-of-mouth I found out about it”. (NHS service user, Male, Glasgow)

“They never show an advert with an alcoholic service.” (Social Work service user, Male, Glasgow).

A slightly different picture emerged in the Borders where current alcohol service users appeared to have greater awareness than others of available services.

“[There is information] everywhere. When you walk into the GPs surgery, you will see a big yellow sign that says ‘alcohol is a very dangerous drug’. I think there are handouts as well you can get in the doctor’s.” (Voluntary sector service user, Male, Borders).

However, even in an area where the perception was that sufficient information was available about alcohol services, some service users expressed concern that people might still find it difficult to access the information.

“There’s lots of information out there but I would tend to think it’s there but you have to go and look for it lots of times.” (Voluntary sector previous service user, Male, Borders)

“I think it is quite difficult to get hold of the information. I heard about [service] by accident. Now the leaflet is in my doctor’s surgery but it doesn’t look like it’s about help with alcohol. It is just stuck in with a million other leaflets.” (Voluntary sector service user, Female, Edinburgh)

Some of the ‘drinkers’ said they simply would not know where to go, and thought they would simply have to look in the telephone book or on the Internet or visit a Citizen’s Advice Bureau to find out about services.

Again, apart from the people who had had contact with services, knowledge about what services actually offered people with alcohol-related problems was limited.

AWARENESS OF SERVICES FOR FAMILIES AND FRIENDS OF PEOPLE WITH ALCOHOL-RELATED PROBLEMS

All respondents were asked about their awareness of services for families and friends of people with alcohol-related problems. Overall, awareness of these types of services was even lower than knowledge of services for people with alcohol problems. A small number of service users, and friends or relatives of alcohol misusers, referred to Al-Anon but awareness of this specific service was clearly much lower than that of AA. Again, as might be expected, ‘drinkers’ had the lowest level of awareness of such services.

“I don’t think there are groups for families to go to and talk about how it has affected them.” (Drinker, Female, Edinburgh)

Having said that, some current and previous service users showed very low levels of awareness of services to help their friends and families.

“My husband was talking to me the other day and he said it was a pity that [name of service] didn’t have a place for the husbands or the partners and that. ... My daughter went once, my youngest thinks I just like to go and get drunk, I think if she understood it better, that would be good ” (Voluntary sector service user, Female, Edinburgh)

Only in the Borders voluntary service for people with alcohol problems did most service users know that such a service was available.

Despite being the target group for this type of service provision, family and friends of people with alcohol problems were as unlikely as other respondents to be aware of services to help them. Obviously, those currently in contact with a service were likely to have increased levels of knowledge, but prior to this contact they had as little awareness as non-service users. Moreover, they were often still unaware of other services that might be able to help them – even though it was felt that there was a need for such provision

“I don’t think there is anything [other than this].” (Partner of private sector service user, Glasgow)

“If there was [a service for families and friends] I’d be there, believe me. If I knew of any services that could tell me how to cope with this or whatever then I’d be there believe me, I’d be there.” (Partner of non-service user, Female, Glasgow)

SUMMARY

The research found low levels of awareness of organisations providing help or advice for people with alcohol-related problems, with some assuming that few sources were available. This was the case across all the different participant groups, although those who had had some contact with a service displayed higher levels of awareness than those who had not. In the majority of cases, once contact had been made with a service, awareness and knowledge of other service providers appeared to increase.

The local GP was most commonly identified as a potential source of advice or help, primarily because of a lack of knowledge about other service providers. Most participants were aware of Alcoholics Anonymous. A small number of non-service users were able to name other specific services, but most of the services mentioned were more generic, such as counselling, GP and psychologists.

Levels of awareness of services for friends and families of those with an alcohol problem were generally even lower, not only among ‘drinkers’ but also among current alcohol service users and the friends and family service user target groups. Some thought that such services simply did not exist but all thought that there was a need for provision of help and advice for families and friends of alcohol misusers. Participants felt that a range of services should be offered (such as one-to-one counselling and group sessions) to suit individual needs.

Regardless of the participants’ levels of knowledge of available services, there was a widespread consensus that alcohol services are needed in Scotland – both for the misuser and their friends and families - but they are not publicised widely enough. Interestingly, there was a perception that drugs misuse services were both more prevalent and more effectively publicised.

CHAPTER EIGHT: CONTACTING SERVICES

This Chapter presents participants' perceptions of contacting alcohol services and their subsequent experiences. The first part briefly discusses attitudes towards the need for alcohol services, before presenting a more detailed discussion of perceived barriers to accessing services. The final part of the Chapter examines how these barriers are overcome and, more specifically, what makes or encourages people to take the first step in contacting an alcohol service.

IS THERE A NEED FOR ALCOHOL-RELATED SERVICES?

The research clearly highlighted a need for alcohol-related services – all participant types agreed that there was a need for both services aimed at people with alcohol problems and their families and friends. Most people felt that, in terms of current service provision, services for people with alcohol problems were likely to be more prevalent than services for people close to them. However, as already noted in the previous chapter, awareness of specific services was limited.

In general, there was a strong feeling that the prevalence of alcohol problems in Scottish society was high and that there were insufficient services to deal with this. Some of this perception can be explained by the lack of awareness of existing services, with many people simply assuming there were not any. When asked what types of services are needed, most people first spoke of those to help people with alcohol problems rather than their friends or families. Those with alcohol problems were more likely than others to spontaneously identify a need for services aimed at family and friends. Interestingly, despite being a key target group, family and friends of alcohol misusers tended not to refer to services aimed at themselves unless directly asked and, although recognising the need for such services, they tended to prioritise services for the alcohol misuser.

*“It is really the person who is drinking you want to get there, not yourself.”
(Daughter of non-service user, Female, Borders)*

All groups of respondents recognised that problems caused by alcohol do not only impact on the misuser but on those surrounding them and, in light of this, there was strong support for services aimed at the family and friends of alcohol misusers. Family and friends themselves often felt that this impact was not recognised by other people or by alcohol misusers. Because of the social stigma attached to alcohol problems, many felt unable to speak to anyone about their problems and, therefore, services to help and support them were seen as crucial.

“[The family and friends] are the sufferers in the long run. They are the ones that have to bear it all.” (Partner of Social Work service user, Female, Glasgow).

‘Drinkers’ also recognised a need for such services, particularly if children were involved, because of the wide-ranging impact of the problem.

“It just ruins so many lives, it really does.” (Drinker, Female, Edinburgh)

*“*I made my Mum totally depressed. I made her nearly take a nervous breakdown.*

Moderator: What do think she would have benefited from?

**Someone to talk to, someone in the same situation, because the amount of people that came to my house, the same age as me, doing the same things as me, all their mums must have been the same.”*

(Drinker, Female, Fife)

This need was strongly echoed by alcohol misusers themselves, who recognised their own behaviour often had an impact on those around them.

*“*There is a huge need [for services] for the family.*

***Yes, absolutely.*

**Every bit as much a need as there is a need for alcoholics.*

***If we work on the figure that an alcoholic affects seven [other people], it depends on which alcoholic, believe me there are some who affect an awful lot more than seven, let’s take a mean figure of ten, one alcoholic affecting ten. No-one is really getting away without being affected at one level or another.”*

(Voluntary sector service users, Mixed, Glasgow)

“If there had been places ten years ago I might not be divorced,” (Social Work service users, Male, Glasgow).

So, as shown above, the research highlighted a consensus opinion that Scotland does have a need for services for both those with alcohol-related problems and the people close to them. But, even if these services are made available and people are informed of their existence, the research found that there are significant barriers to making contact with them and these are addressed in the remainder of this Chapter.

BARRIERS TO CONTACTING SERVICES

The barriers identified fell in to two main categories – psychological and practical – and each of these is discussed in turn below. The psychological barriers are discussed first because they were most strongly identified and also because these need to be overcome before any contact will be made with a service, irrespective of practical barriers.

Psychological barriers to contact

The main psychological barriers are admitting the problem to both the self and others; the context of the individual’s drinking behaviour; the fear of what impact seeking help might have on the family unit, other personal relationships and employment.

Admitting the problem

The most commonly identified barrier to contacting a service was the unwillingness of people to admit when there was a problem with alcohol. This ‘denial’ was most pronounced among those with alcohol problems but was also sometimes experienced by those close to them; with families and friends also being reluctant to ‘see’ the problem. This view was expressed by all participant types and was, in particular, highlighted by some of the ‘drinkers’ some of whom were clearly in a state of denial themselves about their relationship with alcohol.

“The ability to admit they have a problem. There are a lot of people walking around out there that have a problem and they don’t think they have a problem.” (NHS service user, Male, Edinburgh)

Many participants felt that even if people did make contact with a service – for example, because a family member pressured them to do so - it was unlikely to be helpful if they failed to admit they had a problem and take responsibility for tackling it. The perception that a person needs to accept they have a problem before seeking help appears to be borne out by the experience of the friends and families of alcohol misusers. Again, one of the main problems to be addressed is how to get people to recognise this.

“It doesn’t matter if the person needs help, what matters is if the person knows they need help.” (Family member of non-service user, Male, Edinburgh)

“I handed my mother a leaflet once for alcoholics anonymous and I got banned from the house for a month. (Drinker, male, Borders)

“I pushed him to the ‘phone time and again to ‘phone AA! He wouldn’t do that because he said he wasn’t alcoholic. He must have realised that the drink was taking over.” (Partner of voluntary service user, Female, Borders)

However, even if someone admits they have a problem, it was thought that some people simply did not want help.

“My brother admits he has got a problem but he still doesn’t want help.” (Drinker, Male, Borders)

Once someone has recognised and admitted they have a problem with alcohol, participants felt admitting this to other people posed a further obstacle to contacting a service.

“I did try to hint and hint and I was wanting someone to say to me ‘come and do this’. Then I eventually told the truth later, it was a litre and a half. It was [the psychiatrist] who picked up from me. I wanted her to pick up from me. I was divulging something but I wasn’t saying directly that I had a problem.” (Private sector service user, Male, Glasgow)

“I did go and see a doctor but I think I was too ashamed to admit just how much I was drinking. She asked me are you drinking and deep down I was too ashamed. I wanted to but I didn’t have the guts to tell her exactly how much I was drinking and, you know, I thought maybe she should have noticed. (Private sector previous service user, Female, Glasgow).

Contextualising individual drinking behaviour

Whether or not someone admits to having a problem appears to be linked with their perceptions of what constitutes alcohol misuse or alcoholism and the drinking behaviour of social peers. While many people do seem to think, for example, that they drink 'too much', they also feel they only need to seek help if they 'hit rock bottom' (Male, Glasgow). This seemed to be particularly evident among those participants who had contact with people they considered to be 'alcoholics' – their own drinking behaviour was then seen to be relatively minor.

"There are a couple of people in my family who are alcoholics and I say I drink a lot. But compared to my family, I would say I don't drink a lot. If I went to the doctors I would be saying I was an alcoholic when I wasn't. I would have to make out I drink as much as what they drink." (Drinker, Male, Borders)

"For so many years you hide it from yourself. I felt no reason to talk to a doctor. Everyone went to the local, so why would I be any different." (Private sector previous service user, Male, Glasgow)

The issue of recognition of a problem is complex, being influenced by the context within which the drinking is done. For example, one participant's social life was based on drinking - 'being drunk' was common among his friends and, because of this, he felt that he did not have a problem as, in his eyes, he could continue to function in his 'normal' daily routine:

*"*I could go up there and have four or five pints, come down the road to do what needs to be done and then go out in the garden until 10 or 11 at night and not hurting anybody. I don't think that there is anything wrong with that, even though I know some people do.*

Interviewer: So you wouldn't say that you have a problem with alcohol?

**Not when I am off it I don't. When I am on it, it is hard to get my mouth open in the morning and juice or water doesn't do it for me although I can have a couple of tins of beer and then I am okay."*

(Family member of non-service user, Male, Fife)

Fear of impact on the family unit

The interviews with family and friends suggested that some people were apprehensive about seeking help for the person with the alcohol problem, even when they thought it would be beneficial. Again this linked to the problem drinker's reluctance to admit there was a problem – suggesting to someone in denial that they contact a service was viewed with trepidation.

"Interviewer: What was his reaction when you suggested he call AA?

**He went berserk.*

Interviewer: What did he say?

Rubbish and stop interfering...I just gave him the phone number and said 'phone them, try phoning. They'll help you. You've got a problem, think about it.'

(Friend of non-service user, Female, Borders)

In addition to her friend, this respondent's mother also had a drink problem. While she would be fully supportive if her mother initiated contact with a service, she was reluctant to do so herself as she felt it would be disloyal to her mother, especially as she felt her mother would be embarrassed and ashamed of her behaviour being publicly acknowledged. Similarly, one young person felt she could not suggest her father contact anyone for help because he refused to admit he had a problem. One woman regularly discussed her partner's alcohol misuse with him but had never raised the issue of seeking help or advice from someone - *'It is not something we have ever spoken about.'*

Some alcohol misusers who had children expressed concern about making contact with alcohol services because of the risk of social service becoming involved and what their perceptions of the misuser might be.

"I felt [...admitting to having a problem with alcohol] could jeopardise my work and things like that ... and that if I admitted I was an alcoholic that social work could maybe think I was a bad mum and take my daughter off me" (Private sector service user, Female, Glasgow)

"If my children were younger, I would have been scared in case they were taken off me." (Voluntary sector service user, Female, Edinburgh)

Perceptions of who services are aimed at

It seems likely that perceptions of who services are aimed at, and the terminology used, may act as a disincentive for both the alcohol misuser and the person close to them seeking help. This was often mentioned in relation to AA - perhaps because it is the most widely known service - in that it was identified as a service for 'alcoholics', a term that many people had difficulty relating to. It seems that some people would be more willing to approach a service if they thought it was to help people who were, for example, starting to get into trouble with their drinking or seeking to help to control their drinking.

This links to a general perception of hypocrisy surrounding 'alcoholism' and 'alcohol problems'. In Chapter 4, it was highlighted that alcohol plays a pivotal role in society. The research suggests that because excessive drinking and drunkenness are, to some extent, accepted as normal, anyone who seeks help for alcohol-related is suggesting that their problem is somehow worse than others, when this might not be the case. For example, one woman spoke of how a neighbour commented on her husband's 'alcohol problem' in a derogatory manner, yet the neighbour showed a similar pattern of drinking behaviour and suffered similar consequences. In fact, the only difference between the two was that her husband had sought help and her neighbour had not. Despite showing very similar behaviours, the neighbour could now differentiate himself from the 'alcoholic' and label himself as 'normal.'

Perceptions of others

All participant types spoke of shame, embarrassment, fear of stigmatisation, and concerns about anonymity and confidentiality, as acting as barriers to contacting services.

“I think a lot of people are scared because once you make that first step you are labelled [an alcoholic]” (Voluntary sector service user, Female, Edinburgh)

“Shame. Fear of what might happen ... It is shyness and shame I think that puts people off” (Voluntary sector service user, Male, Borders)

Those close to the alcohol misuser often denied there was a problem and hesitated about seeking help for as long as possible to protect themselves from the ‘*shame*’ and ‘*embarrassment*’ of living with someone with an alcohol problem. Some participants, for example, spoke of the lack of support from relatives and friends because of misunderstandings of alcohol problems.

*“*It is an illness. If you’ve got cancer or something else, people will bend over backwards to help you. The minute you’ve got alcoholism...*

***The stigma.*

**Because people think you can stop it.”*

(Partners of Social Work service users, Female, Glasgow)

Fear of employers’ reactions

In particular, concerns were expressed in relation to employers finding out about alcohol problems, although this varied according to the types of jobs people had. For example, for publicans, alcohol problems were almost seen as a danger of the trade, and support mechanisms were becoming increasingly common. In contrast, one service user’s employer believed the treatment being given was for depression rather than alcohol problems, simply because the alcohol misuser was frightened of the consequences of admitting the nature of the problem.

‘Drinkers’ also expressed concerns that seeking help might have a negative impact on career prospects.

*“*It would have an effect on your career being an alcoholic. Being a lawyer and going to AA meetings.*

***One would prefer to keep it to oneself.*

****It has such a stigma hasn’t it? People don’t identify alcohol abuse as a problem like smoking addiction. They see it more as an illness, more of a depletion of character. It is someone who is pathetic almost”.*

(Drinkers, Males, Glasgow)

Practical barriers to contact

Even if the psychological barriers can be overcome, respondents felt that there were a number of practical factors acting as barriers to contacting services for both alcohol misusers and their family and friends.

Financial requirements

Both those with alcohol problems, and their families and friends, identified financial concerns as a barrier to seeking help for alcohol problems. Some had approached private services but found the cost prohibitively expensive.

“About five years ago, just before my marriage broke up I came up for assessment and was asked all the questions. She said you have a drink problem but you can’t come in because [private health insurance provider] won’t pay for it. It’s going to cost you so much. And I said ‘if they won’t pay for it, I can’t afford it myself’” (Private sector service user, Male, Glasgow)

Some of the private service users involved in the research were, or had been, NHS funded but most were self-funded and, in all cases, this was seen as a significant financial burden. While they were fortunate enough to be able to pay this fee, they recognised that a large proportion of those seeking help would be unable to afford it. Private services were generally seen as providing help to the ‘rich’ or people with the most severe alcohol-related problems, who had already tried all other types of service, and therefore received funding to attend such a service.

