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TITLE

An exploration of the lived experiences of people with alcohol related harm in Scotland.

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An exploration of the lived experiences of people with alcohol related harm in Scotland.

Abstract

Background; Alcohol consumption has posed well documented problems for Scottish society, in terms of morbidity, mortality and wider societal costs.

Objectives; To investigate the lived experiences and drinking behaviours of people with alcohol-related harm in Scotland, against a backdrop of recent economic downturn, falling incomes, welfare reform and changes to state benefits.

Methods; As part of a larger Scottish study (2012-2014) of 639 individuals attending hospital or admitted, relating to an alcohol problem, 20 participants completed semi-structured interviews about their drinking and purchasing habits which were subjected to thematic analysis.

Conclusions; Key themes elucidated participants' everyday drink-related behaviours within their local environment including drinking triggers, sourcing alcohol, resourcing alcohol purchase and views relating to substitution. The majority of participants had experienced reduced income, and adapted their alcohol purchasing behaviours accordingly, including 'trading down' to cheaper alcohol. A reduction in food purchasing and heating was a common outcome, as was falling into, or increasing current, debt. More attention should be paid to the prevalence and accessibility of alcohol within local communities. Ultimately, as long as there is highly visible and easily accessible cheap alcohol, heavy drinkers may struggle to undertake positive steps to reduce their damaging consumption levels.

(197 words)

An exploration of the lived experiences of people with alcohol related harm in Scotland.

Introduction

Despite recent welcome improvements in Scottish alcohol-related mortality and morbidity statistics (Beeston et al., 2016), alcohol consumption still exacts a considerable societal cost. Comparison with Scotland's neighbouring UK countries is disconcerting (ONS, 2014); in 2012 the male alcohol-related mortality rate per 100,000 population in England was 14.7 (24.8 in Scotland) and for women the respective rates were 7.3 and 10.5 (ONS, 2014). In 2014, 18% more alcohol was sold per adult in Scotland than in England and Wales (Robinson et al., 2015).

Background

UK alcohol affordability has increased significantly (BMA, 2012); in Scotland it is currently 60 per cent more affordable than in 1980 (Scottish Government, 2015a). Research shows a positive relationship between affordability and consumption (Anderson & Baumberg, 2006). However, of relevance, are several factors impacting on personal finances, e.g. economic downturn (2007-2013) and increasing prices, UK welfare reform (HM Government, 2012) including housing benefit (which has for many resulted in social benefit delays, reductions and sanctions), falling incomes and unemployment (Scottish Parliament, 2015). Those within the lower Scottish Index of Multiple Deprivation (SIMD) quintiles (Scottish Government, 2012) are particularly impacted.

In Scotland, alcohol is available as 'on-sales' (public houses, bars, restaurants) and off-sales (supermarkets, off-licences, corner shops etc.). In the latter case, the alcohol cost price is typically considerably less than that paid for on-sales; an average of 52 pence per unit (ppu)

compared to 166ppu in 2014 (Robinson et al., 2015). (One UK unit of alcohol equals 8g of pure ethanol). Off-sales account for the majority (72%) of Scottish alcohol purchases (Robinson et al. 2015), and for 95% of sales amongst those with alcohol-related harm (Gill et al., 2015). Off-sales are consumed off the premises, typically at home, or outside in the street. The number of off-sale licenses issued in Scotland has gradually increased over the past few years (Scottish Government, 2015b).

Deprivation has an important impact on Scottish consumption; those who live in the least deprived areas are most likely to drink at increased levels, those in the most deprived areas less so (Shipton & Whyte, 2011). However, the most deprived heavy drinkers experience a disproportionately higher level of harm attributable to alcohol (MacNaughton & Gillan, 2011). For example, in 2014/15, the hospital stay rate for patients with alcohol-related conditions was nearly eight times greater for those living in the most deprived areas compared to those in the least deprived (ISD, 2015). Nevertheless, recent research indicates that the cheapest drinks are not the preserve of the most deprived drinkers, being purchased across all income groups (Black et al., 2011; Rice, 2014).

