ALCOHOL MISUSE INFORMATION
IN SCOTLAND

Report to
The Scottish Advisory Committee on Alcohol Misuse

Dr. Lesley Graham
Mrs. Margaret Davies
Mr. Peter Knight

Information and Statistics Division
December 2000
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INTRODUCTION

1.1 Background

In 1992, the document Scotland’s Health A Challenge To Us All\(^1\) identified alcohol misuse as a problem. A national target had been set to reduce alcohol consumption of those drinking to excess by 20% from 1986 figures.

In 1998, the government published Towards a Healthier Scotland\(^2\), establishing alcohol misuse as a government priority and setting out new national targets for 1995-2010 ‘to reduce men and women (age 16-64 years) exceeding weekly limits from 33% to 29% and 13% to 11% respectively’. Concurrently, a report was produced\(^3\) by the working group set up to consider the recommendations of a National Conference on Alcohol held in October 1997. This had identified the need for robust information on alcohol misuse. The report recommended the setting up of a national committee, which would advise on information needs.

The Scottish Advisory Committee on Alcohol Misuse (SACAM) first met in April 1999. One objective of the first Action Plan\(^4\) is to ‘develop and implement a Scottish Alcohol Misuse Information Strategy’. In order to inform that strategy, in May 2000, the Information and Statistics Division, Scotland (ISD) was commissioned to undertake a scoping study of alcohol misuse information. This report presents the findings of that study.

1.2 Aim

To carry out a critical appraisal of alcohol misuse information which could contribute to the development of a Scottish Alcohol Misuse Information Strategy.

1.3 Objectives

1. To identify and describe the information on alcohol misuse currently collected and/or used by service providers.
2. To identify the uses made of the information.
3. To describe the strengths and limitations of such information.
4. To identify any information gaps.
5. To seek views on how alcohol misuse information would be most appropriately delivered.
6. To engage the field in the development process.
7. To report findings and outline possible options.

1.4 Approach

In order to obtain as wide a perspective as possible, it was essential that a large cross section of users and providers of information were able to contribute. The scoping exercise adopted two complementary approaches. A broad-brush approach was taken by conducting a postal survey (for questionnaire, see Appendix 1) of key service providers (Appendix 2). A more
in-depth approach was carried out through a series of semi-structured interviews with key informants in the alcohol field (see Appendix 3 for interviewees). Where relevant, the results were supplemented by additional research.

A wide ranging response was received with representation from key agencies (see Appendix 2).

1.5 Report Format

The report is divided into three parts. Part One (Introduction) gives a background and description of the scoping study. Part Two provides a detailed account of Alcohol Misuse Information in Scotland, drawing extensively on the findings of the postal survey and interviews. Part Three (Conclusions) discusses the key findings and suggests proposals for consideration in the development of an Alcohol Misuse Information Strategy.

1.6 Acknowledgements

The Information and Statistics Division is extremely grateful for the support given to it by all the respondents who contributed guidance and opinions, often providing considerable detail, on the important information issues in the alcohol misuse field.

Data entry and administration of the survey was carried out by Martin Hunter.
INTRODUCTION

The information scoping study has highlighted the considerable range of information on alcohol misuse. The following summary of sources includes information that is provided in reports and statistical bulletins, including those from routine data collection and surveys. Some national and local datasets contain information that is not routinely published. A number of information systems overlap both health and social care settings reflecting their increasing convergence. There is also a wealth of health education/promotion material and the organisations providing this are noted. Detailed information is available from these organisations.

The information and data sources described have been compiled from interviews, postal questionnaires and supplementary research. The findings from the postal survey and interviews are the source of perceived gaps and of some comments on limitations and strengths of the data. Feedback from interviews and postal questionnaires has also helped to inform discussion of issues and options proposed at the end of each section. Material on information and data sources is organised under the following headings:

- Consumption
- Social Care
- Health Education/Promotion
- Ill-Health and Harm
- Crime and Criminal Justice
- Other: Costs; Occupational Health; Research

Part Two concludes with a summary of the reported uses made of alcohol misuse information and the preferred means of improving accessibility.
2.1 ALCOHOL MISUSE INFORMATION: CONSUMPTION

Consumption data describe trends in population behaviour with regard to drinking of alcohol. Consumption data quantifies how many people are potentially at risk through drinking to excess. In recognition of this, national targets to reduce excess consumption have been set in Scotland. Routine consumption data are required for monitoring these targets.