“I ‘phoned [a private service] to find out how much it was and it was way beyond our means. I know for a fact there are national health people in there but to get in there you’ve got to be in real danger, like setting fire to the house and battering you.” (Partner of Social Work service user, Female, Glasgow)

Some service users had been concerned about possible financial losses if contacting particular types of services – for example, residential treatment centres and potential loss of benefits.

“If you could go some place for five weeks and them not touch your money. If you stay there for six weeks they’ll take your book off you. Say you are on something like income support and all that, it used to be thirteen weeks to get it back. It takes you six months now to get it back. If you stay in some place for seven or eight weeks they’ve taken your book. You have got to go through all that again. People wouldn’t want the hassle”. (Social Work service user, Male, Glasgow)

Referral procedures

Although the effectiveness of different types of service is discussed later on in the report, it should be noted that, for some, the referral procedures were considered a barrier to contact.

Appointment systems were often seen as failing to address the need for immediate contact. In this sense, some people felt that their attempt to seek help had been delayed. The length of time between making initial contact with someone about access to alcohol services and the first service contact was seen as a problem by many of the service users. It was thought that this allows people to fall back outside of the system.

“Well it takes a long time to get referred to somewhere. There is about a six month gap or something.” (Voluntary sector service user, Female, Edinburgh)

“Years ago, once you got yourself sober you could come up here and knock on the door. Then they put a notice on the door saying you had to get referred by your doctor. I was referred by my doctor but I had to wait three weeks and I thought I would never last three weeks. So I just went on the drink again. I don’t even know if I turned up for the appointment.” (NHS, service user, Male, Glasgow)

Several service users suggested that even a minimal amount of contact with a service during the waiting period would increase the chances of service users following up their initial contact. For example, if someone is waiting to enter a residential unit, they should be allocated a counsellor who they can speak to in the interim period.

As already mentioned above, there was some concern about general practitioners’ ability to effectively deal with people approaching them about alcohol-related problems. While some general practitioners were knowledgeable and informed, others appeared to have little awareness of how to deal with the issue or knowledge of other services that could help. Moreover, some appeared to be reluctant to see the problem as alcohol-based.

There were occasions where an initial approach for help had been made - usually, but not exclusively, through the local GP - but help had not been forthcoming.

“I was told ‘go away and fix that [the drinking problem] then come back and we’ll fix the rest.” (Social Work service user, Male, Glasgow)

“I had ‘phoned them up [voluntary support organisation] before and this man told me that he didn’t think I had a drink problem.” (Voluntary sector service user, Female, Edinburgh)

Some of those participating in the ‘drinkers’ groups had previously been to doctor about drinking, or knew others who had done so, and felt that the alcohol issue had not been adequately addressed, for example, preferring to diagnose the problem as depression.

“When I started drinking quite heavily I was going to the doctor and saying to him that I have an alcohol problem. The doctor just kept telling me that I was depressed and it was understandable. It took me ages for me to get them to accept it. I think I was drinking more in the end to convince them that I did have a problem...Eventually when I got really bad I went up to the [hospital] because I requested it – it wasn’t because the doctor though I needed to go.” (Drinker, Female, Edinburgh)

“My Gran went to the doctor...She basically told her she was depressed and put her on anti-depressants. That wasn’t the answer, she was an alcoholic

and needed help with alcohol...It comes to the point where she is doped up to her eye balls on anti-depressants.” (Drinker, Female, Fife)

However, there were also more positive experiences with doctors. One woman spoke of a relative who was currently on a GP-based detoxification programme and, while it was not proving 100% effective, she felt that the doctor had addressed his problem.

“He gets these tablets and I don’t know what they are or what they do for him but he is supposed to have a maximum of eight a day. He went to the doctor and said he had a drink problem and he wanted help. When he feels the urge to drink he is to take a tablet.”(Drinker, Female, Fife)

Contacting a GP is a vital first step for people experiencing problems. This contact can be crucial in determining diagnosis, providing a form of brief intervention and, importantly providing access to other services. This clearly suggests that doctors need to be equipped to deal with such consultations and be aware of services available, as they will often be the first, and in some ways, most important contact

Attitudes of service providers

Inappropriate attitudes from those perceived as sources of help were identified as a further barrier - both in relation to deciding to contact someone and in relation to whether an appropriate referral was made after initial contact.

“They look at it as being self-inflicted. If you need a transplant and you’re an alcoholic you’ll be told you’re not getting one. They take money off you for fifty years, the government take money off you all that time.” (Social Work service user, Male, Glasgow)

“Some of the GPs are very reluctant to help you. I treat it as a disease and they don’t. A lot of doctors don’t” (NHS service user, Male, Glasgow)

Caring responsibilities

Several participants with alcohol problems and those with family members and friends with problems mentioned caring responsibilities as being a major barrier to seeking help.

“I am sitting here with youth on my side and I’m loving it, every minute of it, but I’ve got two young kids and I find it hard to attend meetings on a regular basis because of them. Again if the service was all-encompassing, a crèche, or something to cater for children” (Social Work service user, Male, Glasgow)

“It was difficult to arrange a regular time to be able to come to regular meetings because I’m a full-time carer for my mother – I couldn’t easily leave her for an hour or so every week” (Voluntary sector service user, Female, Borders)

As a result of this, many called for the provision of crèche facilities, although there was some concern about children discussing ‘*their daddy’s problem*’ with other kids. Additionally, some parents were concerned that their children may be exposed to more information and experiences than necessary.

SERVICE CONTACT CATALYSTS

It is clear that despite the perceived barriers to service access outlined above, some people do make contact with alcohol services. This section examines what events or situations act as the catalyst for taking the step to seek outside help. Contacting services was commonly viewed as ‘the last resort’, with contact only been made when the situation was no longer sustainable. Service users, family and friends and ‘drinkers’ all spoke of seeking help from their existing social networks before seeking help from external providers.

As a person needs to admit they have a problem before they contact a service providing help or advice for people with alcohol-related problems, what is it that makes them admit they have a problem? The most common perception and experience among ‘drinkers’ was that ‘*something bad has probably got to happen to them before they wake up and realise*’ (Male, Drinker, Glasgow). This perception was borne out by those who knew someone close to them with an alcohol-related problem:

*“He lost his job, his girlfriend and his bairn is away with his girlfriend.”
(Drinker, Female, Fife)*

Service users also identified a serious problem or crisis - often health related - as the major catalyst to contact. In several cases the crisis had been severe enough to remove any element of choice. Contacting service as a pre-emptive measure was rare.

“I was warned that my next drink might be my last ... I was waking up in the night and needing a drink” (Voluntary sector service user, Male, Borders)

“If I hadn’t had the stroke, I wouldn’t be off the drink” (Social Work service user, Male, Glasgow)

“I was told that I was going to either die of the cancer or die an alcoholic so when I looked at myself I said well on the death certificate, I don’t want it to say I died an alcoholic.” (NHS service user, Male, Glasgow)

Similarly, the realisation that potentially irrevocable damage had been done to a relationship, employment or housing situation was sometimes the catalyst for seeking help in a number of situations.

“For me, I became suicidal, the other thing was that I lost my family, my mother and that will not speak to me at all. They won’t even let me near the door. I lost my wife, my house and my car – everything. I lost it all through drink.” (NHS service user, Male, Glasgow)

In a small number of cases, employers had encouraged people with alcohol problems to seek assistance. Other service users felt that employers could have a useful role to play in encouraging people to ask for help before the problem had got out of control. This was seen

as having the potential dual role of preventing loss of employment and helping to reduce the stigma associated with having a problem with alcohol.

Among those who had made an active choice to contact services (rather than having that choice forced upon them by a crisis of some kind), there was agreement that *'you just come to a point where you know [you need help]'*. There was no one particular event that had prompted them to contact a service - it was more a realisation that the situation was no longer under control.

"I think you just know within yourself. You just come to a point. There are so many things wrong with you. You are doing the same things every day. Life is just passing you by. You just decide" (Social Work service user, Male, Glasgow)

"We call it the personal gutter. Different people have different personal gutters which tends to be emotional and psychological as well as physical and financial" (Voluntary sector service user, Female, Glasgow)

The involvement of children was often seen as a catalyst to contacting a service, particularly if custody was being challenged.

"If there are bairns involved and there are custody battles and such like, they know that will go against them so they have to do something about it." (Drinker, Female, Fife)

The common view among service users, their family and friends and 'drinkers' is that alcohol services are being treated largely as a last resort. This is linked to the cultural attitude of drinking only becoming problematic when someone's behaviour becomes 'extreme', for example, being hospitalised, losing his or her family or job, and drinking continuously.

"It's amazing to think it is still swept under the carpet." (Drinker, Female, Edinburgh)

The challenge, therefore, is identifying how to encourage people to make contact earlier in the process. Again, this is partly associated with perceptions of who alcohol services are aimed at, and the language and terminology employed to describe alcohol services.

SUMMARY

All participant types felt that there was a clear need for services aimed at both individuals with alcohol problems and their families and friends. However, there were clearly identified barriers - psychological and practical - to people making contact with such services. All participant types – including those with alcohol-related problems – felt the first and strongest barrier to contact is the unwillingness of the alcohol misuser (and to a lesser extent those around the misuser) to admit that there is a problem that needs addressing. Following on from this, there was a concern that emotions, such as embarrassment and shame, would discourage contact being made with a service.

For family and friends of those with alcohol-related problems, a further barrier appeared to be the deep-rooted loyalty towards the misuser – while it was realised that seeking help would benefit their loved one, it was also seen as betraying them. Others were reluctant to seek help from some organisations because of preconceived perceptions of the type of person or problem that they deal with. Both family and friends and the alcohol misuser themselves identified practical barriers to contacting services, such as financial demands, opening hours, existing care responsibilities.

Alcohol services tend to be seen as providing help and support to the most ‘desperate’ people. In terms of taking the step to contact a service, in most cases it was seen to be the ‘last resort’ and to be prompted by a crisis of some kind, relating to, for example, ill-health, custody battles or the collapse of personal relationships. However, the research clearly highlighted the need to encourage people to make contact with services at a much earlier stage. This links back to discussions of cultural attitudes and terminology – services tend to be seen as being for ‘alcoholics’ (that is, as defined by research participants, people whose lives are falling apart) not for people with less severe problems, which could be addressed more easily. The main challenge, therefore, is to encourage people to recognise a *potential* problem at an early stage and seek to address this as soon as possible.

CHAPTER NINE: PERCEPTIONS OF WHAT WORKS

This Chapter focuses primarily on the views of those people who have had some contact with a service providing help, advice or support for people affected by alcohol. This covers ‘drinkers’, families and friends and alcohol misusers. Those who have not had any contact with services offered some interesting but limited views on this subject - these tended to be speculative rather than based on any kind of informed experience. The views of those with direct experience of services should, therefore be given more weight when considering ‘what works’. Nevertheless, the views of others are important as they may inform the discussion of how to encourage people to approach services.

This chapter contributes to the following consultation questions: ‘what specific objectives and activities designed to achieve these, would you like to see in the Plan for Action?’ and ‘what gaps do you identify in action that is currently being taken?’

VIEW OF ‘DRINKERS’

While ‘drinkers’ made general suggestions about what types of service might be appropriate and useful - for example, individual counselling, group sessions, ‘drop-in’ facilities and detoxification medication - they had limited knowledge about the type of help provided for people with alcohol-related problems and the type of services needed.

There was some discussion about the mode of delivery – for example, while most participants spoke of services as being based in some sort of premises, there was a suggestion that home visits might be useful for people concerned about anonymity. Continuity of contact person was also identified as an important factor in developing a trusting relationship between the professional and the client.

“Maybe some folk prefer a house visit and at the same time that would allow you to analyse their living conditions, their habits, things like that, which I think would be a good idea rather than someone being taken from their own environment and brought into a room and speaking to someone they don’t know. I think the person they speak to should be consistent as well. That builds a relationship and trust.” (Drinker, Male, Glasgow)

For female drinkers, the most important need identified was having ‘someone to speak to’. Although there was recognition that group sessions may be of value, in the first instance one-to-one contact appeared to be the preferred option. It was felt that initially many people would lack the confidence to discuss their problems in a group setting

“Somebody that would help you if you broke down, not someone who would sit totally clinical. You would want someone who could give you a cuddle and try and find out what the problems were behind your drinking.” (Drinker, Female, Fife)

This perception was also demonstrated in the discussions with some service users.

As in the discussions with current and previous alcohol service users, it was suggested that alcohol problems could only be dealt with effectively if the counsellor, for example, had direct experience of similar problems themselves.

*“*There is no point in a sober person telling a drunk to get sober.*

***You need an alcoholic that has come out of it.”*

(Drinkers, Female, Fife)

One issue raised during the course of the groups was whether or not those with alcohol problems needed a service that encouraged them to stop drinking or one that taught them how to control their drinking. In general, participants felt that there was a need for both strategies and in many ways this was defined by the ‘seriousness’ of the person’s alcohol problem. So, for those who were considered to drink too much a controlled drinking approach was favoured, but for those who participants labelled as ‘alcoholic’ many felt the abstinence approach was the only one likely to succeed.

“I think with alcoholics you have to stop altogether because I think with them it is a case if they do drink again they wouldn’t be able to stop.” (Drinker, Male, Glasgow)

However, as will become clear later in the Chapter, those with direct experience of alcohol-related problems were less likely to discuss the type of service needed in relation to specific drinking behaviours – instead they focused on individual needs.

VIEW OF FAMILY AND FRIENDS

Those with a family member or friend with an alcohol problem were able to offer their views on what they felt worked for both the alcohol misuser and themselves.

In terms of the alcohol misuser, it was strongly felt that a range of different types of services should be available - for example, both group-based sessions and one-to-one counselling. While it was recognised that each individual may benefit from a different approach, it was generally felt that the one-to-one counselling was an essential part of any recovery programme. The prospect of group sessions was daunting. However, in terms of the needs of the friends and family, many of those who had participated in such sessions found them useful. Hearing about other people in similar situations and discussing different coping strategies was deemed beneficial for those living with a problem drinker. Family and friends stressed the benefits of attending a service at the same time as the service user.

“Visibly seeing the support I was getting, supported her” (Voluntary sector previous service user, Male, Borders)

The other common perception was that recovery strategies needed to be long-term and, even in cases of intensive residential treatment, it was essential that the misuser could contact a service at any time for as long as they felt they needed to. This perception arose out of the fact that many people had experienced someone close to them having been successful in the early stages of treatment and then withdrawing (for a variety of reasons, such as the belief that they could ‘beat it’ on their own or because they did not like the service they were

receiving). More often than not these cases ended in the person returning to problem drinking. In particular, people spoke of hospital-based short-term ‘drying-out’ and the apparent lack of understanding of the problem and failure to provide any after-care.

“The first time he was in the clinic he was kept in until he was sort of dried out and then he was out again. Oh, he was in and out many times, but he was just drying out and that was it. Eventually...we got an appointment with a psychiatrist for more meaningful treatment rather than dry him out [and] put him out.” (Family member using voluntary service for family and friends, Male, Borders)

Continuity of staff and consistency in quality of service were also considered crucial to the success of a service. While it is, of course, impossible to guarantee staff continuity there are measures that can be taken to maximise this (such as good conditions of employment, long-term contracts and so on) and measures can be put in place to ensure that contact is maintained with the client even when, for example, their key worker leaves.

It was felt important that the person charged with helping the alcohol misuser fully understood the problem as a whole. This was often only felt to be possible if this person was what participants termed a ‘recovering alcoholic’.

“They should have a reformed alcoholic. Somebody who they can contact and who understands.” (Family member using voluntary service for family and friends, Female, Borders)

Some felt that an important element of any service was to take a broad view of the issue and develop outside interests – family members and friends spoke of the need to make the misuser recognise there is more to life than alcohol. Activities and hobbies were seen to act as a diversion from drinking.

For the sake of the friend or relative it was also felt important that services should not be primarily home-based. The fact that the misuser had to leave the home was often seen as something to look forward to – a break from caring for them. Although it was recognised that there may be limited opportunity to do so, there was support for services taking the misusers away for a number of days treatment, combined with activities – again benefiting the carer but also helping the alcohol misuser both address the problem and develop other interests.

ESSENTIAL ELEMENTS OF ANY SERVICE

This section of the Chapter focuses on the views of current and previous service users, as these groups have direct experience to enable them to contribute towards the debate about what works.

Current service users were generally positive about the services they were currently using and believed that the provision of alcohol services was crucial to people overcoming alcohol-related problems.

“Being here has taught me that I’m not a bad person. This place is brilliant.” (Voluntary sector service user, Female, Edinburgh)

“It saved my life for a start” (NHS previous service user, Male, Edinburgh)

Through their alcohol service ‘careers’ many respondents had experimented with other alcohol services about which they were very critical. However, there were differences in opinion among alcohol service users, with some being highly critical of particular services that others found to be effective and useful. Perhaps the most important point to make in relation to what makes a good service is that different people prefer different types of service and different approaches and this does not necessarily reflect their drinking behaviour or type of problem. In addition, during the course of service use and into recovery, the same people may require different service types. Essentially, alcohol services need to be tailored to the individual needs of the alcohol misuser throughout the whole of the period of service contact.