Scottish governmental responses have included a range of control and prevention measures viz. Changing Scotland's Relationship with Alcohol: A Framework for Action (Scottish Government, 2009), which adopts a whole population approach. To mitigate the effects of low cost and easily accessible alcohol, perceived by government as key factors leading to increased alcohol consumption, the Alcohol etc. (Scotland) Act 2010 (Scottish Parliament, 2010) was implemented in October 2011 and aimed to protect public health by banning quantity discount purchasing and restricting alcohol promotions in off-sales premises. There was a reported consequential reduction in off-trade alcohol sales ascribed to a decrease in

wine sales, but little evidence of an impact on beer, spirits and cider sales (Beeston et al., 2016). Nakamura et al. (2014a) found that banning alcohol multi-buy promotions in Scotland did not reduce alcohol purchasing in the short term, suggesting that wider regulation of price promotion and price would be required.

A further constituent of the comprehensive strategic approach is to reduce alcohol consumption through tackling affordability. Over half (52%) of off-trade alcohol sold in Scotland in 2014 retailed below 50ppu of alcohol (Robinson et al., 2015) equivalent to the minimum unit price considered following ruling of the Alcohol (Minimum Pricing) (Scotland) Act 2012 (Scottish Parliament, 2012). The Act's legality in relation to international trade agreements was challenged by trade bodies representing alcohol producers, and referred to the European Court of Justice. Currently, the outcome, and therefore any implementation date of the Act, remains uncertain.

The heaviest consumers regularly drink alone at home or in domestic premises with other heavy drinkers, as it is cheaper, and perceived as physically safer (Foster & Ferguson, 2012). Though targeted by policy change, their lifestyle likely excludes them from evaluative population level surveys and thereby the informing of theoretical modelling approaches (Sheron, 2014). We have reported elsewhere on the complex inter-relationship between heavy drinkers and their family and friends, who frequently provide practical and financial support, but are heavily relied on by the most disadvantaged drinkers (O'May et al., 2016a), and the views of heavy drinkers on the proposed MUP policy (O'May et al., 2016b). However, description of the specific factors influencing alcohol affordability and accessibility for this community dwelling drinker group is lacking. We aimed therefore to explore and document the lived experiences and drinking behaviours of heavy drinkers,

against the backdrop of Scottish alcohol policy influences (Scottish Parliament, 2005; 2010; 2012) and economic downturn.

Method

This study is part of a two year longitudinal study (in two Scottish cities) involving 639 patients (attending hospitals as out-patient or in-patient as a result of alcohol-related harm) who were interviewed about their drinking and purchasing habits (for details, see Table 1).

Insert Table 1 about here

Participants were asked, approximately 18 months after recruitment to take part in an additional semi-structured face-to-face interview to explore their purchasing and consumption behaviours. Selection criteria were that they had previously been drinking heavily and that the average price they paid was less than 50ppu of alcohol. Care was taken to ensure that they were approximately representative of the total sample by gender, social deprivation quintile, age and site. Participants were contacted by telephone and interviews arranged. Of 28 participants contacted, three failed to respond, two declined to participate, and three failed to attend. Of the 20 interviewed, five declared they were not drinking at the time of the qualitative interview, but reported drinking heavily at some stage in the previous six months.

Prior to interview, participants received by mail details of interview topics, assurance of anonymity and confidentiality, and their right to discontinue the interview at any point, with no detrimental consequences. Interviews took place in a health service site familiar to the participant.

Interviews were conducted by the researchers who had administered the earlier quantitative interviews, to capitalise on the degree of trust already established. Each participant was

remunerated with a £10 gift voucher (high street store). Interviews (20-50 minutes in length) were conducted between October 2013 and March 2014, and recorded using an encrypted digital recorder. An additional member of the research team was also in attendance (with permission) to observe the interview, make notes, subsequently transcribe the recordings and analyse the data.

Interviews were transcribed verbatim, by the first author, and during this process initial thoughts and ideas were recorded as an essential part of the analytic process (Riessman, 1993). Experiential thematic analysis was conducted, which focused on the participants' standpoint, how they experienced and made sense of the world (Braun and Clarke, 2006). All transcripts were read several times to identify categories of relevance to the research aims; emerging themes and commonalities were noted. These categories were then grouped according to consistency in topic, as well as in relation to the research aims. Themes were thereby constructed, representing recurring topics.