Data on consumption can be either at a population or individual level. Population consumption data is derived from the overall amount of alcohol consumed by a population and is usually calculated per capita. An example of this is the volume of alcohol on which duty has been paid (see Customs and Excise below). By contrast individual consumption data is derived from the amount of alcohol consumed as reported by an individual. Individual consumption is usually described in units of alcohol where 1 unit = 8g alcohol = 10ml of 100% alcohol (roughly equivalent to 0.5 pint beer a small glass of wine or a single measure of spirits). It is reported as either daily or weekly consumption. Other indicators include amount consumed at any one time.

2.1.1 Population Consumption

Customs and Excise

Per capita consumption can be derived from Customs and Excise statistics. These calculate per capita consumption of 100% litres of alcohol based on duty paid. They are not derived at points of sale and therefore are not available at local level (i.e. to Health Board/Council level). Only alcohol on which duty has been paid is included. Home brewed alcohol and imported alcohol is not included. Figures do not include alcohol consumed abroad (e.g. on holidays) or purchased illegally such as from smuggled sources. The statistics include alcohol consumed by overseas visitors and alcohol on which duty has been paid but not consumed. They are available by type of beverage. One advantage of this data source is the ability to compare with international figures.

Licensing data

Although not strictly population consumption, licensed premises are directly associated with the availability of alcohol. Licensing information can be used indirectly as a proxy for population consumption. The numbers of liquor licenses by type of premise are collected by Local Councils (Licensing Boards). A central return is made to the Scottish Executive Criminal Justice Department. The information is published in a Statistical Bulletin (Liquor Licensing Statistics) and is also available on the Scottish Executive web site.

2.1.2 Individual Consumption

a) National Surveys

Most information on individual consumption is gathered from routine population surveys. There are five major national surveys undertaken in Scotland.
General Household Survey (GHS)\(^7\)

This is a U.K. wide survey by self-completed questionnaire. The survey has included questions on alcohol every two years since 1978. It samples ages 16 and upwards though prior to 1988, only 18 year olds and over were included. The survey reports average weekly consumption (by type of beverage) and consumption on the heaviest day during the previous week, as units of alcohol. Since 1998, questions have been added to be able to report daily benchmark consumption, in line with the Government’s revised sensible drinking advice. The main strengths of the GHS are the availability of trend data and comparability with the rest of the U.K. The weaknesses include those applicable to many population surveys such as the possible under-reporting of consumption. The sample size in Scotland is less than 2000 so disaggregation of data to sub national level is problematic because of small numbers.

Scottish Health Survey (SHS)\(^8\)

This is a Scottish wide survey employing a variety of methods. Interviews are carried out and augmented with an examination by a nurse, including blood sampling. Special self-completing questionnaires are given to 16 and 17 year olds so they will not be overheard. The first survey was carried out in 1995 with a further survey in 1998. It is to be repeated every 3 years. The sample covers ages 16-64 years but excludes those of all ages living in institutions and the homeless. The sampling was designed to be representative to regional level, as defined by the Scottish Health Survey (7932 interviewed in 1995). Seven regions were defined by aggregation of Health Boards e.g. Lothian and Fife. The questions on alcohol are broadly similar to those used in the GHS prior to 1998. It also assesses alcohol problems using CAGE, a validated screening instrument\(^9\).

The main advantages of the SHS are the availability of consumption data for Scotland down to geographical region and the ability to make comparisons with both the GHS and the English Health Survey (which both use similar methods). Trend data will become available over time. Disadvantages include omissions of those aged over 64, younger teenagers and the homeless. The sampling is only to regional level which does not necessarily correspond to service delivery patterns.