“Like anything else, what works for one person is not necessarily for the next person.” (Voluntary sector previous service user, Male, Borders)

While services need to be tailored to individual needs, it is worth providing an overview of factors that were deemed necessary for an effective service. Service users felt the crucial service requirements were as follows:

- Confidentiality

“If you want to talk to a counsellor you can talk one to one in a private room and let your hair down” (Social Work service user, Male, Glasgow)

- Accessibility (geographically, temporally and financially)

“In a perfect world, I think you should be able to lift the ‘phone at 11 o’clock at night or 2 o’clock in the morning, at any time, rather than unscrew the neck of the bottle.” (Voluntary sector previous service user, Male, Borders)

“It must be free. Cost would be a deterrent to using the service” (Voluntary sector service user, Female, Borders)

- On-going rather than time-limited

“I definitely needed to know that it wasn’t the end of the line, that you weren’t just coming out of hospital and then dumped, you know. It seems less important now but looking back I remember I needed to know there was some sort of structure out there and I wasn’t just dumped in the main street of [name of town]”. (Voluntary sector previous service user, Male, Borders)

- Holistic – encompassing the context and potential causes of the alcohol problem

“We are all sitting here talking about drink but we have all got a million and one problems wrapped up within that drink. Whether it be domestic, debt, house or whatever. You really need a complete service.” (Social Work service user, Male, Glasgow)

- Understanding – those involved in providing the services must demonstrate that they understand the feelings and behaviour of those using the service.

“Unless they’re an alcoholic themselves, they can’t understand.” (Social Work service user, Male, Glasgow)

“No ill feelings [but] I felt that she had absolutely no idea of what I was going through. She did say that she was not an alcoholic. She did tell me her father was an alcoholic so therefore she knew all about it. I can know all about cancer but I still don’t know all about it.” (Private sector previous service user, Female, Glasgow)

- Supportive with a no-blame culture.

“This service is good as it tells you not to be ashamed” (Voluntary sector service user, Female, Borders)

- Take a positive approach

“Its about knowing there is life after drink” (Social Work service user, Male, Glasgow)

- Be tailored to the needs of the individual

“I’m not really an alkie, but I need a wee chat.” (Voluntary sector previous service user, Male, Borders)

“Everybody does it in their own way. This place doesn’t work for everybody.” (Social Work service user, Male, Glasgow)

TYPES OF SERVICE

As discussed above, it is not possible to specify particular service types for different drinker typologies as individual service preferences were not necessarily linked to different drinking patterns – people with very similar drinking patterns and histories may want very different service approaches – and vice versa. This section discusses the range of services perceived to be useful and effective by a range of different people and clearly identifies service characteristics important for all.

Again, this section focuses on the views of service users, both previous and current. Although there were general levels of agreement over these elements of service provision, a major divide in attitudes emerges in relation to whether the service approach should be ‘no alcohol’ or ‘controlled drinking’. There was a clear division among current service users in relation to whether the best approach was ‘no drinking’ or ‘controlled drinking’.

“You can’t control your drinking. I was a social drinker for a while and bit by bit it grows on you. It eats in to you. Any excuse to go back to the bottle.” (Social Work service user, Male, Glasgow)

“You can’t control drinking. It controls you in the end. You have got to stop.” (Voluntary sector service user, Male, Borders)

On the other hand, for some people, the thought of giving up drinking entirely was seen as too difficult.

“Never drinking puts an incredible strain on people – it is not a healthy approach.” (Voluntary sector service user, Female, Borders)

The divide largely appears to be dependent on people’s beliefs about what the causes of alcohol misuse are. For example, those who believe that alcoholism is a disease that certain people are pre-disposed towards tend to favour the ‘no drinking’ model and suggest that ‘controlled drinking’ is both an impossible and dangerous approach. On the other hand, many of those who believe that alcohol misuse is caused by, for example stress, major life crises, worry or boredom, tend to favour the ‘controlled drinking model’. Essentially, the difference appears to be based on whether the alcohol problem is viewed as a permanent state of being or a temporary problem. Differences also occur in relation to the stage or level of alcohol misuse – some people are using services to prevent a problem deteriorating while others are using a service to overcome the problem.

Additionally, the research included one particular group of alcohol service users who adhere to a specific set of rules and principles relating to the disease-based perception of alcohol misuse and take a group based approach to the control of alcoholism. Because of the belief in alcoholism as a disease, this group’s views of what constitutes a good service are quite distinct from other alcohol service users (and many health service professionals). Although this is useful, as it again demonstrates that different approaches suit particular people, the following section focuses on the views of other alcohol service users who tend to have a more homogenous view of what constitutes a good service.

Broadly speaking, the range of services people wished to see included:

- Detoxification programmes/ residential detoxification
- Medication
- Day centres or drop-in centres
- Group meetings or group counselling
- Individual meetings or counselling
- Follow-up support and advice services (practical and psychological)
- Support and advice for family and friends
- Choice about ‘drink’ and ‘no-drink’ approaches

Obviously, it might be the case that some people need only one or two parts of the service whilst others will require a greater range. The important point is that individuals need to be made aware of (and experiment with) the range of options available and to use the ones which work for them personally. Most of the current alcohol service users have tried a range of different services, rejected them and tried others that have been more suitable. For example, some found the regimes of particular services too regimented or intimidating while others felt that the same service had been exactly what they required. It is, therefore crucial that people who make contact with a doctor or alcohol service realise that if the service they try first does not work for them, there are other options available.

Perceptions of all of the main types of services discussed are presented below.

Detoxification programmes and residential detoxification centres

These were seen as a crucial first-step in beginning to tackle the alcohol problem for those whose drinking was so out of control that they were unable to carry on in their usual lives.

“A place like this where you are getting sufficient time to come off. It’s a stop-gap and this place puts the brakes on. Once the brakes are on you leave here and you’ve got to keep the brakes on.” (NHS service user, Male, Edinburgh)

“It’s because one is just so totally immersed. In the four weeks in this place it is so intense. You go through your four steps. You go through your life story in four weeks.” (Private sector service user, Female, Glasgow)

Residential services were seen as preferable to community or home-based detoxification programmes as there was not enough professional support provided by the home-based models.

“I told my GP I needed help to get off it. He referred me to the clinic. Someone comes in to see you for a week, you get help for a week and then that’s it finished. That’s the doctor done his wee bit” (Social Work service user, Male, Glasgow)

“ I just think home detox seems to me to be the most pointless exercise. If you try and catch somebody out or put the frighteners on or something, without putting anything positive there, you can’t impose it.” (Private sector previous service user, Female, Glasgow)

Some current and previous service users spoke of how they learnt to beat the system – they knew what time the nurse would visit to breathalyse them so would leave enough time between the last drink and the visit to ensure they had a ‘clean’ test. As soon as the nurse had left, some would have a drink.

Although residential care is seen as important for those who need it, there were some criticisms of the quality of the residential care and some suggestions about how it could be improved.

“I didn’t think the [hospital] was very good, I didn’t think there was enough to do. I was only there for 10 days and basically I spent them sat in a tiny little smoking room because it was the only room where you were allowed to smoke. ... I thought it was awful and there should have been more things to do. More creative therapy, more individual therapy, intensive work with your key worker.” (Voluntary sector service user, Female, Edinburgh)

“Some days are pretty boring, on days when I have 2 or 3 meetings it breaks the day up. Although meetings aren’t always pleasant, it’s something constructive which is good.” (NHS service user, Male, Edinburgh)

Additionally, the detoxification stage of recovery (whether residential or not) is seen very much as the first step which needs to be supplemented by other services and followed up afterwards. In particular, the point of leaving residential care is an especially vulnerable time.

“When I left here, I felt apprehensive, it’s like a cocoon in here and the day you go out is pretty nerve racking. You go back to your house and often, when you have left it to come up here it is in a bit of a mess.” (NHS service user, Male, Edinburgh)

Medication

There were mixed feelings among service users about the role of medication in the treatment of alcohol problems. For some it was an essential ingredient which had played (or still plays) a crucial role in helping them stop drinking.

“Another thing that makes you want to stop is anti-dis¹¹. You’re dead if you take a drink with them. That’s something to lean on, cause you cannae, definitely take drink with that, that’s for sure, you know.” (NHS previous service user, Male, Edinburgh)

*“*Anti-dis, that makes you relaxed.*

*“**I’m on valium so I don’t get the shakes because I take it in the morning”*

(NHS service users, Male, Glasgow)

Others felt that it was not a good idea to substitute one addiction for another.

*“*They give you pills to take in the place of drink. What are you going to do, stay off the drink and take pills all the time.*

***You end up addicted to the pills”*

(Social Work service users, Male, Glasgow)

Even some of the service users who condoned the use of medication to treat alcohol problems felt that there were dangers associated with the use of some drugs which had not been made clear to them.

*“*I don’t think they explain the dangers of the anti-dis though. I was on it for about 5 months and I took a drink and damn near killed myself.*

***I think it is a danger and there should be another alternative.*

****It is very dangerous stuff.*

**I wasn’t explained enough about it.” (NHS service users, Male, Glasgow)*

¹¹ Antabuse (Disulfiram)

Follow-up support and advice

Continuing follow-up support and advice are perceived as crucial elements of alcohol service provision. This again demonstrates the need for a range of tailored services that can be individualised for each service user.

“The service you get in here afterwards, it’s called the follow-up. It is somewhere for you to go and occupy your mind. You work in the gardens planting flowers and vegetables and they have computer courses.” (NHS service user, Male, Glasgow)

“What I feel they do in here is the after-care. You’re not just dried out and flung out. You are given this programme of recovery to follow. It’s a programme for life, sorry, a programme for living. It’s living.” (Private sector service user, Male, Glasgow)

Another element of continuing support seen as helpful were some kind of help or support lines - something available at any time of the day or night, particularly during the vulnerable periods when people felt most in danger of having a drink.

“I find that the meetings are very important, and a criticism is – and I have told them – that the most vulnerable days for an alcoholic are a Saturday and Sunday and they cancelled those meeting days.” (NHS service user, Male Edinburgh)

Groups and counselling

Again, there were mixed feelings among service users about the role and usefulness of group sessions. As mentioned above, current service users who use the large group-based voluntary services were very enthusiastic about the merits of this kind of approach whereas others preferred smaller groups or one-to-one counselling.

*“*Having to go up there and spout out your life story to strangers, my life is nothing to do with those people”*

***It is like a classroom ... People who are there for the first time are nervous. This type of thing [small group] is much better.”*

(Social work service users, Male, Glasgow)

*“*That is the thing with a counsellor, you are telling them your problems, not listening to other peoples’ problems*

***The one-to-one is much better.*

**One-to-one, I feel like I can talk and speak to her and she will listen and give advice.”*

(NHS service users, Male, Glasgow)

The dynamics and make-up of groups were seen as being very important. There was a belief that people with different addiction problems should not be treated together in one group.

“People with drug problems have been in this sort of twilight zone for so long they have got no social skills. They are a pure embarrassment. We don’t mix, they are aliens to us.” (Social Work service users, Male, Glasgow)

Similarly, in relation to the cohesiveness of groups, some of the female service users felt that it was important to have single sex groups.

“I think it is better [being an all female group] the [name of other service] was dominated by men. I think it is more comfortable with the women.” (Voluntary sector service user, Female, Edinburgh)

Other service users were very positive about their group-based services and were reliant on them to continue controlling their alcohol problem.

“Talk in a group like this keeps us all off drink. You don’t even give much thought to it. In a group of like this of this kind. No problem” (Social Work service user, Male, Glasgow)

It was seen as important that the group was able to get to know one another and had some kind of continuity. Groups where people were continually joining and leaving were not seen as being as useful.

“I think a group of that nature who are willing to take the time and tell you that it might take them years but we are going to stick at it together, is really the best kind of support you can have.” (Voluntary sector service user, Female, Edinburgh)

However, even among those service users who held positive views of group-based services, there was a perception that one-to-one sessions were necessary in the early stages. Some people felt that it was difficult enough to admit to themselves that they had a problem without adding the challenge of admitting it to a group of other people.

“I was frightened of confronting myself within the context of a group.” (Voluntary sector service user, Female, Edinburgh)

Practical, positive approach

An emphasis on how life can be without alcohol and the promotion of alternative ways of spending time were considered to be very important by current and previous service users, particularly those who were following a ‘no drinking’ model of treatment.

“The philosophy in here is once you’ve stopped drinking, which was a lifetime pastime, what are you going to do with your time? They suggest and take you places where you can maybe find things to do to fill your time.” (NHS service user, Male, Glasgow)

“You don’t need to sit in the house. They try to teach you to get back out again. We don’t sit in the house with a bottle of whisky. Go to the swimming. Go for a walk. Don’t just sit there and say ‘I’ve nothing to do’.” (Social Work service user, Male, Glasgow)

GAPS IN SERVICE PROVISION

From the research it is difficult to provide an in-depth discussion of perceived gaps in service provision. In general, the main ‘gap’ appears to be in peoples’ awareness and knowledge of services available. In that sense, the ‘gaps’ identified did not relate to the need for new or different types of services but the provision and promotion of more of the kind of services that are already in existence.

“There aren’t enough groups like this. It is two things, there aren’t enough groups and I think the information about them is not available” (Female, service user, voluntary, Edinburgh)

*“*There should be more places like this.*

***There are not enough of these places.*

**They need to advertise them”*

(NHS service users, Male, Glasgow)

There was also a perception that services for drug users were more widely advertised and available, therefore giving the impression that there is more support for drug misusers than alcohol misusers. Alcohol services should be as visible as drug services.

“If you’re a drug addict and your family is disrupted, they’ll do somersaults to get you back together. See if you’ve got a drink problem they’ll maybe help your wife, maybe, it all depends on the circumstances, but you are left to fend for yourself. It’s your fault it happened whereas if it is a drug problem they will do anything to get you all back together” (Social Work service user, Male, Glasgow)

As shown above, respondents identified a large number of factors essential to any service and, while many services provide these elements, not all do and if this is the case, these can be translated into gaps in service provision.

A specific issue raised by some service users who believe that alcoholism should be treated as a disease, was that health professionals do not necessarily agree with this view and, as a result, did not always offer appropriate treatment.

“I think our biggest problem is the health professionals. They cannot or will not accept that alcoholism is a disease. Whilst they keep playing this game of degrees of drinking problems our people will die and inappropriate referrals will take place.” (Voluntary sector service user, Male, Glasgow)

“Willpower will not work on a disease, it does not work on cancer or diabetes so why should we expect it to work on alcoholism.” (Private sector previous service user, Male, Glasgow)

Again, this indicates that all of those who may be approached by someone with alcohol-related problems looking for help should be aware of all the different types of services available and be capable of assessing which service would be best suited to a particular individual. Nevertheless, the main point to be made in relation to gaps in service provision is people perceive there to be a huge gap, principally because limited publicity results in a perception that there are no services to help people with alcohol related problems. While there may be room for increased service provision, a number of such services clearly exist and people need to be made aware of this.

SUMMARY

Participants saw some characteristics of services as essential requirements of any kind of alcohol-related service provision. Confidentiality was considered to be a crucial element of any service provision, and this was generally framed in terms of the fear of stigma surrounding alcohol misuse. Several issues relating to the accessibility of services arose in the research. Participants felt that services should be free, easy to get to, and available at the times when they were most needed (which is often during evenings and weekends). They also felt services should also provide childcare facilities.

There was a widespread belief that a holistic, positive and practical approach was required. Alcohol problems need to be examined within the broader context of people’s lives and services should consider the potential causes of the alcohol problem. Moreover, practical help should be provided to enable service users to fill the gap in their lives left by not drinking alcohol (or drinking less alcohol). Participants also felt that service provision should be on-going rather than time-limited and that follow-up services were crucial to prevent the alcohol problem recurring.

There was little consensus in relation to which types of alcohol services actually work, however, there was widespread consensus that there is a need for a range of services – with different methods for different people and at different stages in their treatment. Perhaps the most important point to note in relation to perceptions of what works is that alcohol services need to be tailored to the individual needs of the clients and be revised during the process of service contact. Opinions were divided as to whether a ‘no drinking’ or a ‘controlled drinking’ model was most effective. Although participants disagreed on the relative merits of different service approaches, it was generally felt that the range of services should comprise detoxification programmes, medication, day or drop-in centres, group counselling, individual counselling, follow-up support and advice (practical and psychological) and support and advice for family and friends.

Overall, the limited knowledge people have about what services are available suggests that there needs to be increased publicity about the existence of alcohol services and what they offer.

CHAPTER TEN: THE WAY FORWARD – VIEWS ON TACKLING ALCOHOL MISUSE IN SCOTLAND

The research also explored perceptions about what should be done to tackle alcohol misuse in Scotland. Although the qualitative research is not statistically representative of the adult population, there is clearly a widespread view that Scotland does indeed have a problem with alcohol. It was universally felt that Scottish culture was heavily based on alcohol and that binge-drinking and drunkenness were common behaviours that had, to some extent, been normalised. Participants felt that there was a problem with alcohol, and although they were reluctant to identify themselves as part of it, there was support for measures being taken in an attempt to tackle the issue.

In addition to the findings generated from the survey of the general public, the interviews and groups discussions also raised a number of possible ways forward, namely - health promotion campaigns and materials; education of children and young people; law enforcement; and, finally, the need for cultural change. Each of these is discussed below.

Again this chapter contributes to the following consultation questions: ‘what specific objectives and activities designed to achieve these, would you like to see in the Plan for Action?’ and ‘what gaps do you identify in action that is currently being taken?’