Verification of coding was confirmed by a second research team member. All authors had iterative discussions regarding the construction of themes and their interpretation, using the constant comparative method to help identify reasons for patterns and contradictions in the data.

Ethical approval was provided by the NHS Research Ethics Committee and was reviewed by the relevant Caldicott Guardians. All participants gave signed consent to participate and be audio-recorded, and for their anonymised raw data to be used in publications.

Results

Drinkers described in detail how they negotiated, frequently on a daily basis, the external and internal challenges to maintaining their required levels of alcohol consumption. A number of

key themes identified from the data highlight participants' strategies and approaches, irrespective of their income or living conditions, necessitated by their dependence.

Drinking triggers

Stress and depression were reported as key stressors for drinking, and this participant had experienced the recent death of her partner and a parent

... as soon as something triggers my mood, I seem to hit back to the alcohol again. You know, I stop taking the Antabuse [medication] to enable me to drink, because I know that's my comfort zone ... I've already tried to take my life a few times. ... but simple wee things trigger my depression, it just pushes me over the edge [P6, female].

Another participant, who suffered depression following his parents' death, declared that drinking was the only thing that "blocked things out".

Often, despite not specifically planning to buy alcohol, respondents felt challenged when surrounded by alcohol marketing and advertising, or by premises which sold alcohol alongside other items.

... and I end up no food - alcohol. Because I see the sign ... and then it's like ticking in my head. Well if I just have this for the day, and I won't have any tomorrow, and each day, I think like this, and each day I keep saying to myself, right, I'm not buying any more alcohol ... never works, never works. [P6, female]

Another felt that by selling a litre bottle of spirits more cheaply than a 70cl bottle, supermarkets were encouraging people to buy more than they intended; *If you're getting it cheaper, you're going to buy more. You drink more, because it's cheaper, and you can afford more [P19, male].*

Christmas was highlighted as a particularly challenging time of year, with offers in shops and advertising on TV, which could act as a catalyst, at a time when even moderate drinkers stocked up on alcohol bargains

... when I came out of rehab, I relapsed at Christmas ... I don't know what made me do it, but I picked up 4 cans, and I enjoyed it, and that was it. And 2 days later, I was drinking again. [P10, male]

This was reinforced by another current abstainer who said he would have to avoid people who were celebrating

... the difficult time is going to be Christmas, my 50th birthday is next in 2 weeks' time, and these things going on. There will maybe be a trigger, aye, but I'm determined to keep going ... there's drink everywhere in the shop, that's what I'm kind of worried about ... but I'm going to try my best [P7, male]

Of interest are the reasons which some participants used to justify their own behaviour and associate the reason for drinking with other factors. One participant, who had been abstinent for six months, said he had started drinking again, subsequent to having obtained paid work;

Unfortunately, I managed to get a couple of wee jobs, and I didn't turn up for 5 days, and I went down and I bought 2 beers Unfortunately, after that, I went right back down to the shop, and I bought another 8 after that... and I never went back to work. [P1, male]

While another participant reported:

I was told, don't go back to work just yet ... my old boss ... was standing outside my front door, and he begged me to go back and work for him again. And I went back

to work, and I hated it. So I sort of let everybody down, they told me not to go back to work ... so I went back on the drink, coz I'd let myself down as well. [P12, male]

An inevitability about returning to drinking alcohol is implied in both the above examples; the first caused by having access to money, “*then I forgot what ... my main focus was, which was to get me better*” [P1, male], and the second, who indicated that feeling under pressure meant a return to alcohol.

Several participants had experienced seizures brought about by suddenly stopping or drastically reducing their intake. Fear of triggering a potentially fatal seizure was cited as a reason to continue drinking. One reported using alcohol in a controlled fashion, ensuring that he always had some available upon waking.