Health Education Population Survey\(^10\)

This has been carried out by the Health Education Board for Scotland (HEBS) every 6 months since 1996 using computer assisted personal interviews. The survey samples ages 16-74. It asks a series of questions on alcohol. It does not assess daily/weekly consumption but does enquire about drinking excessively. In particular it asks about unit awareness and knowledge of safe limits. Limitations of the survey include the small sample size (900) and the lack of compatibility with the SHS and GHS on consumption. One strength is the assessment of respondents knowledge of units as a measure of consumption, an integral part of sensible drinking advice.
Smoking, Drinking and Drug Use among Young Teenagers

This is a biennial survey carried out in the U.K. with an individual report for Scotland. The series began in 1982, but drinking was not covered in Scotland until 1990. The survey is carried out by self-completed questionnaire in school with interviewer present (but no teacher). A sample of schoolchildren aged 12-15 (3538 in 1998) is taken from a sample of 150 schools (including independent schools) throughout Scotland. Questions on drinking were first included in 1990. These ask if alcohol has been drunk in the last 7 days, how much, and by type of beverage. The amount is reported in units of alcohol. Further questions include with whom the school children in the sample drank and where alcohol was bought. The major advantage of this survey is that it covers young people of ages not included in the SHS and the GHS. As the survey is carried out every two years, changes in trends are timely. The weekly consumption methodology allows comparison with the adult surveys. One important limitation is that the sampling strategy does not permit estimates to be made at local level. The survey omits those excluded from school and does not include special schools.

Health Behaviour of Scottish Schoolchildren (HBSC)

This survey is part of an international study by the World Health Organisation and has been carried out every four years since 1990. It surveys 11,13 and 15 year olds from selected classes from schools in Scotland, stratified by Education Authority (5631 pupils in 1998). It is carried out by self-completed anonymous questionnaire in the presence of a teacher. It does not report unit consumption either daily or weekly. Questions include whether ever having been drunk and how often drink is consumed. Advantages of the survey are that the sample size is relatively large and that international comparisons can be made. Limitations include lack of reporting at local level and the lack of daily or weekly consumption to allow comparison with the other major surveys. This survey will also omit those excluded from school.

All surveys are subject to problems of potential bias from non responders. These may include people with different, possibly heavier, consumption patterns than responders.

b) Local Surveys

A number of Health Boards have carried out surveys of their local population in recent years. Six of eight Health Board responses to the questionnaire reported having carried out lifestyle surveys. These included questions on alcohol consumption. Some surveys were one-off whilst others are recurrent. One survey in Orkney was on alcohol use alone. Grampian has carried out a youth survey.

Local lifestyle surveys have the advantage of providing data on alcohol consumption for use at local level with numbers large enough to allow more detailed analysis by age and gender. However different surveys may use different methodologies when assessing consumption so that comparisons cannot always be made between different areas. In recognition of this problem, the Scottish Needs Assessment Programme (SNAP) developed a core set of questions for use in local lifestyle surveys. These are currently under review.
c) Patient/Client Contacts

Individual alcohol consumption is part of a routine medical history and should be collected in adult general medical/surgical/obstetric and psychiatric admissions to hospital (secondary care). In the primary care setting, alcohol consumption is usually enquired about at contacts such as a new patient consultation/well person check and opportunistically by primary care clinicians (GP/practice nurse/health visitor) (see Ill Health and Harm).

Attendance at specialist alcohol services (including voluntary agencies) involves an assessment of the patient/client problems and needs in relation to alcohol misuse. Not all services collect details on individual consumption.

It should be noted that individual consumption data alone does not indicate whether such consumption is problematic. However they form a useful benchmark in identifying those potentially at risk. They can be used periodically throughout treatment and as an outcome indicator. Information on drinking patterns can be helpful in establishing at risk consumption for example asking the most number of units consumed on a single day in the previous week. Excessive consumption can cause a wide range of problems: physical psychological and social. Many instruments used in screening for alcohol problems such as CAGE and AUDIT identify problems associated with misuse.