HEALTH PROMOTION

In general, participants felt availability of information about alcohol and its effects, and about alcohol-related services, were inadequate. While people could easily recall the detail of advertisements to *promote* alcohol, few people could remember campaigns or warnings about the dangers of alcohol.

“They don’t advertise it as being bad for you, they advertise it for you to buy it.” (Partner of non-service user, female, Glasgow)

When there was some evidence of recall of alcohol-related health promotion advertisements, participants commented that they tended to focus on young people or on alcohol in relation to a specific type of behaviour or issue, such as drink-driving or domestic violence.

“Do you remember the advert with the woman sitting in the pub and she turns round and her face is all battered? But that is to do with abuse but still through drink because her man batters her through drink sort of thing”. (Drinker, Female, Fife)

“They tell you through advertising that so many people are killed every whatever minutes by drunk drivers, why don’t they say ‘every seven minutes somebody dies through drinking all their life’?” (Social Work service user, Male, Glasgow)

In general, health promotion campaigns were mainly associated with illegal drugs or smoking. While people recognised the dangers of alcohol, it was also felt that these were not highlighted in the same way as dangers associated with illegal drug misuse and smoking.

“There are hundreds [of advertisements] on smoking and abuse but there are not any on alcohol”. (Drinkers, Females, Fife)

Many people spoke of the health warnings that appear on cigarette packets and felt there was no reason why similar warnings could not appear on alcohol. Having said that, some participants noted that there was no evidence to suggest that by doing so people would change their drinking behaviour.

“One thing that does annoy me is that on cigarettes there is a warning on them that they can damage your health. On spirits or things like that there is no warning when obviously it can if you drink too much.” (Voluntary sector service user, Female, Edinburgh)

Although there was some scepticism about the effectiveness of health promotion materials in relation to alcohol – *‘I think [campaigns] have a 30 second lifespan, truthfully’ (Male, drinkers, Glasgow)* - there was some support for providing such information. Respondents did not wish to see ‘anti-drinking’ message, as it was deemed unrealistic because of the central, and often positive, role alcohol plays in Scottish society. Nevertheless, a harm reduction approach was considered desirable – that is, teaching people how to drink sensibly and increasing awareness of the health impact of excessive alcohol consumption. There was a general feeling that many people did not know about the severe impact alcohol can have on lives, both in terms of health and more generally. Even some of those people in contact with alcohol-related services were not fully aware of the impact of alcohol and it was felt that they would benefit as much as anybody else from having access to more information.

“My husband was sitting in the doctor’s the other day and there was a big poster up telling you what alcohol did to the body and he sat and read that in shock.” (Partner Social Work service user, Female, Glasgow)

In terms of the tone of any advertising or information campaign, there were mixed views. Some felt that it should take an informative approach but there was also some support for the use of ‘shock tactics’. Because of the apparent knowledge gap about the effects of alcohol, people with alcohol problems in particular felt that it would be most effective to focus on the ‘extreme’ impact it can have.

“The one thing that I find very crucial was when I came up here and saw people that had just been admitted. You cannot put a spoon of soup to your mouth without it going all over the place, you can hardly even pour it into a mug and pick it up. I think a film, blocking out the identity, of someone who’s in a state like that. That would be beneficial. They should also say how quickly it can affect you” (NHS service user, Male, Edinburgh)

The most commonly mentioned methods for communicating messages about sensible drinking and the harmful affects of alcohol misuse were television and radio advertising, posters, information booklets and visits to schools.

While participants were very supportive of such communications techniques, there was some doubt about the effectiveness of such techniques. Many felt that because alcohol use/misuse is a legal behaviour deeply ingrained in Scottish culture, there is little that can be done to combat it. Although suggestions were made as to the type and tone of adverts and information aimed at reducing alcohol misuse, current service users in particular were not optimistic about the potential success of such approaches.

“People will do what they want to do, as long as it is legal.” (Drinker, Male, Glasgow)

*“*I don’t think there is anything they can do about alcohol. They’ve got a bit more control with drugs because they are seizing them as they come in [to the country] but drink is accepted as a social thing.*

***They’ll never stop people drinking.”*

(Drinkers, Females, Fife)

EDUCATING CHILDREN AND YOUNG PEOPLE

This research did not focus specifically on alcohol and young people and children, as this has been addressed in a separate study. Nevertheless, the discussions highlighted strong support for information about the dangers of alcohol and sensible drinking being communicated to young people at an early age, for example, at primary school. Although participants felt that children and young people will always experiment with alcohol, most thought it was best to educate them and to focus on sensible drinking and minimising harm associated with drinking.

“You can’t stop a child experimenting... It would be much better to try and educate the kids to drink properly rather than tell them the evils of drink because they will go away and drink a bottle of vodka and probably kill themselves.” (Private sector service user, Male, Glasgow)

Again, the importance of education is linked to the role alcohol plays in society. Young people see alcohol use as a natural part of adult life - something that everybody around them is doing – and therefore they may be unaware of the potential dangers. Those with alcohol problems felt quite strongly that young people should be taught that alcohol could be as destructive as illegal drugs.

LAW ENFORCEMENT

As in the findings from the quantitative survey, the groups and interviews found no consensus of opinion regarding changes to law enforcement. Some participants felt very strongly that a relaxation of the current licensing laws would lead to a reduction in the problems of binge drinking and problem drinking more generally. Strict closing times were seen by others to encourage ‘greedy drinking’.

“If it is coming towards the end of the night I always try to get them all down.”(Drinkers, Males, Glasgow)

“It is the same if you lock all the chocolate away, you always want it, whereas if it is there all the time you are not that fussed are you?”(Family and friend of non-service user, Female, Borders)

Current licensing laws were also seen by some to encourage young people to drink – the rationale being the more it is prohibited, the more likely they will abuse it. It was thought a more ‘continentalised’ approach would encourage a more sensible approach to alcohol use.

“At home [another European country] you can be 13 years old – a boy – and go to a wine shop and buy whatever you like. You can buy booze at two in the morning... We are not so repressed when it comes to alcohol. Things are much more open and I think that’s a good thing. Pubs and clubs are open until six in the morning or whenever the last customer leaves. We are more relaxed. [In Scotland] we have to drink quickly because half eleven or twelve o’clock the pub is going to be closed.”(Drinker, Male, Glasgow)

Similarly, for some the idea of *reducing* the opening hours of licensed premises was likely to lead to even more binge-type drinking.

“[Shorter hours] would be worse because people are dying to get as much drunk before 11 in a local pub.” (Drinker, Female, Fife)

However, others felt that any extension to licensing laws would do little to tackle the problem of alcohol misuse. Alcohol was seen as something that is already very accessible, through pubs, clubs, cafes, restaurants, supermarkets and so on and for some participants, relaxing the licensing laws would simply exacerbate the problem. While some thought longer opening hours would reduce the phenomenon of bulk buying at last orders, others felt it would simply postpone it until whatever time the premises closed.

*“*I used to drink in a pub that closed at 10pm and at 9.45pm you couldn’t get near the bar because everybody was buying pints and pints and nips and nips. They’ve now extended the drinking hours.”*

***They are no longer cramming it all in.*

****They are still doing it at quarter to two in the morning!”*

(Drinkers, Male, Borders)

NEED FOR CULTURAL CHANGE

“The whole attitude towards drinking has to change, [to one] which sees excessive drinking as bad, [but where] using alcohol as part of daily life is normal and treated as normal. And then you don’t go out to get plastered.” (Voluntary sector previous service user, Male, Borders)

It was widely recognised that in order to tackle alcohol misuse in Scotland, there must be a fundamental shift in cultural attitudes towards alcohol. This is obviously a difficult task and one that is inextricably linked to other strategies, such as education, licensing laws and so on. A shift in attitude will not just simply occur – it needs to be facilitated.

As we have seen, the pub plays a central role in social lives of many Scottish people and the research also highlighted a perceived connection between alcohol consumption and boredom. As suggested by some of the participants, the centrality of alcohol to people's lives might be reduced if there were alternative meeting places and more activities available. For many, going to the pub was convenient and cheap compared with other leisure activities (such as going to the cinema or playing sport). It was suggested that the accessibility of other forms of leisure might encourage people to spend less time in the pub.

However, there also needs to a cultural shift in *how* alcohol is consumed once at the pub. In the first instance, it should be acceptable to go to the pub without having an alcoholic drink and without feeling pressured to 'join in'. Second, people need to recognise how to drink sensibly. These desired cultural shifts can be influenced by health promotion and education strategies. But, as mentioned above, many felt that attempts to change what is seen as 'normal' drinking behaviour may be dismissed.

"It is like telling someone not to do something they enjoy. It's like telling a kid not to drink lemonade or eat sweets." (Drinkers, Male, Glasgow)

The prospect of a fundamental cultural change in attitudes towards alcohol was seen as remote. What may be more realistic is educating people about sensible drinking and increasing awareness of how to recognise signs of problem drinking and reducing the stigma attached to this. These factors, combined with increasing awareness and provision of services for alcohol-related problems, may reduce the number of people developing alcohol-related problems. The research quite clearly emphasised a need to change perceptions of alcohol-related problems. People will be reluctant to seek help while such problems continue to be stigmatised, which could lead to the experience of further problems.

While everybody has a role to play in this, some groups, such as employers, were identified as being able to play a proactive role.

"On the one hand I don't think they are doing a lot on alcoholism but then you read in the press and in the media so many thousand working days are lost through people abusing alcohol. They are losing x amounts of money through people taking time off work so why don't they do something about it? Why don't they speak to the individual who is off every Monday?" (NHS service users, Male, Glasgow)

In some cases, employers had encouraged people with alcohol problems to seek assistance (in one or two cases employers had actually arranged and paid for treatment) but, for others, the fear of how their employer would react meant help would not be sought until absolutely necessary. Some service users suggested that employers could be a useful catalyst for encouraging employees to seek help and helping to reduce the social unacceptability of having a problem with alcohol. Of the minority of participants who had a supportive employer, their support was greatly appreciated as it was recognised that most people did not receive such a reaction.

SUMMARY

Overall, participants clearly felt that alcohol misuse is a problem that needs tackling. There were, however, mixed opinions about how this should be approached and a strong feeling that this would be a very difficult, if not impossible, task. Calls were made for more information, education and advertising on both sensible drinking and the harmful effects of drinking. It was widely agreed that the main barrier to tackling alcohol misuse consists of the prevailing cultural attitudes to alcohol in Scotland and there needs to be a fundamental change here before any change in alcohol-related behaviour will take place.

CHAPTER ELEVEN: CONCLUSIONS

This final Chapter of the report brings together the data and analysis presented in previous chapters and draws some conclusions. These conclusions contribute to a number of questions asked in the written consultation paper and have been considered alongside other evidence in the development of the Plan for Action on Alcohol Misuse.

AWARENESS AND EDUCATION

There is a need to raise awareness and educate people – including young people – about the potential dangers of alcohol. In general, participants felt that health promotion campaigns currently focussed on the use of illegal drugs and smoking – there was little awareness of any information or advertising warning against the dangers of excessive alcohol consumption. While there was clearly support for the increased use of advertising and information on safe levels of drinking *and* the dangers of excessive drinking, many people felt that these would be of limited use in facilitating behavioural change. Again, this appeared to result from the fact the alcohol plays such a central role in Scottish culture. In this sense it was felt that education about alcohol was crucial, particularly at an early age, for example, primary school level.

PERCEPTIONS OF ALCOHOL MISUSE

There is a need to challenge the acceptability of drunkenness and alcohol misuse. Participants recognised the need for a cultural shift in attitudes to drinking – both to reduce the level of alcohol misuse and to encourage people to seek help at an early stage. For some people, and in particular for those living in more deprived areas, it seems that excessive alcohol consumption is part of their way of life not just at the individual but also at the community level. Having said that, it is not unique to particular sections of society and the research clearly shows that people from a range of backgrounds are at risk of developing alcohol problems. Tackling alcohol misuse will inevitably be difficult because this behaviour has, to some extent, become normalised.

There is a need to challenge the belief that alcohol only becomes a problem once it has taken over somebody's life. Although most people participating in the research agreed that Scotland has a problem with alcohol, with the exception of service users, few people translated their definitions of alcohol misuse, alcohol problem and alcoholism into their own behaviour. This is linked to the high prevalence and acceptance of excessive drinking which enables people to think there is always someone who is drinking more than they are and, therefore, they personally do not have a problem with alcohol. The research suggests that any attempt to tackle alcohol-related problems must pay considerable attention to the terminology applied. While it is no longer a common term used in health and social work fields, people do still refer to 'alcoholics' and 'alcoholism'. However, this tends to conjure up images of the most extreme kinds of drinking behaviour and again, it allows people to believe that they are not 'misusing' alcohol because they are not in that situation. Nevertheless, the term 'alcohol misuse' was neither commonly used nor understood among participants.

ALCOHOL SERVICES

Barriers

Attempts must be made to breakdown both the psychological and practical barriers to seeking help for alcohol problems. Perhaps some of the biggest obstacles to be overcome are the fear of stigmatisation, feelings of embarrassment and confidentiality and anonymity concerns. The first two of these barriers are strongly intertwined with cultural attitudes towards alcohol. As alcohol is consumed by most adults in Scotland, and by some very heavily, seeking help for an alcohol problem was often seen as a sign of weakness or lack of control in an area that most people can manage successfully. There was almost an expectation that people *should* be able to handle alcohol and that only the ‘weakest’ got into trouble with it, therefore it was seen as shameful. It was apparent from discussions that a great deal of hypocrisy surrounds this issue – many people feel it is acceptable to be ‘big drinkers’ but once help is sought, perceptions of this person become increasingly negative.

This poses a problem for policy-makers. On the one hand, there is desire to change drinking patterns and promote a cultural shift that suggests ‘getting legless’ is no longer socially acceptable and thereby increasing the likelihood of people recognising they may have a problem at an earlier stage. In this sense, there is a perceived need to stigmatise what is currently widely thought of as acceptable drinking behaviour. However, on the other hand, there is a need to reduce the stigmatisation associated with alcohol problems if people are to be encouraged to use alcohol services. We then need to ask, is it possible to achieve these both these aims simultaneously?

The perception that services are for ‘desperate people’ needs to be dispelled – services can be both preventative and curative. If alcohol problems are seen as the most extreme type of drinking behaviour, then services will be identified as an appropriate option for only a small group of people, having curative rather than preventative aims. Until society recognises that problems with alcohol begin much earlier on than the stage at which somebody is totally dependent on alcohol and their life is falling apart, it is unlikely that services will be used by anyone other than those with the most severe problems.

In terms of the practical barriers to contact, childcare and other caring responsibilities were seen to limit the opportunities of both the problem drinker and their families and friends to seek help from non-home based services. Similarly, for some there was a perception that seeking help would require financial input from those requesting support. For those who had made contact with at least one service, there was concern about waiting times – by the time the service had arranged an appointment, some people had reconsidered their decision to seek help.

Publicity for services

The existence and purpose of alcohol-related services must be publicised more effectively. While the confusion around definitions of alcohol misuse / alcohol problems is perhaps a key barrier to people accessing services, the research found that limited awareness among all participants of what kind of help is available and who provides it is also a problem. Because

of this lack of awareness, most participants felt their GP would be their first point of contact, primarily because they would not or did not know where else to go. This clearly suggests that doctors need to be equipped to deal with such consultations and be aware of services available, as they will often be the first, and in some ways, the most important contact made for both referral and support in the long term. Experiences of some of the research participants who had visited doctors about alcohol problems suggest that there is room for improvement.

The only service to help and support people with alcohol problems universally known was Alcoholics Anonymous, however, participants had little, if any, insight into the kind of service this organisation provided. Once a person has made contact with a service of some kind – whether it be statutory, voluntary or private – it seems that awareness of other services rises. Information needs appear to be met, albeit belatedly, once a person is ‘inside’ the system. Significantly, the research found that publicity about services often occurs by ‘word-of-mouth’ from other service users rather than through any ‘official’ information channels.

Services required

There was clear consensus that provision of help for alcohol misusers and their families should be increased and that there is a need for a wide range of flexible services to deal with different types of problems and different types of people. In many cases, participants had tried a range of services and approaches before finding one that suited their particular problem or personality. Given the perceived barriers to contacting services, it is particularly important that once people do make contact with a service, they are made aware that there are a range of different service approaches and if the first one they try does not suit them, there are other options. This would help ensure that once people had made the initial step of making contact, they do not subsequently leave the system. As doctors are often the first point of contact for someone seeking help, it is crucial that doctors are provided with the appropriate training and information about available services. Again in relation to preventing people from leaving the system, it was considered to be important that some kind of service is provided immediately. If someone is being offered a delayed appointment or placed on a waiting list, there should be some form of contact with a counsellor in the meantime.

Although it is clear that there are different perceptions of what kind of alcohol services work (particularly in relation to whether the approach should be ‘no alcohol’ or ‘controlled drinking’), there are several characteristics of services which most participants considered to be essential. The research found that a service needs to be:

- confidential
- accessible (geographically, temporally and financially)
- on-going rather than time-limited
- broadly based – encompassing the context and potential causes of the alcohol problem
- understanding – those involved in providing the services must demonstrate that they understand the feelings and behaviour of those using the service
- supportive with a no-blame culture
- positive in approach

- tailored to the needs of the individual

As outlined above, this ‘tailoring’ of services (or combinations of services) for individual needs is particularly important. It might be that some individuals’ service requirements can be met through weekly meetings with a counsellor, while other people may need a package of services that changes as they progress through their recovery or treatment.