... but I'm up at 06.00, 06.30, and the first thing I'll do is I'll have a drink, and it's not to get drunk, it's just to stop shaking. It's like medicine. And then I'm like that all the way through the day, right up until I go to bed. So even though 4-5 litres of strong white cider sounds a lot, for me, because of the tolerance, my body asks for it. I don't actually get drunk on that. ... I always make sure that I've got something to drink the next day anyway ... I'll probably buy an extra bottle ... that I won't even open, and that will be for when I get up. [P5, male]

Sourcing alcohol

Many purchased from a favourite outlet in their locality, but on occasion bought elsewhere, whether a local licensed grocer (corner shop) or a supermarket. Cheapest price or geographical proximity would determine which. Practical issues, such as the weight and bulk of bottles and cans, and access to public transport, dictated how and where some participants shopped.

... so sometimes I do my shopping and then just go ... 80 yards down the road to my local shop, and get it there, the [cider], which is more expensive, but it still does the same job ... Because I can't carry the beer and the shopping at the same time, usually. Maybe one bottle of cider, and some shopping, but not a full week's shopping and cider, or beer. They're both fairly heavy things. [P9, male]

One participant looked for deals while shopping for food, and then friends would drive him to the supermarket so he could buy a 20-can pack of cider. Physical health could be pertinent

But sometimes ... if my back is too sore to walk that distance, I just go to the corner shop which is like two about minutes away from the house. So that is the difference, 70p – it's either having an extremely sore back and walk for 70p, or go to the corner shop [P6, female].

Others stated that they did not seek out special offers but shopped locally, regardless of the price. Just getting alcohol was the priority for some, but the majority of participants generally looked for local deals or offers (despite the fact that these were banned following the Alcohol etc. (Scotland) Act (Scottish Parliament, 2010), irrespective of the provider. All participants reported having several outlets selling alcohol very near their home. A ubiquitous local supply was noted *“It's too easy to get hold of it. It's just too easy”* [P8, male], and *“It's in every shop where I stay ... it's in your face every time you walk in”* [P18, male].

Resourcing the purchase of alcohol

For the majority, sourcing cheap alcohol locally was a priority. Some addressed financial difficulties by pooling money, alcohol, or both, with others in a similar situation. State benefits could be shared

... because it sort of spreads the money out ... and well, it's just like a wee vicious circle, we all help each other out, when somebody's not got any money, well, he gets paid tomorrow, so it just works like that ... [P12, male]

Others never shared resources, describing themselves as 'lone drinkers', for whom borrowing money was the preferred way to enable them to continue buying alcohol. Sometimes this was done under false pretences "*I use the excuse that it's to get power for my electric and stuff, but I've already covered the bills, so em, I'm lying to people to get money for alcohol.* [P6, female].

Informal credit was obtained from local licensed corner shops, usually when waiting for benefits, or wages, to come through

Yeah, I could walk in, and say I'll pay you when I get paid ... I could only get up to a certain limit ... the highest I went to was £36, and I went back down actually the same night, and he said, "I cannae do it", and I says, "I've only got 2 days till I get paid", and he said "you've got £36 on there, so I cannae do anything else for you". [P1, male]

Some drinkers varied the type of beverage, but kept the volume of consumption the same, while others bought the same product daily, for example, eight litres of white cider in one case. Switching to a cheaper brand or type of alcohol was generally triggered by a reduction in income

I have been buying cheaper drink, em, because access to money has been more difficult. Because my husband if I do have a relapse, he'll take my card off me, and ... whatever money I've got, I go for the cheaper option rather than going for the nice bottle of wine that I would usually go for [P4, female]

For several, a reduction in income was caused by changes to welfare policy, which in turn necessitated a reduction in alcohol purchases, such as switching from a full bottle of vodka, to a half bottle. Rent rises and increased household bills impacted on available monies

... but with money being fairly tight, my drinking has been a bit limited. My rent has gone up ... an increase of £10 a month ... my council tax has gone up, and eh, also my heating has doubled this year. ... I'm finding things have changed a lot because I'm having to find an extra £40 per month for bills this year [P9, male]

This participant stated that as food was a priority, he would cut back on his alcohol consumption and switch to cheap cider. However, others said they would eat less to pay for alcohol.

Well, I'll eat once a day, so I can afford my alcohol before I can feed myself. It's like, drink comes before food, definitely. ... food doesn't make me feel better, drink does [P15, male]

The predicament I'm in now, it's drink or heating the house, basically. Food doesn't really come into it [P17, male].