2.1.3 Perceived Information Gaps

One of the purposes of the information scope was to highlight the gaps in alcohol misuse information. The following are the gaps as reported from the survey and interviews regarding consumption data:

- a national lifestyle survey that samples from all Health Board areas
- data shown by age and gender, in particular for those under 16
- and at local level
- standardisation of data collection e.g. for measures of consumption
- type of beverage
- patterns of drinking (e.g. binge)
- trends over time
- awareness of the unit measures and sensible drinking

Perceived gaps in information on licensing concerned the following:

- information at local level
- by type of license
- trends over time
- mapping of licenses
2.1.4 Key Issues

Many organisations reported the value of consumption data for monitoring trends and targets. Respondents were concerned about the evidence of a rising trend of consumption by young people. They felt it important to be able to monitor trends in young people and children under 16 years old.

The fact that some of the perceived gaps are available from existing national surveys suggest this may be due to reasons such as lack of awareness, access skills and time for analysis and indicate a need for improved dissemination.

Undertaking several major school surveys is possible duplication of effort. The arrangements for future school surveys are currently being addressed by a review group led by ISD.

The interest shown in licensing data suggests that availability of these statistics could be more widely publicised.
2.2 ALCOHOL MISUSE INFORMATION: ILL HEALTH AND HARM

2.2.1 NHS Treatment

Patients with alcohol misuse problems come into contact with health services in a variety of settings and for a variety of reasons. Information may therefore be collected at various places and times during the course of a patient’s treatment and care. Data recorded within different settings may differ in content and in detail.

a) National Data from Hospitals

An important source of information on the health impact of excessive alcohol consumption is the continuously accumulating data collected on patients admitted to hospital. These data are supplied to ISD directly from NHS hospitals in Scotland on standard returns known as Scottish Morbidity Records (SMR’s). The relevant hospital SMR returns cover admissions to psychiatric specialties (SMR04), general acute specialties (SMR01) and maternity (SMR02).

Important features of these SMR returns are that they allow for the recording of both a main diagnosis and several supplementary diagnoses (based on the International Classification of Diseases (ICD) coding systems), the latter a frequent means of identifying cases where alcohol abuse is a relevant underlying issue for the treatment of the patient.

The returns are a rich source of demographic data, providing information on age, gender and place of residence. This allows further analysis by factors such as social deprivation or by at risk groups e.g. young people or women. The data provide evidence of the longer term impact of alcohol misuse e.g. alcohol psychosis, as well as short term complications of excessive use where patients may be admitted following injury, etc.

The SMR’s are reported on every new episode. One important feature of these SMR returns however is that it is possible to link records using probability matching techniques to analyse on an individual patient basis. Data based on these linked episodes are not routinely published at present, however ad hoc studies are carried out, subject to prior rigorous privacy guidance.

SMR01 and its earlier version (SMR1) have existed for almost 40 years, although the level of detail and completeness of diagnostic coding improved markedly with the introduction of the ICD9 (World Health Organisation’s International Classification of Diseases 9th Revision) diagnostic classification and a revision to SMR1 in 1980. Thus 20 years of data are available as a basis for analysis of alcohol-related conditions.

SMR04 differs from other SMR schemes in that it is a two-part return, corresponding to the patients admission to and discharge from hospital. Diagnoses may change from the diagnosis recorded at admission to that recorded at discharge. In general, diagnosis at discharge is normally considered to be the more accurate.
Certain patients require long term care due to alcohol related brain damage (Alcohol Dementia and Wernicke-Korsakoff syndrome). SMR 04 data can be used to identify those admitted but not discharged from hospital psychiatric inpatient care. Difficulty in assessing numbers of such patients in residential care was highlighted by a report of a Working Group in Glasgow.[13]

With regard to diagnoses associated with the misuse of alcohol, any examination of national data or comparison between different parts of the country has to be treated with caution as the practice of treatment of patients with a diagnosis of alcohol misuse may vary. Some areas continue to treat patients in an inpatient setting whilst others are treated in the community e.g. home detoxification.