KEY FINDINGS

The research has highlighted some important issues surrounding the role alcohol plays in society, perceptions of what constitute problem drinking and awareness of and attitudes towards services. In addition, it explored issues surrounding participants’ perceptions of ‘what works’. The key findings of the research have a number of implications for the Plan for Action on Alcohol Misuse, namely –

- there is a need to raise awareness and educate people - including young people -of the potential dangers of alcohol
- the acceptability of drunkenness and alcohol misuse should be challenged
- the belief that alcohol only becomes a problem once it has taken over somebody’s life also needs to be challenged
- perceptions that services are for ‘desperate people’ need to be dispelled – services can be both preventative and curative
- attempts must be made to breakdown both the psychological and practical barriers to seeking help for alcohol problems
- the existence and purpose of alcohol-related services must be publicised more effectively
- the provision of help for alcohol misusers and their families and friends should be increased
- a wide range of flexible services is required to deal with different types of problems and different types of people

APPENDIX A: RECRUITMENT QUESTIONNAIRES

ATTITUDES TOWARDS ALCOHOL AND USE OF SERVICES (7456)

DEPTH INTERVIEWS

RECRUITMENT QUESTIONNAIRE:

FRIENDS AND FAMILY OF POTENTIAL USERS

NAME	Age	
	18-29	1
ADDRESS	30-44	2
.....	45-59	3
.....	60+	4
	Sex	
POSTCODE	Male	1
Telephone number	Female	2
OCCUPATION OF CHIEF INCOME EARNER	SEG	
.....	A	1
	B	2
	C1	3
	C2	4
	DE	5
	Location	
	Glasgow	1
	Edinburgh	2
	Fife	3
	Galashiels	4

DECLARATION: Interview conducted by me with respondent named above in accordance with the instructions and the MRS Code of Conduct

Interviewer Date

Good morning/afternoon/evening. My name is..... and I am from NFO System Three, an independent research agency. As part of a wider public consultation process, the Scottish Executive has asked us to carry out some discussions with members of the public about attitudes towards alcohol use and alcohol related services.

Q1 SHOW CARD

Do you, or anyone in your household, work in any of the areas on this card?

No, none	1	Q2

Marketing	2	END
Market research	3	
Journalism	4	
Public Relations	5	

IF WORK IN ANY OF NAMED PROFESSIONS, DO NOT RECRUIT

Q2 Do you, or anyone in your household, currently work in services providing help and assistance for people with alcohol related problems?

Yes	1	END

No	2	Q3

IF THEY OR ANY MEMBER OF THE HOUSEHOLD WORK IN SERVICES FOR PEOPLE WITH ALCOHOL RELATED PROBLEMS, DO NOT RECRUIT

Q3 Have you ever attended a research group discussion?

Yes	1	Q4

No	2	Q5

Q4 When did you last attend a group discussion?

Within last 12 months	1	END

More than 12 months ago	2	Q5

IF ATTENDED A GROUP WITHIN PAST 12 MONTHS, DO NOT RECRUIT

SHOWCARD

Q5 Do you have any **close** friends or family members whose drinking has caused problems for you, for them or for other members of your family? This card gives examples of the kind of things I am talking about.

Yes	1	Q6

No	2	END
Don't know	3	

**IF 'NO' OR 'DON'T KNOW', DO NOT RECRUIT.
IF 'YES', GO TO Q6.**

Q6 As far as you know, has this person ever had contact with any services for people concerned about their drinking habits?

Yes	1	END

No	2	Q7
Don't know	3	

**If YES, DO NOT RECRUIT.
If NO OR DON'T KNOW, GO TO Q7.**

Q7 Would you be interested in taking part in a discussion about attitudes towards alcohol use and alcohol related services?

Yes	1	

No	2	

ATTITUDES TOWARDS ALCOHOL AND USE OF SERVICES (7456)
RECRUITMENT QUESTIONNAIRE: MINI-GROUPS WITH ‘DRINKERS’

NAME	Age	
	18-29	1
ADDRESS	30-44	2
.....	45-59	3
.....	60+	4
	Sex	
POSTCODE	Male	1
Telephone number	Female	2
OCCUPATION OF CHIEF INCOME EARNER	SEG	
.....	A	1
	B	2
	C1	3
	C2	4
	DE	5
	Location	
	Glasgow	1
	Edinburgh	2
	Fife	3
	Galashiels	4

DECLARATION: Interview conducted by me with respondent named above in accordance with the instructions and the MRS Code of Conduct

Interviewer Date

Good morning/afternoon/evening. My name is..... and I am from NFO System Three, an independent research agency. As part of a project we are conducting for the Scottish Executive, we are recruiting members of the public to take part in discussions relating to attitudes towards and experience of drinking alcohol.

Q1 SHOW CARD

Do you, or anyone in your household, work in any of the areas on this card?

No, none	1	Q2

Marketing	2	END
Market research	3	
Journalism	4	
Public relations	5	

IF WORK IN ANY OF NAMED PROFESSIONS, DO NOT RECRUIT

Q2 Do you, or anyone in your household, currently work in services providing help and assistance for people with alcohol related problems?

Yes	1	END

No	2	Q3

IF THEY OR ANY MEMBER OF THE HOUSEHOLD WORK IN SERVICES FOR PEOPLE WITH ALCOHOL RELATED PROBLEMS, DO NOT RECRUIT

Q3 Have you ever attended a research group discussion?

Yes	1	Q4

No	2	Q5

Q4 When did you last attend a group discussion?

Within last 12 months	1	END

More than 12 months ago	2	Q5

IF ATTENDED A GROUP WITHIN PAST 12 MONTHS, DO NOT RECRUIT

Q5	Do you ever drink alcohol?	Yes	1	Q6

		No	2	END

**IF THEY DO NOT DRINK ALCOHOL, CODE 2, DO NOT RECRUIT.
IF DRINK ALCOHOL, CODE 1, GO TO Q6**

Q6	In the past 6 months, how often have you had more to drink than you think you should have?	Never	1	
		Up to three times	2	END

		Four times or more	2	Q7

**IF NEVER OR UP TO 3 TIMES, DO NOT RECRUIT.
IF FOUR TIMES OR MORE, GO TO Q7**

SHOW CARD

Q7 Thinking about occasions when you have been drinking, have any of these things happened to you *on more than one occasion* in the last 12 months? Please read out the letters that correspond to the statement.

- | | | | | |
|-------|---|---|-----|--|
| A. | In the morning I was unable to remember bits of the night before | 1 | | |
| | B. I felt so ill that I wasn't able to do anything the next day | 2 | | |
| | C. I caused myself an injury (for example, through falling over) | 3 | Q7 | |
| | D. I put myself at risk in some way | 4 | | |
| | E. I had an argument with my family or friends | 5 | | |
| | F. I did something I regretted to either property or another person | 6 | | |
| ----- | | | | |
| | G. No, none of these | 7 | END | |

**IF HAVEN'T DONE ANY OF THESE (CODE 7), DO NOT RECRUIT.
IF CODED 1 TO 6, GO TO Q7.**

Q7	Would you be interested in taking part in a discussion about attitudes towards alcohol use and alcohol related services?	Yes	1	

		No	2	

APPENDIX B: PARTICIPANT TYPES: CHARACTERISTICS AND DRINKING BEHAVIOUR

The purpose of this Appendix is simply to provide some background detail on the type of drinking behaviour found among each of the main groups participating in the research.

This qualitative research used purposive sampling techniques to recruit people who are known to drink alcohol regularly and sometimes, if not often, heavily. Therefore, the picture presented here is in no way representative of the wider general population.

‘Drinkers’

All participants in the focus groups of so called ‘drinkers’ drank alcohol on a regular basis, although some drank more frequently and excessively than others. Without trying to place respondents into categories, it was clear that some of those who took part currently had an alcohol problem – or had done so in the past. One group – that with young males in Glasgow – stood out as being slightly different from the other groups. These males were all current or recently graduated university students and their attitudes and experiences provided an interesting comparison with the three other groups. In general, the participants in this group were also from more affluent socio-economic backgrounds. While they did engage in binge-drinking behaviour and did sometimes ‘drink to get drunk’, alcohol appeared to be a less-central to their lives. Drinking for them was almost a stage they were going through – an accepted part of being a student – and more isolated from their general day-to-day routine. For other participants, alcohol played a more central role in their lives – not only on an individual basis but also in terms of their communities. Excessive drinking was part of their culture – starting with very young people and continuing in old age. Most people in these groups knew at least one person with an alcohol problem.

Demographics of ‘drinkers’

Group	Sex	Location	Age group	SEG
1	Male	Glasgow	18-25	C1
2	Male	Borders	30+	C1C2DE
3	Female	Fife	18-25	E
4	Female	Edinburgh	30+	C2DE

SEG = Socio-economic grouping. See Page 10 for definitions of each category.

Families and friends of people with alcohol problems

Although it was discussed in most of the interviews and focus groups with families and friends of alcohol misusers, personal drinking behaviour was not the focus of the discussion and sometimes, because of the flow of conversation, it was not raised at all. Nevertheless, where this was discussed it highlighted an interesting divergence of behaviour, ranging from

total abstinence – often in support of the misuser – to excessive drinking which clearly constituted an alcohol problem. Many of those who actually lived with an alcohol misuser tended to drink little, if any, alcohol. Sometimes this was a result of feeling guilty and not wanting to tempt the misuser, for others it was because they simply saw alcohol as a destructive force. However, this again shows how the alcohol misusers behaviour can restrict the behaviour of those close to them – many felt they could not go to the pub, (either on their own or with the alcohol misuser), visit friends or have a celebratory drink on special occasions.

Demographics of friends and family members of non-service users

Interview	Sex	Location	Age group	SEG
1	Female	Glasgow	30-44	DE
2	Female	Borders	30-44	DE
3	Female	Fife	18-29	C1
4	Female	Edinburgh	60+	B
5	Male	Fife	30-44	DE
6	Male	Edinburgh	30-44	B

SEG = Socio-economic grouping

As friends and families of service users were recruited directly through the agencies, and not a recruitment questionnaire, it is not possible to provide an accurate breakdown of their demographic characteristics.

Current and previous service users: drinking behaviour past and present

It is worth noting that service users did not really focus on the amount of alcohol they were consuming, but were more concerned about the affect that drinking was having on their lives. Drinking behaviour, or the recognition of an alcohol problem is not seen in terms of how many bottles or units of alcohol for example.

“It is not the amount, it is what it does to us once we start drinking. We think we can control it, we will just have one, but we can’t.” (Previous user of private service.)

The groups and interviews did not specifically explore drinking patterns but were discussed in relation to when drink becomes a problem.

There are considerable differences in the past and present drinking patterns of the current and previous service users. The different patterns tend to be reflected in the type of service and treatment which people are currently involved in, and peoples’ reasons for contacting a service. The range of alcohol consumed by service users in the past ranged from binge-drinking (although this was less common than frequent drinking) and drinking a bottle of wine each day at one end of the scale to consuming multiple bottles of spirits a day at the other. Similarly, the role alcohol had previously played in peoples’ lives varied. Some

service users had been drinking heavily over a long period of time without perceiving it to be a problem but had come to a point where some kind of crisis occurred. For others, contact with alcohol services had been a recurring theme over a number of years with alcohol free periods of varying lengths in between contacts. Furthermore, some service users had made contact with alcohol services to prevent a problem becoming worse.

In terms of current drinking behaviours, many no longer drank alcohol at all, while some adhered to the controlled-drinking' model.

As these participants were recruited directly through the agencies it is not possible to provide an accurate breakdown of their demographic characteristics.

APPENDIX C: QUESTIONS USED FOR QUANTITATIVE RESEARCH

Q.1 SHOWCARD I'm going to read out a number of statements about alcohol misuse and I'd like you to tell me how strongly you agree or disagree with each. (Agree strongly/agree slightly/neither agree not disagree/disagree slightly/disagree strongly.)

“Men are much more likely than women to experience problems with alcohol”

“Alcohol misuse is increasing among young people in Scotland”

“Most violent crime is alcohol-related”

Q.2 SHOWCARD If you or somebody close to you (for example a friend or member of your family) was experiencing problems with alcohol use, how confident are you that you would know how to find and contact services or organisations providing help and advice?

Very confident

Fairly confident

Not very confident

Not at all confident

Don't know

Q.3 Have you ever contacted a service or organisation for help or advice about alcohol, either on your own behalf or on behalf of someone close to you?

Yes – on my own behalf

Yes – on behalf of someone else

No

Q.4 SHOWCARD How effective do you think the following might be in helping to tackle the problem of alcohol misuse in Scotland? (Very/Fairly/Not very/Not at all) ROTATE, TICK START.

Advertising campaigns on sensible drinking

Stricter enforcement of existing laws relating to drink driving, street disorder, licensed premises, under-age drinking etc

Extending opening hours for licensed premises

Reducing opening hours for licensed premises

Providing more information/ education on the dangers of drinking

Improving services for people with alcohol problems

APPENDIX D: REFERENCES

Goddard E (1996), *Teenage Drinking in 1994*. London: HMSO.

Overview of National Alcohol Policies in the 15 countries of the EU. Prepared by French Society of Public Health and European Commission DGV (1998).

Scottish Executive (2001) Consultation Paper on Plan for Action on Alcohol Misuse.

Scottish Executive Department of Health (1998) Scottish Health Survey 1998, Volume One, Edited by Andrew Shaw, Ann McMunn and Julia Field.

APPENDIX E: DATA TABULATIONS

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

**B.1 LEVEL OF AGREEMENT WITH THE FOLLOWING STATEMENT ABOUT ALCOHOL MISUSE
"MEN ARE MUCH MORE LIKELY THAN WOMEN TO EXPERIENCE PROBLEMS WITH ALCOHOL"**

BASE : ALL RESPONDENTS

	Total	SEX		AGE			CLASS		HOUSEHOLD SIZE				CHILDREN UNDER 16		MARITAL STATUS			WORKING STATUS			AREA		
		Male	Fe- male	16 -34	35 -54	55+	ABC1	C2DE	1	2	3	4+	Yes	No	Marr- ied	Sing- le	Widow /sep /div	Full time	Part time	Not Work- ing	West	East/ South	North
Unweighted base	1061	469	592	325	372	364	474	587	217	363	208	273	355	706	651	210	200	383	162	516	453	357	251
Weighted base	1061	509	552	350	361	350	499	562	206	360	213	282	366	695	646	230	186	409	164	488	450	360	252
Agree strongly (+2)	163 15%	89 17%	74 13%	61 17%	58 16%	44 12%	77 16%	85 15%	20 10%	55 15%	40 19%	48 17%	67 18%	96 14%	104 16%	37 16%	22 12%	58 14%	28 17%	77 16%	72 16%	52 15%	38 15%
Agree slightly (+1)	228 21%	122 24%	105 19%	85 24%	71 20%	72 20%	124 25%	104 18%	37 18%	83 23%	46 22%	62 22%	73 20%	155 22%	135 21%	62 27%	31 16%	96 23%	35 21%	97 20%	108 24%	82 23%	37 15%
Neither agree nor disagree (0)	169 16%	83 16%	86 16%	42 12%	65 18%	61 18%	72 14%	97 17%	44 21%	50 14%	37 17%	38 13%	46 13%	123 18%	100 15%	33 14%	37 20%	64 16%	23 14%	82 17%	67 15%	47 13%	55 22%
Disagree slightly (-1)	300 28%	138 27%	162 29%	90 26%	104 29%	106 30%	133 27%	167 30%	63 31%	105 29%	48 22%	83 30%	109 30%	191 27%	185 29%	55 24%	59 32%	115 28%	47 29%	138 28%	111 25%	114 32%	75 30%
Disagree strongly (-2)	176 17%	66 13%	110 20%	67 19%	56 15%	53 15%	82 16%	94 17%	31 15%	60 17%	39 18%	47 17%	65 18%	111 16%	109 17%	36 16%	31 16%	67 16%	27 17%	81 17%	78 17%	52 15%	45 18%
Don't know	26 2%	11 2%	14 3%	5 1%	7 2%	14 4%	11 2%	15 3%	12 6%	6 2%	4 2%	4 1%	6 2%	20 3%	12 2%	7 3%	7 4%	9 2%	3 2%	14 3%	13 3%	12 3%	- -
Mean	-0.10	0.06	-0.24	-0.05	-0.08	-0.16	-0.04	-0.15	-0.25	-0.09	*	-0.07	-0.09	-0.10	-0.10	0.04	-0.26	-0.10	-0.07	-0.10	-0.03	-0.09	-0.21
Std. Dev.	1.346	1.329	1.346	1.413	1.333	1.289	1.354	1.338	1.224	1.354	1.400	1.374	1.404	1.315	1.358	1.359	1.272	1.333	1.378	1.348	1.374	1.328	1.320
Std. Error	0.042	0.062	0.056	0.079	0.070	0.069	0.063	0.056	0.085	0.072	0.098	0.084	0.075	0.050	0.054	0.095	0.092	0.069	0.109	0.060	0.066	0.071	0.083
Error Variance	0.002	0.004	0.003	0.006	0.005	0.005	0.004	0.003	0.007	0.005	0.010	0.007	0.006	0.003	0.003	0.009	0.008	0.005	0.012	0.004	0.004	0.005	0.007