Debt was common, particularly regarding utility providers

I struggle to pay my electricity, it's a card meter, and in fact, I've not paid my gas since January [9 months], and that does my heating and hot water, coz it's either pay the gas or pay the electricity, or don't drink and pay both. [P5, male]

One participant said she had not paid her phone bill and had bought less, and cheaper, food in order to afford alcohol, and had in the past borrowed money to pay her electricity when she had spent all her money on alcohol.

The perpetual cycle of borrowing money, being in debt and paying money back, was highlighted

I'll borrow money that I can afford, and then have to pay it back, and then start all over again. It's payday is pay out day, so I'm always behind [P15, male].

A few participants reported budgeting, such that they paid their bills, shopped for essentials, which for some included food for their dog, and then bought alcohol with what they had left

I'm on benefit, and I get paid fortnightly. The one thing I always make sure is, well 95% of the time anyway, is when I get my benefit, I'll go out and I'll buy 2 weeks' worth of groceries that I need, so I know that is always there. And I do the same for the dog. ... And then I'll buy alcohol. [P5, male]

Views relating to substitution

Opposition to utilising counterfeit or illicit alcohol to counteract increased alcohol prices, or to supplement alcohol purchases was unanimous. Health scares and concerns around potential contaminants, such as methanol were mentioned. There was an acknowledged irony regarding their fear of poisoning or harm given the potential toxicity of alcohol

I know it sounds funny, but em, I'm scared of what I put in my body. I know if it's on sale in a supermarket, then it's relatively safe. I wouldn't know what I'd be buying, and I wouldn't know what was in it, and that would scare me. Which sounds mad because obviously you're putting poison into your body anyway, but I wouldn't buy it, because of the fear of what was in it [P4, female].

Another said “... Contraband and that, I would never dream of going near that, even though it's dirt cheap... I'm too worried about my health! [laughs]” [P6, female].

One respondent stated he knew where he could obtain cheap illegally produced strong amber cider, and also illicit vodka

Counterfeit alcohol – just now, I could get a bottle of, it says [name] vodka on it, but it's counterfeit, for £5, but I wouldn't buy that, because I don't know what is in it. It might not be ethanol, it might be methanol that's in it, and you wake up blind or something. I just wouldn't touch that. [P5, male]

Home-brewing was also dismissed because it was seen as laborious and participants felt that they would probably resort to drinking it before it was ready. The use of drugs as an alcohol substitute was not mentioned by any participant.

Discussion

This is one of the first UK studies to explore the accounts of heavy drinkers, using a qualitative approach, which provides an insight into their experiences, practices and perspectives, and shows the complex choices, decisions and mechanisms worked through by these heterogeneous alcohol-dependent individuals. Strategies adopted to ensure an alcohol supply were wide-ranging, sometimes tried and tested, and at other times, reactive.

Participants were generally pragmatic, living for the 'here and now', rather than planning ahead. They were less protected from abrupt changes, such as price rises, or welfare reductions. Increased food prices and reduced income resulted in some participants cutting back on food and/or heating, in order to pay for alcohol. Many had electricity and gas prepayment meters (often the most expensive way to pay for services) and if unable to pay, jeopardised their supplies.

'External' factors, which were 'imposed' on them or were outwith their control, and which dictated, to a greater or lesser extent, their purchasing behaviour, such as price and

accessibility of alcohol, were described. Internal factors, including personal characteristics, indicated ways in which individuals attempted to organise and manage their alcohol consumption, or in the case of a few, abstinence. We explored with participants how they negotiated their alcohol purchasing and consumption on a day-by-day basis, against a backdrop of many changes. Additionally, we learned how for those actively trying to achieve or sustain abstinence, the ubiquity and proximity of alcohol outlets could prove highly challenging.

Our study has limitations, being exploratory and lacking generalizability. Participants were purposively selected to be representative of our total sample, but bias could have been introduced by the enrolment process, in which participants self-selected to participate in the one-to-one interview. Social desirability bias was a risk, participants providing information they thought we wanted to hear. However, this was the fourth interview for these participants, they had knowledge of the study and its aims, were familiar with the interviewer and conscious that the interviewer had no potential to impact on their treatment.