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

**B.1 LEVEL OF AGREEMENT WITH THE FOLLOWING STATEMENT ABOUT ALCOHOL MISUSE
"MEN ARE MUCH MORE LIKELY THAN WOMEN TO EXPERIENCE PROBLEMS WITH ALCOHOL"**

BASE : ALL RESPONDENTS

B.3 WHETHER HAVE EVER CONTACTED A SERVICE OR ORGANISATION FOR HELP OR ADVICE ABOUT ALCOHOL

	TOTAL	Yes - on my own behalf	Yes - on behalf of someone else	Yes - total	No	Don't know
Unweighted base	1061	21	95	113	946	2
Weighted base	1061	21	93	111	948	2
Agree strongly (+2)	163 15%	1 5%	12 13%	13 12%	150 16%	-
Agree slightly (+1)	228 21%	3 15%	21 22%	24 21%	204 22%	-
Neither agree nor disagree (0)	169 16%	7 32%	12 12%	16 15%	152 16%	1 44%
Disagree slightly (-1)	300 28%	7 35%	26 27%	32 29%	267 28%	1 56%
Disagree strongly (-2)	176 17%	2 9%	23 25%	25 23%	151 16%	-
Don't know	26 2%	1 5%	-	1 1%	25 3%	-
Mean	-0.10	-0.30	-0.30	-0.30	-0.07	-0.56
Std. Dev.	1.346	1.027	1.394	1.349	1.345	0.702
Std. Error	0.042	0.230	0.143	0.127	0.044	0.496
Error Variance	0.002	0.053	0.020	0.016	0.002	0.246

Prepared by NFO System Three (2324)

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

**B.1 LEVEL OF AGREEMENT WITH THE FOLLOWING STATEMENT ABOUT ALCOHOL MISUSE
"ALCOHOL MISUSE IS INCREASING AMONG YOUNG PEOPLE IN SCOTLAND"**

BASE : ALL RESPONDENTS

	Total	SEX		AGE			CLASS		HOUSEHOLD SIZE				CHILDREN UNDER 16		MARITAL STATUS			WORKING STATUS			AREA		
		Male	Fe- male	16 -34	35 -54	55+	ABC1	C2DE	1	2	3	4+	Yes	No	Marr- ied	Sing- le	Widow /sep /div	Full time	Part time	Not Work- ing	West	East/ South	North
Unweighted base	1061	469	592	325	372	364	474	587	217	363	208	273	355	706	651	210	200	383	162	516	453	357	251
Weighted base	1061	509	552	350	361	350	499	562	206	360	213	282	366	695	646	230	186	409	164	488	450	360	252
Agree strongly (+2)	779 73%	352 69%	427 77%	251 72%	259 72%	269 77%	346 69%	432 77%	153 74%	258 72%	160 75%	208 74%	267 73%	512 74%	464 72%	164 71%	151 82%	273 67%	123 75%	383 78%	336 75%	264 73%	179 71%
Agree slightly (+1)	204 19%	104 20%	100 18%	74 21%	69 19%	61 18%	108 22%	97 17%	43 21%	71 20%	37 17%	53 19%	70 19%	135 19%	127 20%	50 22%	27 15%	93 23%	32 20%	79 16%	84 19%	73 20%	47 19%
Neither agree nor disagree (0)	44 4%	32 6%	12 2%	18 5%	21 6%	5 1%	26 5%	19 3%	5 2%	15 4%	10 4%	15 5%	20 6%	24 3%	33 5%	9 4%	3 2%	30 7%	5 3%	10 2%	15 3%	15 4%	14 6%
Disagree slightly (-1)	13 1%	6 1%	7 1%	3 1%	5 2%	4 1%	6 1%	7 1%	2 1%	4 1%	2 1%	5 2%	6 2%	7 1%	10 2%	3 1%	- 2%	7 2%	- 2%	6 1%	8 2%	2 1%	3 1%
Disagree strongly (-2)	6 1%	4 1%	2 *	2 1%	3 1%	1 *	3 1%	3 1%	1 1%	4 1%	1 *	- -	1 *	5 1%	2 *	2 1%	2 1%	4 1%	- -	2 *	1 *	- -	5 2%
Don't know	15 1%	11 2%	4 1%	3 1%	2 1%	10 3%	10 2%	5 1%	3 2%	7 2%	3 2%	2 1%	2 *	13 2%	10 2%	2 1%	2 1%	4 1%	3 2%	8 2%	6 1%	6 2%	3 1%
Mean	1.66	1.59	1.72	1.63	1.61	1.74	1.62	1.70	1.70	1.63	1.68	1.65	1.63	1.67	1.64	1.63	1.78	1.54	1.74	1.74	1.68	1.69	1.58
Std. Dev.	0.672	0.733	0.605	0.683	0.738	0.574	0.697	0.647	0.609	0.720	0.659	0.663	0.697	0.658	0.681	0.713	0.569	0.776	0.504	0.609	0.645	0.577	0.823
Std. Error	0.021	0.034	0.025	0.038	0.038	0.031	0.032	0.027	0.042	0.038	0.046	0.040	0.037	0.025	0.027	0.049	0.040	0.040	0.040	0.027	0.031	0.031	0.052
Error Variance	*	0.001	0.001	0.001	0.001	0.001	0.001	0.001	0.002	0.001	0.002	0.002	0.001	0.001	0.001	0.002	0.002	0.002	0.002	0.001	0.001	0.001	0.003

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

**B.1 LEVEL OF AGREEMENT WITH THE FOLLOWING STATEMENT ABOUT ALCOHOL MISUSE
"ALCOHOL MISUSE IS INCREASING AMONG YOUNG PEOPLE IN SCOTLAND"**

BASE : ALL RESPONDENTS

B.3 WHETHER HAVE EVER CONTACTED A SERVICE OR ORGANISATION FOR HELP OR ADVICE ABOUT ALCOHOL

	TOTAL	Yes - on my own behalf	Yes - on behalf of someone else	Yes - total	No	Don't know
Unweighted base	1061	21	95	113	946	2
Weighted base	1061	21	93	111	948	2
Agree strongly (+2)	779 73%	18 87%	74 79%	90 81%	688 73%	1 44%
Agree slightly (+1)	204 19%	2 8%	14 15%	16 14%	187 20%	1 56%
Neither agree nor disagree (0)	44 4%	1 5%	4 4%	4 4%	40 4%	-
Disagree slightly (-1)	13 1%	-	1 1%	1 1%	12 1%	-
Disagree strongly (-2)	6 1%	-	-	0 0%	6 1%	-
Don't know	15 1%	-	-	0 0%	15 2%	-
Mean	1.66	1.83	1.73	1.75	1.65	1.44
Std. Dev.	0.672	0.496	0.599	0.565	0.683	0.702
Std. Error	0.021	0.108	0.061	0.053	0.022	0.496
Error Variance	*	0.012	0.004	0.003	0.001	0.246

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

**B.1 LEVEL OF AGREEMENT WITH THE FOLLOWING STATEMENT ABOUT ALCOHOL MISUSE
"MOST VIOLENT CRIME IS ALCOHOL-RELATED"**

BASE : ALL RESPONDENTS

	Total	SEX		AGE			CLASS		HOUSEHOLD SIZE				CHILDREN UNDER 16		MARITAL STATUS			WORKING STATUS			AREA		
		Male	Fe- male	16 -34	35 -54	55+	ABC1	C2DE	1	2	3	4+	Yes	No	Marr- ied	Sing- le	Widow /sep /div	Full time	Part time	Not Work- ing	West	East/ South	North
Unweighted base	1061	469	592	325	372	364	474	587	217	363	208	273	355	706	651	210	200	383	162	516	453	357	251
Weighted base	1061	509	552	350	361	350	499	562	206	360	213	282	366	695	646	230	186	409	164	488	450	360	252
Agree strongly (+2)	368 35%	187 37%	181 33%	95 27%	128 36%	145 41%	158 32%	210 37%	76 37%	128 36%	71 33%	94 33%	109 30%	259 37%	224 35%	65 28%	79 43%	127 31%	45 28%	196 40%	180 40%	104 29%	84 34%
Agree slightly (+1)	376 35%	177 35%	199 36%	129 37%	125 35%	122 35%	190 38%	186 33%	81 39%	116 32%	79 37%	100 36%	135 37%	241 35%	210 33%	98 43%	68 36%	145 35%	66 40%	165 34%	152 34%	131 36%	93 37%
Neither agree nor disagree (0)	88 8%	41 8%	47 9%	39 11%	31 9%	18 5%	47 9%	41 7%	15 7%	31 9%	14 7%	27 10%	33 9%	55 8%	54 8%	21 9%	12 6%	39 10%	17 10%	32 6%	32 7%	35 10%	21 8%
Disagree slightly (-1)	169 16%	74 15%	95 17%	70 20%	57 16%	42 12%	77 15%	92 16%	23 11%	62 17%	34 16%	50 18%	66 18%	102 15%	112 17%	39 17%	17 9%	75 18%	25 15%	68 14%	62 14%	65 18%	43 17%
Disagree strongly (-2)	43 4%	23 5%	20 4%	16 5%	14 4%	12 3%	17 3%	25 5%	4 2%	15 4%	13 6%	10 4%	20 5%	23 3%	35 5%	5 2%	3 2%	17 4%	6 4%	20 4%	18 4%	17 5%	7 3%
Don't know	18 2%	7 1%	11 2%	1 *	6 2%	11 3%	9 2%	9 2%	8 4%	7 2%	3 1%	1 *	3 1%	15 2%	10 1%	2 1%	7 4%	6 1%	4 3%	8 2%	7 2%	8 2%	3 1%
Mean	0.82	0.86	0.79	0.62	0.83	1.02	0.81	0.84	1.02	0.79	0.76	0.77	0.68	0.90	0.75	0.78	1.13	0.72	0.74	0.93	0.93	0.69	0.82
Std. Dev.	1.192	1.200	1.185	1.211	1.195	1.136	1.152	1.227	1.048	1.228	1.246	1.193	1.233	1.163	1.256	1.101	1.013	1.206	1.149	1.187	1.184	1.211	1.163
Std. Error	0.037	0.056	0.049	0.067	0.063	0.060	0.053	0.051	0.072	0.065	0.087	0.072	0.066	0.044	0.050	0.076	0.073	0.062	0.091	0.053	0.056	0.065	0.074
Error Variance	0.001	0.003	0.002	0.005	0.004	0.004	0.003	0.003	0.005	0.004	0.008	0.005	0.004	0.002	0.002	0.006	0.005	0.004	0.008	0.003	0.003	0.004	0.005

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

**B.1 LEVEL OF AGREEMENT WITH THE FOLLOING STATEMENT ABOUT ALCOHOL MISUSE
"MOST VIOLENT CRIME IS ALCOHOL-RELATED"**

BASE : ALL RESPONDENTS

B.3 WHETHER HAVE EVER CONTACTED A SERVICE OR ORGANISATION FOR HELP OR ADVICE ABOUT ALCOHOL

	TOTAL	Yes - on my own behalf	Yes - on behalf of someone else	Yes - total	No	Don't know
Unweighted base	1061	21	95	113	946	2
Weighted base	1061	21	93	111	948	2
Agree strongly (+2)	368 35%	14 65%	38 40%	48 43%	319 34%	1 44%
Agree slightly (+1)	376 35%	3 13%	26 27%	28 25%	347 37%	1 56%
Neither agree nor disagree (0)	88 8%	1 5%	8 9%	9 8%	79 8%	-
Disagree slightly (-1)	169 16%	1 7%	16 17%	18 16%	151 16%	-
Disagree strongly (-2)	43 4%	2 10%	3 3%	5 5%	37 4%	-
Don't know	18 2%	-	3 3%	3 3%	15 2%	-
Mean	0.82	1.17	0.86	0.89	0.81	1.44
Std. Dev.	1.192	1.388	1.239	1.272	1.184	0.702
Std. Error	0.037	0.303	0.129	0.121	0.039	0.496
Error Variance	0.001	0.092	0.017	0.015	0.002	0.246

Prepared by NFO System Three (2324)

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

**B.2 HOW CONFIDENT WOULD BE TO FIND AND CONTACT SERVICES OR ORGANISATIONS PROVIDING HELP AND ADVICE
IF SELF OR SOMEBODY CLOSE TO SELF WAS EXPERIENCING PROBLEMS WITH ALCOHOL USE**

BASE : ALL RESPONDENTS

	Total	SEX		AGE			CLASS		HOUSEHOLD SIZE				CHILDREN UNDER 16		MARITAL STATUS			WORKING STATUS			AREA		
		Male	Fe- male	16 -34	35 -54	55+	ABC1	C2DE	1	2	3	4+	Yes	No	Marr- ied	Sing- le	Widow /sep /div	Full time	Part time	Not Work- ing	West	East/ South	North
Unweighted base	1061	469	592	325	372	364	474	587	217	363	208	273	355	706	651	210	200	383	162	516	453	357	251
Weighted base	1061	509	552	350	361	350	499	562	206	360	213	282	366	695	646	230	186	409	164	488	450	360	252
Very confident (+4)	334 32%	150 30%	184 33%	108 31%	131 36%	96 27%	164 33%	170 30%	59 28%	119 33%	62 29%	95 34%	127 35%	207 30%	216 34%	59 26%	59 32%	140 34%	54 33%	141 29%	141 31%	109 30%	84 33%
Fairly confident (+3)	418 39%	211 41%	207 38%	145 41%	153 42%	120 34%	223 45%	195 35%	71 34%	137 38%	98 46%	112 40%	147 40%	271 39%	269 42%	95 41%	53 29%	178 44%	69 42%	170 35%	178 39%	140 39%	100 40%
Not very confident (+2)	167 16%	73 14%	94 17%	62 18%	45 13%	60 17%	66 13%	100 18%	28 13%	58 16%	34 16%	48 17%	55 15%	111 16%	92 14%	43 19%	31 17%	54 13%	23 14%	90 18%	61 14%	64 18%	42 17%
Not at all confident (+1)	99 9%	55 11%	44 8%	24 7%	23 6%	52 15%	35 7%	64 11%	33 16%	32 9%	14 7%	20 7%	27 7%	72 10%	49 8%	21 9%	29 15%	25 6%	15 9%	60 12%	34 8%	40 11%	25 10%
Don't know	43 4%	20 4%	23 4%	12 3%	9 3%	22 6%	9 2%	34 6%	16 8%	13 4%	6 3%	8 3%	10 3%	33 5%	18 3%	11 5%	13 7%	13 3%	2 1%	27 6%	36 8%	6 2%	1 *
Mean	2.97	2.93	3.00	2.99	3.11	2.79	3.06	2.89	2.82	2.99	3.00	3.03	3.05	2.93	3.04	2.88	2.83	3.09	3.01	2.85	3.03	2.90	2.97
Std. Dev.	0.939	0.951	0.928	0.887	0.867	1.035	0.872	0.992	1.056	0.940	0.861	0.902	0.902	0.957	0.898	0.921	1.080	0.853	0.925	1.000	0.907	0.969	0.947
Std. Error	0.029	0.045	0.039	0.050	0.045	0.056	0.040	0.042	0.075	0.050	0.060	0.055	0.048	0.037	0.036	0.065	0.079	0.044	0.073	0.045	0.044	0.052	0.060
Error Variance	0.001	0.002	0.002	0.003	0.002	0.003	0.002	0.002	0.006	0.003	0.004	0.003	0.002	0.001	0.001	0.004	0.006	0.002	0.005	0.002	0.002	0.003	0.004

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

Absolutes/col percents
Table 5

B.3 WHETHER HAVE EVER CONTACTED A SERVICE OR ORGANISATION FOR HELP OR ADVICE ABOUT ALCOHOL

BASE : ALL RESPONDENTS

	SEX		AGE			CLASS		HOUSEHOLD SIZE				CHILDREN UNDER 16		MARITAL STATUS			WORKING STATUS			AREA			
	Total	Male	Fe- male	16 -34	35 -54	55+	ABC1	C2DE	1	2	3	4+	Yes	No	Marr- ied	Sing- le	Widow /sep /div	Full time	Part time	Not Work- ing	West	East/ South	North
Unweighted base	1061	469	592	325	372	364	474	587	217	363	208	273	355	706	651	210	200	383	162	516	453	357	251
Weighted base	1061	509	552	350	361	350	499	562	206	360	213	282	366	695	646	230	186	409	164	488	450	360	252
Yes - on my own behalf	21 2%	14 3%	7 1%	4 1%	11 3%	6 2%	5 1%	16 3%	8 4%	6 2%	4 2%	3 1%	5 1%	16 2%	9 1%	3 1%	9 5%	8 2%	1 1%	12 2%	14 3%	2 1%	5 2%
Yes - on behalf of someone else	93 9%	35 7%	58 11%	31 9%	39 11%	23 7%	49 10%	45 8%	16 8%	29 8%	17 8%	30 11%	42 12%	51 7%	55 8%	18 8%	20 11%	39 9%	15 9%	40 8%	44 10%	31 9%	18 7%
Yes - total	111 10%	47 9%	64 12%	34 10%	49 14%	28 8%	54 11%	57 10%	22 11%	35 10%	20 10%	33 12%	46 13%	65 9%	63 10%	22 9%	26 14%	46 11%	16 10%	49 10%	56 12%	33 9%	22 9%
No	948 89%	461 91%	487 88%	315 90%	311 86%	321 92%	445 89%	503 89%	183 89%	325 90%	193 90%	247 88%	318 87%	630 91%	581 90%	208 91%	158 85%	362 88%	148 90%	438 90%	392 87%	326 91%	230 91%
Don't know	2 *	1 *	1 *	1 *	- .	1 *	- .	2 *	1 *	- .	- .	1 *	1 *	1 *	- .	1 *	1 *	1 *	- .	1 *	2 *	- .	- .