Policy changes which impact upon the price of alcohol, will inevitably affect this particular group of people, some more so than others. Of key importance is the ability to 'trade down' to cheaper brands and types of alcohol, and should that option be removed, following, for example, the introduction of MUP, then their ability to obtain alcohol, particularly in large quantities, will be severely restricted. Cook et al. (2011) reported that even if prices are increased, drinkers can avoid reducing their drinking through sacrificing other purchases or necessities. Our findings are in agreement, but for some drinkers there is currently the fall-back of cheaper alcohol. We documented a resistance to use illicitly produced alcohol, but were that to become the only source of cheap alcohol, drinkers' restraint could be sorely tested.

Proposed policy to introduce MUP is unlikely to be significantly regressive at the UK population level, but households containing the heaviest purchasers of alcohol would likely be the most affected (Ludbrook et al., 2012). Indeed, earlier work has shown the tendency of heavy drinkers to purchase cheaply, with mean prices well below the proposed MUP's fifty pence per unit (Black et al., 2011, Gill et al., 2015). Additionally, careful consideration needs to be given to the families of low-income harmful drinkers who might be disadvantaged if consumption is maintained, despite higher prices. These financial constraints may well be in addition to existing multiple stresses and coping dilemmas being experienced by affected family members (Orford et al., 2010), thereby putting them at increased risk for ill-health, potentially resulting in increased personal and public service costs (Orford et al., 2013). Ideally, pricing policies would be supported by adequate social care and alcohol support services, which include affected family members. Certainly, some authors (e.g. Duffy & Snowdon, 2012) suggest that the modelling used for minimum unit pricing impact underestimates the economic effect on heavier drinkers, owing to the disproportionate quantity of alcohol they consume. However, the review by Makela et al. (2015) advocates that policies which aim to keep the price of alcoholic drinks high, and particularly those having a stronger effect on the consumption of the lower income drinker, such as MUP, may help to minimize the overall level of alcohol-related health problems and thereby reduce absolute inequalities.

Conclusions

Despite recent changes to the UK welfare system and an economic downturn, most participants were still able to maintain consumption levels, especially those consuming the cheaper drinks, namely white cider and vodka. This maintenance, however, depended on the

mechanisms employed, which often impacted for example on food intake, or ability to pay utility bills.

In a recent systematic review, Gmel et al. (2016) found evidence of an association between alcohol outlet density and harm but little evidence of causality, and concluded that alcohol outlet density had minimal effect on individual-level alcohol use. However, regarding accessibility, all our participants reported having supermarkets or corner shops, often several, close by, making it easy to buy alcohol, “*too easy*” as stated by one respondent. This is consistent with the reported increase in off-sale licenses (Scottish Government, 2015b), and the findings of Forsyth et al. (2014) that most of the shopkeepers they interviewed in Glasgow served customers who tended to live locally and were personally known. The positioning of alcohol alongside other merchandise, making its purchase harder to resist when shopping for food or other household products, has been reported by others (Nakamura et al., 2014b). Crucially for those trying to sustain abstinence, the large and numerous discounts and heavy seasonal promotion of cheap alcohol, particularly around Christmas and New Year, were problematic.

We have described the mechanisms by which greater affordability and availability of alcohol contribute to higher levels of drinking among already heavy drinkers. Richardson et al. (2015) found significantly higher rates of alcohol-related morbidity and mortality in neighbourhoods with higher alcohol outlet densities, and in more income-deprived neighbourhoods. While cheap alcohol remains highly visible and easily accessible, Scotland’s alcogenic culture will be slow to change. The success of population wide approaches may depend on parallel changes in drinking culture. Cohn (2016) suggests that policy makers would do well to take into account existing beliefs and attitudes at population level, and treat them as potentially productive resources to ascertain the cultural acceptability of

interventions designed to address heavy drinking. Certainly, it will be important to evaluate the impact of MUP, particularly among marginalised harmful drinkers who purchase almost exclusively cheap alcohol, such as those recruited to this study, if and when it is introduced.

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