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

**B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND
"ADVERTISING CAMPAIGNS ON SENSIBLE DRINKING"**

BASE : ALL RESPONDENTS

	Total	SEX		AGE			CLASS		HOUSEHOLD SIZE				CHILDREN UNDER 16		MARITAL STATUS			WORKING STATUS			AREA		
		Male	Fe- male	16 -34	35 -54	55+	ABC1	C2DE	1	2	3	4+	Yes	No	Marr- ied	Sing- le	Widow /sep /div	Full time	Part time	Not Work- ing	West	East/ South	North
Unweighted base	1061	469	592	325	372	364	474	587	217	363	208	273	355	706	651	210	200	383	162	516	453	357	251
Weighted base	1061	509	552	350	361	350	499	562	206	360	213	282	366	695	646	230	186	409	164	488	450	360	252
Very effective (+4)	177 17%	65 13%	112 20%	58 17%	67 19%	52 15%	71 14%	106 19%	27 13%	55 15%	43 20%	53 19%	72 20%	105 15%	106 16%	44 19%	27 15%	49 12%	31 19%	98 20%	93 21%	55 15%	29 11%
Fairly effective (+3)	462 43%	231 45%	231 42%	158 45%	170 47%	134 38%	228 46%	233 41%	73 36%	161 45%	91 43%	136 48%	168 46%	294 42%	297 46%	95 41%	70 38%	196 48%	73 45%	192 39%	197 44%	161 45%	103 41%
Not very effective (+2)	265 25%	138 27%	127 23%	90 26%	83 23%	92 26%	135 27%	130 23%	61 30%	89 25%	50 24%	65 23%	88 24%	177 26%	155 24%	63 27%	48 26%	100 24%	35 22%	130 27%	94 21%	98 27%	73 29%
Not at all effective (+1)	134 13%	64 12%	70 13%	39 11%	38 10%	57 16%	55 11%	79 14%	35 17%	47 13%	26 12%	26 9%	34 9%	100 14%	76 12%	27 12%	31 17%	55 14%	23 14%	55 11%	50 11%	41 11%	43 17%
Don't know	23 2%	12 2%	12 2%	5 1%	4 1%	15 4%	9 2%	14 3%	11 5%	8 2%	2 1%	3 1%	4 1%	19 3%	13 2%	1 *	10 5%	9 2%	1 1%	13 3%	17 4%	4 1%	3 1%
Mean	2.66	2.60	2.71	2.68	2.74	2.54	2.65	2.67	2.47	2.63	2.72	2.77	2.77	2.60	2.68	2.68	2.54	2.60	2.68	2.70	2.77	2.65	2.48
Std. Dev.	0.909	0.872	0.939	0.886	0.882	0.950	0.864	0.947	0.938	0.902	0.929	0.860	0.876	0.921	0.890	0.918	0.957	0.874	0.941	0.925	0.915	0.880	0.911
Std. Error	0.028	0.041	0.039	0.050	0.046	0.051	0.040	0.040	0.065	0.048	0.065	0.052	0.047	0.035	0.035	0.064	0.069	0.045	0.074	0.041	0.044	0.047	0.058
Error Variance	0.001	0.002	0.002	0.002	0.002	0.003	0.002	0.002	0.004	0.002	0.004	0.003	0.002	0.001	0.001	0.004	0.005	0.002	0.006	0.002	0.002	0.002	0.003

**B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND
"ADVERTISING CAMPAIGNS ON SENSIBLE DRINKING"**

BASE : ALL RESPONDENTS

B.3 WHETHER HAVE EVER CONTACTED A SERVICE OR ORGANISATION FOR HELP OR ADVICE ABOUT ALCOHOL

	TOTAL	Yes - on my own behalf	Yes - on behalf of someone else	Yes - total	No	Don't know
Unweighted base	1061	21	95	113	946	2
Weighted base	1061	21	93	111	948	2
Very effective (+4)	177 <i>17%</i>	7 <i>33%</i>	21 <i>23%</i>	28 <i>25%</i>	148 <i>16%</i>	1 <i>44%</i>
Fairly effective (+3)	462 <i>43%</i>	9 <i>43%</i>	32 <i>34%</i>	39 <i>35%</i>	423 <i>45%</i>	-
Not very effective (+2)	265 <i>25%</i>	3 <i>13%</i>	25 <i>27%</i>	27 <i>24%</i>	238 <i>25%</i>	-
Not at all effective (+1)	134 <i>13%</i>	1 <i>6%</i>	12 <i>13%</i>	14 <i>12%</i>	120 <i>13%</i>	-
Don't know	23 <i>2%</i>	1 <i>5%</i>	2 <i>3%</i>	4 <i>3%</i>	19 <i>2%</i>	1 <i>56%</i>
Mean	2.66	3.08	2.69	2.76	2.64	4.00
Std. Dev.	0.909	0.888	0.986	0.987	0.898	-
Std. Error	0.028	0.198	0.102	0.094	0.030	-
Error Variance	0.001	0.039	0.010	0.009	0.001	-

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

**B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND
"STRICTER ENFORCEMENT OF EXISTING LAWS RELATING TO DRINK DRIVING, STREET DISORDER, LICENSED PREMISES, UNDER-AGE DRINKING, ETC."**

BASE : ALL RESPONDENTS

	Total	SEX		AGE			CLASS		HOUSEHOLD SIZE				CHILDREN UNDER 16		MARITAL STATUS			WORKING STATUS			AREA		
		Male	Fe- male	16 -34	35 -54	55+	ABC1	C2DE	1	2	3	4+	Yes	No	Marr- ied	Sing- le	Widow /sep /div	Full time	Part time	Not Work- ing	West	East/ South	North
Unweighted base	1061	469	592	325	372	364	474	587	217	363	208	273	355	706	651	210	200	383	162	516	453	357	251
Weighted base	1061	509	552	350	361	350	499	562	206	360	213	282	366	695	646	230	186	409	164	488	450	360	252
Very effective (+4)	548 52%	231 45%	317 58%	164 47%	184 51%	200 57%	230 46%	319 57%	111 54%	190 53%	99 47%	148 53%	194 53%	354 51%	335 52%	98 43%	115 62%	181 44%	83 51%	284 58%	231 51%	207 57%	111 44%
Fairly effective (+3)	344 32%	176 34%	169 31%	115 33%	122 34%	107 31%	180 36%	164 29%	63 31%	112 31%	78 37%	91 32%	115 32%	229 33%	217 34%	78 34%	49 26%	143 35%	62 38%	139 29%	137 30%	109 30%	99 39%
Not very effective (+2)	109 10%	66 13%	43 8%	43 12%	40 11%	26 7%	59 12%	50 9%	18 9%	35 10%	21 10%	35 12%	42 11%	67 10%	63 10%	32 14%	13 7%	49 12%	15 9%	45 9%	47 10%	31 9%	31 12%
Not at all effective (+1)	51 5%	31 6%	20 4%	23 7%	14 4%	13 4%	28 6%	23 4%	11 5%	19 5%	13 6%	7 3%	12 3%	39 6%	24 4%	21 9%	6 3%	29 7%	3 2%	19 4%	29 6%	11 3%	11 4%
Don't know	9 1%	6 1%	3 *	4 1%	-	4 1%	2 *	6 1%	3 2%	3 1%	1 1%	1 *	2 1%	6 1%	5 1%	1 *	2 1%	7 2%	-	2 *	6 1%	2 1%	1 *
Mean	3.32	3.21	3.43	3.22	3.32	3.43	3.23	3.40	3.34	3.33	3.25	3.35	3.35	3.30	3.35	3.11	3.49	3.18	3.38	3.41	3.28	3.43	3.24
Std. Dev.	0.845	0.892	0.786	0.908	0.826	0.787	0.868	0.817	0.861	0.859	0.871	0.796	0.812	0.862	0.807	0.960	0.771	0.910	0.730	0.812	0.900	0.779	0.824
Std. Error	0.026	0.041	0.032	0.051	0.043	0.041	0.040	0.034	0.059	0.045	0.061	0.048	0.043	0.033	0.032	0.066	0.055	0.047	0.057	0.036	0.043	0.041	0.052
Error Variance	0.001	0.002	0.001	0.003	0.002	0.002	0.002	0.001	0.003	0.002	0.004	0.002	0.002	0.001	0.001	0.004	0.003	0.002	0.003	0.001	0.002	0.002	0.003

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

**B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND
"STRICTER ENFORCEMENT OF EXISTING LAWS RELATING TO DRINK DRIVING, STREET DISORDER, LICENSED PREMISES, UNDER-AGE DRINKING, ETC."**

BASE : ALL RESPONDENTS

B.3 WHETHER HAVE EVER CONTACTED A SERVICE OR ORGANISATION FOR HELP OR ADVICE ABOUT ALCOHOL

	TOTAL	Yes - on my own behalf	Yes - on behalf of someone else	Yes - total	No	Don't know
Unweighted base	1061	21	95	113	946	2
Weighted base	1061	21	93	111	948	2
Very effective (+4)	548 <i>52%</i>	12 <i>59%</i>	50 <i>53%</i>	59 <i>53%</i>	488 <i>51%</i>	2 <i>100%</i>
Fairly effective (+3)	344 <i>32%</i>	5 <i>24%</i>	27 <i>29%</i>	32 <i>29%</i>	313 <i>33%</i>	-
Not very effective (+2)	109 <i>10%</i>	2 <i>11%</i>	11 <i>12%</i>	14 <i>12%</i>	95 <i>10%</i>	-
Not at all effective (+1)	51 <i>5%</i>	1 <i>6%</i>	4 <i>5%</i>	6 <i>5%</i>	45 <i>5%</i>	-
Don't know	9 <i>1%</i>	-	1 <i>1%</i>	1 <i>1%</i>	7 <i>1%</i>	-
Mean	3.32	3.36	3.32	3.31	3.32	4.00
Std. Dev.	0.845	0.924	0.869	0.880	0.842	0.000
Std. Error	0.026	0.202	0.090	0.083	0.027	0.000
Error Variance	0.001	0.041	0.008	0.007	0.001	0.000

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

**B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND
"EXTENDING OPENING HOURS FOR LICENSED PREMISES"**

BASE : ALL RESPONDENTS

	Total	SEX		AGE			CLASS		HOUSEHOLD SIZE				CHILDREN UNDER 16		MARITAL STATUS			WORKING STATUS			AREA		
		Male	Fe- male	16 -34	35 -54	55+	ABC1	C2DE	1	2	3	4+	Yes	No	Marr- ied	Sing- le	Widow /sep /div	Full time	Part time	Not Work- ing	West	East/ South	North
Unweighted base	1061	469	592	325	372	364	474	587	217	363	208	273	355	706	651	210	200	383	162	516	453	357	251
Weighted base	1061	509	552	350	361	350	499	562	206	360	213	282	366	695	646	230	186	409	164	488	450	360	252
Very effective (+4)	36 3%	25 5%	11 2%	11 3%	15 4%	10 3%	16 3%	20 4%	9 4%	11 3%	6 3%	10 4%	11 3%	25 4%	22 3%	9 4%	5 3%	16 4%	4 2%	17 3%	19 4%	9 2%	9 3%
Fairly effective (+3)	197 19%	116 23%	81 15%	71 20%	69 19%	57 16%	86 17%	111 20%	35 17%	68 19%	41 19%	53 19%	67 18%	130 19%	115 18%	58 25%	24 13%	93 23%	27 17%	76 16%	83 19%	68 19%	45 18%
Not very effective (+2)	371 35%	180 35%	191 35%	136 39%	134 37%	100 29%	197 40%	174 31%	60 29%	128 36%	82 38%	100 36%	138 38%	233 33%	248 38%	69 30%	54 29%	153 37%	62 38%	156 32%	133 30%	143 40%	95 38%
Not at all effective (+1)	412 39%	165 32%	247 45%	119 34%	136 38%	158 45%	183 37%	229 41%	90 44%	138 38%	74 35%	110 39%	140 38%	272 39%	238 37%	85 37%	89 48%	138 34%	67 41%	207 42%	186 41%	129 36%	97 38%
Don't know	45 4%	23 5%	21 4%	13 4%	7 2%	25 7%	16 3%	29 5%	13 6%	14 4%	10 5%	8 3%	9 3%	36 5%	22 3%	9 4%	14 7%	10 2%	3 2%	32 7%	29 6%	11 3%	6 2%
Mean	1.86	2.00	1.73	1.93	1.90	1.75	1.87	1.85	1.81	1.86	1.90	1.87	1.86	1.86	1.87	1.96	1.69	1.97	1.80	1.79	1.84	1.87	1.86
Std. Dev.	0.850	0.886	0.795	0.833	0.857	0.852	0.823	0.874	0.888	0.841	0.828	0.853	0.828	0.862	0.832	0.899	0.830	0.858	0.806	0.851	0.892	0.807	0.840
Std. Error	0.027	0.042	0.033	0.047	0.045	0.046	0.038	0.037	0.062	0.045	0.059	0.052	0.045	0.033	0.033	0.063	0.061	0.044	0.064	0.039	0.043	0.043	0.054
Error Variance	0.001	0.002	0.001	0.002	0.002	0.002	0.001	0.001	0.004	0.002	0.003	0.003	0.002	0.001	0.001	0.004	0.004	0.002	0.004	0.002	0.002	0.002	0.003

**B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND
"EXTENDING OPENING HOURS FOR LICENSED PREMISES"**

BASE : ALL RESPONDENTS

B.3 WHETHER HAVE EVER CONTACTED A SERVICE OR ORGANISATION FOR HELP OR ADVICE ABOUT ALCOHOL

	TOTAL	Yes - on my own behalf	Yes - on behalf of someone else	Yes - total	No	Don't know
Unweighted base	1061	21	95	113	946	2
Weighted base	1061	21	93	111	948	2
Very effective (+4)	36 3%	2 9%	3 3%	5 4%	31 3%	-
Fairly effective (+3)	197 19%	6 28%	16 17%	22 20%	175 18%	-
Not very effective (+2)	371 35%	3 14%	24 26%	25 22%	345 36%	1 56%
Not at all effective (+1)	412 39%	10 49%	48 52%	57 52%	354 37%	1 44%
Don't know	45 4%	-	2 2%	2 2%	43 5%	-
Mean	1.86	1.97	1.72	1.77	1.87	1.56
Std. Dev.	0.850	1.088	0.873	0.926	0.841	0.702
Std. Error	0.027	0.237	0.091	0.088	0.028	0.496
Error Variance	0.001	0.056	0.008	0.008	0.001	0.246

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

**B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND
"REDUCING OPENING HOURS FOR LICENSED PREMISES"**

BASE : ALL RESPONDENTS

	Total	SEX		AGE			CLASS		HOUSEHOLD SIZE				CHILDREN UNDER 16		MARITAL STATUS			WORKING STATUS			AREA		
		Male	Fe-male	16-34	35-54	55+	ABC1	C2DE	1	2	3	4+	Yes	No	Marr-ied	Sing-le	Widow /sep /div	Full time	Part time	Not Work-ing	West	East/South	North
Unweighted base	1061	469	592	325	372	364	474	587	217	363	208	273	355	706	651	210	200	383	162	516	453	357	251
Weighted base	1061	509	552	350	361	350	499	562	206	360	213	282	366	695	646	230	186	409	164	488	450	360	252
Very effective (+4)	81 8%	27 5%	54 10%	26 7%	25 7%	30 8%	24 5%	57 10%	23 11%	24 7%	17 8%	18 6%	30 8%	51 7%	39 6%	18 8%	24 13%	20 5%	17 10%	44 9%	42 9%	20 5%	19 8%
Fairly effective (+3)	214 20%	84 17%	130 24%	85 24%	64 18%	65 18%	94 19%	121 21%	38 18%	65 18%	41 19%	71 25%	89 24%	125 18%	121 19%	54 23%	40 22%	62 15%	44 27%	108 22%	93 21%	70 19%	51 20%
Not very effective (+2)	378 36%	184 36%	194 35%	133 38%	134 37%	111 32%	200 40%	178 32%	75 36%	124 35%	79 37%	100 35%	130 35%	248 36%	228 35%	90 39%	60 32%	156 38%	57 35%	165 34%	146 32%	135 38%	97 38%
Not at all effective (+1)	357 34%	196 39%	161 29%	101 29%	133 37%	124 35%	171 34%	186 33%	63 30%	136 38%	69 33%	89 32%	110 30%	248 36%	241 37%	65 28%	51 28%	165 40%	43 26%	150 31%	147 33%	130 36%	81 32%
Don't know	30 3%	18 4%	12 2%	5 1%	5 1%	21 6%	9 2%	21 4%	8 4%	11 3%	8 4%	4 1%	7 2%	23 3%	18 3%	3 1%	10 5%	7 2%	2 1%	22 4%	21 5%	6 2%	3 1%
Mean	2.02	1.88	2.14	2.11	1.95	2.00	1.94	2.09	2.10	1.93	2.02	2.07	2.11	1.97	1.93	2.11	2.21	1.84	2.22	2.10	2.07	1.94	2.04
Std. Dev.	0.933	0.882	0.961	0.913	0.916	0.966	0.860	0.990	0.979	0.919	0.929	0.914	0.936	0.928	0.905	0.915	1.015	0.859	0.960	0.960	0.975	0.885	0.921
Std. Error	0.029	0.041	0.040	0.051	0.048	0.052	0.040	0.042	0.068	0.049	0.066	0.056	0.050	0.036	0.036	0.063	0.074	0.044	0.076	0.043	0.047	0.047	0.058
Error Variance	0.001	0.002	0.002	0.003	0.002	0.003	0.002	0.002	0.005	0.002	0.004	0.003	0.003	0.001	0.001	0.004	0.005	0.002	0.006	0.002	0.002	0.002	0.003

**B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND
"REDUCING OPENING HOURS FOR LICENSED PREMISES"**

BASE : ALL RESPONDENTS

B.3 WHETHER HAVE EVER CONTACTED A SERVICE OR ORGANISATION FOR HELP OR ADVICE ABOUT ALCOHOL

	TOTAL	Yes - on my own behalf	Yes - on behalf of someone else	Yes - total	No	Don't know
Unweighted base	1061	21	95	113	946	2
Weighted base	1061	21	93	111	948	2
Very effective (+4)	81 8%	2 9%	8 8%	8 8%	73 8%	-
Fairly effective (+3)	214 20%	3 13%	22 24%	25 22%	190 20%	-
Not very effective (+2)	378 36%	5 22%	28 30%	32 28%	345 36%	1 56%
Not at all effective (+1)	357 34%	12 56%	35 37%	45 41%	311 33%	1 44%
Don't know	30 3%	-	1 1%	1 1%	29 3%	-
Mean	2.02	1.76	2.03	1.97	2.03	1.56
Std. Dev.	0.933	1.024	0.976	0.975	0.928	0.702
Std. Error	0.029	0.223	0.101	0.092	0.031	0.496
Error Variance	0.001	0.050	0.010	0.008	0.001	0.246

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

**B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND
"PROVIDING MORE INFORMATION/ EDUCATION ON THE DANGERS OF DRINKING"**

BASE : ALL RESPONDENTS

	Total	SEX		AGE			CLASS		HOUSEHOLD SIZE				CHILDREN UNDER 16		MARITAL STATUS			WORKING STATUS			AREA		
		Male	Fe- male	16 -34	35 -54	55+	ABC1	C2DE	1	2	3	4+	Yes	No	Marr- ied	Sing- le	Widow /sep /div	Full time	Part time	Not Work- ing	West	East/ South	North
Unweighted base	1061	469	592	325	372	364	474	587	217	363	208	273	355	706	651	210	200	383	162	516	453	357	251
Weighted base	1061	509	552	350	361	350	499	562	206	360	213	282	366	695	646	230	186	409	164	488	450	360	252
Very effective (+4)	309 29%	134 26%	176 32%	103 30%	118 33%	87 25%	137 27%	172 31%	52 25%	96 27%	67 31%	95 34%	115 32%	194 28%	187 29%	73 32%	49 26%	107 26%	52 32%	150 31%	159 35%	90 25%	60 24%
Fairly effective (+3)	502 47%	245 48%	257 46%	164 47%	172 48%	166 47%	253 51%	249 44%	91 44%	180 50%	95 45%	135 48%	174 48%	328 47%	317 49%	102 45%	82 44%	209 51%	79 48%	214 44%	203 45%	184 51%	114 46%
Not very effective (+2)	164 15%	90 18%	74 13%	53 15%	55 15%	56 16%	73 15%	91 16%	39 19%	57 16%	35 16%	33 12%	51 14%	113 16%	93 14%	37 16%	34 18%	62 15%	22 13%	81 17%	52 12%	59 17%	52 21%
Not at all effective (+1)	73 7%	38 7%	35 6%	27 8%	13 4%	33 9%	30 6%	43 8%	19 9%	22 6%	14 7%	17 6%	23 6%	50 7%	42 7%	16 7%	14 8%	29 7%	11 6%	33 7%	28 6%	24 7%	21 8%
Don't know	13 1%	2 *	11 2%	3 1%	2 1%	8 2%	6 1%	7 1%	5 3%	5 1%	2 1%	1 *	3 1%	10 1%	7 1%	1 *	5 3%	2 1%	1 1%	10 2%	7 2%	2 1%	4 2%
Mean	3.00	2.94	3.06	2.99	3.10	2.90	3.01	2.99	2.88	2.98	3.02	3.09	3.05	2.97	3.01	3.02	2.92	2.97	3.06	3.01	3.11	2.95	2.86
Std. Dev.	0.855	0.859	0.847	0.873	0.789	0.892	0.817	0.887	0.902	0.828	0.869	0.836	0.841	0.861	0.839	0.875	0.884	0.839	0.843	0.872	0.848	0.829	0.880
Std. Error	0.026	0.040	0.035	0.049	0.041	0.047	0.038	0.037	0.062	0.044	0.061	0.051	0.045	0.033	0.033	0.060	0.063	0.043	0.066	0.039	0.040	0.044	0.056
Error Variance	0.001	0.002	0.001	0.002	0.002	0.002	0.001	0.001	0.004	0.002	0.004	0.003	0.002	0.001	0.001	0.004	0.004	0.002	0.004	0.002	0.002	0.002	0.003

**B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND
"PROVIDING MORE INFORMATION/ EDUCATION ON THE DANGERS OF DRINKING"**

BASE : ALL RESPONDENTS

B.3 WHETHER HAVE EVER CONTACTED A SERVICE OR ORGANISATION FOR HELP OR ADVICE ABOUT ALCOHOL

	TOTAL	Yes - on my own behalf	Yes - on behalf of someone else	Yes - total	No	Don't know
Unweighted base	1061	21	95	113	946	2
Weighted base	1061	21	93	111	948	2
Very effective (+4)	309 29%	9 43%	26 27%	34 31%	275 29%	-
Fairly effective (+3)	502 47%	8 37%	49 53%	55 50%	445 47%	2 100%
Not very effective (+2)	164 15%	4 21%	11 12%	14 13%	150 16%	-
Not at all effective (+1)	73 7%	-	7 8%	7 7%	66 7%	-
Don't know	13 1%	-	-	0 0%	13 1%	-
Mean	3.00	3.22	3.00	3.05	2.99	3.00
Std. Dev.	0.855	0.783	0.844	0.840	0.858	0.000
Std. Error	0.026	0.171	0.087	0.079	0.028	0.000
Error Variance	0.001	0.029	0.008	0.006	0.001	0.000

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

**B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND
"IMPROVING SERVICES FOR PEOPLE WITH ALCOHOL PROBLEMS"**

BASE : ALL RESPONDENTS

	Total	SEX		AGE			CLASS		HOUSEHOLD SIZE				CHILDREN UNDER 16		MARITAL STATUS			WORKING STATUS			AREA		
		Male	Fe- male	16 -34	35 -54	55+	ABC1	C2DE	1	2	3	4+	Yes	No	Marr- ied	Sing- le	Widow /sep /div	Full time	Part time	Not Work- ing	West	East/ South	North
Unweighted base	1061	469	592	325	372	364	474	587	217	363	208	273	355	706	651	210	200	383	162	516	453	357	251
Weighted base	1061	509	552	350	361	350	499	562	206	360	213	282	366	695	646	230	186	409	164	488	450	360	252
Very effective (+4)	347 33%	156 31%	191 35%	139 40%	116 32%	93 26%	155 31%	192 34%	56 27%	117 32%	64 30%	111 39%	135 37%	213 31%	204 32%	91 40%	52 28%	117 29%	58 35%	172 35%	176 39%	109 30%	62 25%
Fairly effective (+3)	500 47%	241 47%	259 47%	159 46%	180 50%	160 46%	257 51%	243 43%	93 45%	160 44%	109 51%	137 49%	175 48%	325 47%	316 49%	101 44%	82 44%	214 52%	79 48%	206 42%	193 43%	182 51%	124 49%
Not very effective (+2)	132 12%	74 14%	58 11%	33 9%	42 12%	57 16%	52 10%	80 14%	30 15%	63 17%	25 12%	15 5%	31 9%	101 15%	79 12%	27 12%	26 14%	53 13%	11 7%	69 14%	45 10%	42 12%	46 18%
Not at all effective (+1)	40 4%	22 4%	18 3%	13 4%	10 3%	17 5%	15 3%	25 4%	6 3%	12 3%	9 4%	13 5%	14 4%	26 4%	27 4%	5 2%	8 5%	13 3%	8 5%	19 4%	15 3%	18 5%	8 3%
Don't know	42 4%	16 3%	25 5%	6 2%	12 3%	24 7%	19 4%	23 4%	21 10%	8 2%	7 3%	6 2%	10 3%	31 4%	19 3%	5 2%	17 9%	12 3%	8 5%	21 4%	21 5%	9 3%	12 5%
Mean	3.13	3.08	3.18	3.23	3.15	3.00	3.15	3.12	3.07	3.09	3.11	3.25	3.21	3.09	3.11	3.25	3.05	3.10	3.20	3.14	3.24	3.09	3.00
Std. Dev.	0.782	0.801	0.761	0.774	0.740	0.819	0.735	0.822	0.774	0.802	0.767	0.764	0.766	0.788	0.783	0.743	0.815	0.744	0.781	0.814	0.772	0.791	0.765
Std. Error	0.025	0.038	0.032	0.043	0.039	0.044	0.034	0.035	0.056	0.043	0.054	0.047	0.041	0.030	0.031	0.052	0.061	0.039	0.063	0.037	0.037	0.042	0.049
Error Variance	0.001	0.001	0.001	0.002	0.002	0.002	0.001	0.001	0.003	0.002	0.003	0.002	0.002	0.001	0.001	0.003	0.004	0.001	0.004	0.001	0.001	0.002	0.002

**B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND
"IMPROVING SERVICES FOR PEOPLE WITH ALCOHOL PROBLEMS"**

BASE : ALL RESPONDENTS

B.3 WHETHER HAVE EVER CONTACTED A SERVICE OR ORGANISATION FOR HELP OR ADVICE ABOUT ALCOHOL

	TOTAL	Yes - on my own behalf	Yes - on behalf of someone else	Yes - total	No	Don't know
Unweighted base	1061	21	95	113	946	2
Weighted base	1061	21	93	111	948	2
Very effective (+4)	347 33%	13 63%	43 46%	53 48%	293 31%	1 56%
Fairly effective (+3)	500 47%	5 25%	35 37%	40 36%	459 48%	1 44%
Not very effective (+2)	132 12%	3 13%	10 10%	11 10%	121 13%	-
Not at all effective (+1)	40 4%	-	4 4%	4 3%	37 4%	-
Don't know	42 4%	-	3 3%	3 3%	39 4%	-
Mean	3.13	3.50	3.28	3.32	3.11	3.56
Std. Dev.	0.782	0.727	0.818	0.799	0.777	0.702
Std. Error	0.025	0.159	0.085	0.076	0.026	0.496
Error Variance	0.001	0.025	0.007	0.006	0.001	0.246

SCOTTISH OPINION SURVEY - ALCOHOL MISUSE : JUNE 2001

B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND - SUMMARY

BASE : ALL RESPONDENTS

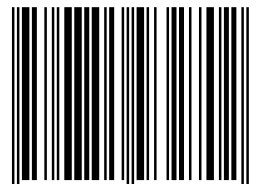
	TOTAL	VERY EFFECTIVE (+4)	FAIRLY EFFECTIVE (+3)	NOT VERY EFFECTIVE (+2)	NOT AT ALL EFFECTIVE (+1)	DK/NS	MEAN	STD. DEV.
Advertising campaigns on sensible drinking	1061	177 17%	462 43%	265 25%	134 13%	23 2%	2.66	0.909
Stricter enforcement of existing laws relating to drink driving, street disorder, licensed premises, under-age drinking, etc.	1061	548 52%	344 32%	109 10%	51 5%	9 1%	3.32	0.845
Extending opening hours for licensed premises	1061	36 3%	197 19%	371 35%	412 39%	45 4%	1.86	0.850
Reducing opening hours for licensed premises	1061	81 8%	214 20%	378 36%	357 34%	30 3%	2.02	0.933
Providing more information/education on the dangers of drinking	1061	309 29%	502 47%	164 15%	73 7%	13 1%	3.00	0.855
Improving services for people with alcohol problems	1061	347 33%	500 47%	132 12%	40 4%	42 4%	3.13	0.782

Page	Table	Title	Base	Totals
1	1	B.1 LEVEL OF AGREEMENT WITH THE FOLLOWING STATEMENT ABOUT ALCOHOL MISUSE "MEN ARE MUCH MORE LIKELY THAN WOMEN TO EXPERIENCE PROBLEMS WITH ALCOHOL"	ALL RESPONDENTS Weighted base	1061
2	1	B.1 LEVEL OF AGREEMENT WITH THE FOLLOWING STATEMENT ABOUT ALCOHOL MISUSE "MEN ARE MUCH MORE LIKELY THAN WOMEN TO EXPERIENCE PROBLEMS WITH ALCOHOL"	ALL RESPONDENTS Weighted base	1061
3	2	B.1 LEVEL OF AGREEMENT WITH THE FOLLOWING STATEMENT ABOUT ALCOHOL MISUSE "ALCOHOL MISUSE IS INCREASING AMONG YOUNG PEOPLE IN SCOTLAND"	ALL RESPONDENTS Weighted base	1061
4	2	B.1 LEVEL OF AGREEMENT WITH THE FOLLOWING STATEMENT ABOUT ALCOHOL MISUSE "ALCOHOL MISUSE IS INCREASING AMONG YOUNG PEOPLE IN SCOTLAND"	ALL RESPONDENTS Weighted base	1061
5	3	B.1 LEVEL OF AGREEMENT WITH THE FOLLOWING STATEMENT ABOUT ALCOHOL MISUSE "MOST VIOLENT CRIME IS ALCOHOL-RELATED"	ALL RESPONDENTS Weighted base	1061
6	3	B.1 LEVEL OF AGREEMENT WITH THE FOLLOWING STATEMENT ABOUT ALCOHOL MISUSE "MOST VIOLENT CRIME IS ALCOHOL-RELATED"	ALL RESPONDENTS Weighted base	1061
7	4	B.2 HOW CONFIDENT WOULD BE TO FIND AND CONTACT SERVICES OR ORGANISATIONS PROVIDING HELP AND ADVICE IF SELF OR SOMEBODY CLOSE TO SELF WAS EXPERIENCING PROBLEMS WITH ALCOHOL USE	ALL RESPONDENTS Weighted base	1061
8	5	B.3 WHETHER HAVE EVER CONTACTED A SERVICE OR ORGANISATION FOR HELP OR ADVICE ABOUT ALCOHOL	ALL RESPONDENTS Weighted base	1061
9	6	B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND "ADVERTISING CAMPAIGNS ON SENSIBLE DRINKING"	ALL RESPONDENTS Weighted base	1061
10	6	B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND "ADVERTISING CAMPAIGNS ON SENSIBLE DRINKING"	ALL RESPONDENTS Weighted base	1061
11	7	B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND "STRICTER ENFORCEMENT OF EXISTING LAWS RELATING TO DRINK DRIVING, STREET DISORDER, LICENSED PREMISES, UNDER-AGE DRINKING, ETC."	ALL RESPONDENTS Weighted base	1061

Page	Table	Title	Base	Totals
12	7	B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND "STRICTER ENFORCEMENT OF EXISTING LAWS RELATING TO DRINK DRIVING, STREET DISORDER, LICENSED PREMISES, UNDER-AGE DRINKING, ETC."	ALL RESPONDENTS Weighted base	1061
13	8	B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND "EXTENDING OPENING HOURS FOR LICENSED PREMISES"	ALL RESPONDENTS Weighted base	1061
14	8	B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND "EXTENDING OPENING HOURS FOR LICENSED PREMISES"	ALL RESPONDENTS Weighted base	1061
15	9	B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND "REDUCING OPENING HOURS FOR LICENSED PREMISES"	ALL RESPONDENTS Weighted base	1061
16	9	B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND "REDUCING OPENING HOURS FOR LICENSED PREMISES"	ALL RESPONDENTS Weighted base	1061
17	10	B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND "PROVIDING MORE INFORMATION/ EDUCATION ON THE DANGERS OF DRINKING"	ALL RESPONDENTS Weighted base	1061
18	10	B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND "PROVIDING MORE INFORMATION/ EDUCATION ON THE DANGERS OF DRINKING"	ALL RESPONDENTS Weighted base	1061
19	11	B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND "IMPROVING SERVICES FOR PEOPLE WITH ALCOHOL PROBLEMS"	ALL RESPONDENTS Weighted base	1061
20	11	B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND "IMPROVING SERVICES FOR PEOPLE WITH ALCOHOL PROBLEMS"	ALL RESPONDENTS Weighted base	1061
21	12	B.4 HOW EFFECTIVE THE FOLLOWING MIGHT BE IN HELPING TO TACKLE THE PROBLEM OF ALCOHOL MISUSE IN SCOTLAND - SUMMARY	ALL RESPONDENTS	1061

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