Some alcohol related discharge information derived from the hospital acute and psychiatric data have been published annually since 1997 in Scottish Health Statistics[14], and are also presented on the Scottish Health on the Web (SHOW) website. Quarterly extracts of individual episode records are routinely provided by ISD to Health Boards.

Details about obstetric in-patient discharges are returned routinely to ISD by maternity hospitals on SMR02 forms. An associated return is the SMR11, the neonatal discharge record. There is no routine reporting of alcohol related diagnoses from SMR02 or 11 (conditions such as foetal alcohol syndrome are uncommon). It is probable that there is considerable underreporting of alcohol problems on the SMR02 returns.

It is important to stress that alcohol problems have first to be detected and then reported. Research studies have shown high prevalence of alcohol-related problems in both acute medical wards[9] and surgical wards[15] and the under-detection of those drinking to excess[9]. Introduction of staff training for detection of alcohol problems and services such as Alcohol Liaison nurses (e.g. at the Royal Infirmary in Edinburgh) have sought to address this.

b) Local Data from Hospitals

There seems to be few examples of additional local information collection within acute trusts specifically relating to alcohol. However, one local area reported collection of alcohol related problems for in-patients referred to an alcohol liaison service (Edinburgh Royal Infirmary). West Lothian Healthcare Trust had carried out a one-off review of alcohol related activity to inform local planning. Two trusts (Borders General Hospital Trust and St. John’s Hospital, part of West Lothian Healthcare NHS Trust) reported that they identified alcohol issues in their local collection of information on A&E attendances. The Inventory of Services[16] which is being prepared separately from this information scoping study will provide more information on local data collection in acute trusts.

c) National Data from NHS Primary/Community Care

Doctors, community and practice nurses, and other professionals in the primary care and community settings will frequently meet patients with alcohol problems. There are several sources of information available from this broad setting.
Continuous Morbidity Recording (CMR) is a national data collection scheme of morbidity data from primary care. Diagnostic data is returned from every doctor patient contact. Diagnoses are coded using Read codes, a coding system developed for use in primary care. Diagnostic codes can be mapped to ICD 10 codes, allowing comparison with hospital derived data. At present, 74 practices throughout Scotland (a nationally representative sample) return data monthly to ISD. CMR allows estimation of workload, incidence and prevalence of alcohol related attendance for GPs in general practice. CMR data is subject to quality assurance. CMR data is published in Scottish Health Statistics and on a dedicated website. Alcohol misuse is not however regularly reported.

Patients with alcohol related problems attend other members of the primary care team (e.g. practice nurses may detect problems at well person checks). Collection of morbidity data from Practice Nurses is scheduled to commence shortly in approximately 40 practices. Data collection from Health Visitors and District Nurses is being developed and is established in 9 practices.

CMR and Primary Care Nurse Data Collection are the only routine national source of primary care data.

The Scottish Drugs Misuse Database (SDMD), supported by ISD, collects anonymous data (SMR 22/23) on new problem drug users seen at a range of services mainly general practice and specialist drug services. Whilst a description of this data source is provided here under the heading of NHS services it is important to note that information is also returned from non statutory services and from specialist social work services. The Scottish Prison Service which otherwise does not report alcohol related problems nationally is intending to contribute to the SDMD from next year.

Alcohol is recorded on the SDMD if it is recognised by the doctor/other professional as a concomitant problem to other drug use. A feature of the SDMD is the possibility of assessing incidence of dual dependency in those attending drug services.

Detailed statistical tables (including the number of individuals who report using alcohol by health board and council area) are published by ISD in the annual bulletin, Drug Misuse Statistics Scotland17.

The SDMD currently only holds information on new patients/clients and no information is available on continuing contacts and outcomes. However, as part of the drugs information strategy, the development of the SDMD to allow re-reporting in certain specified cases is planned.

Many patients with an alcohol problem will receive treatment from generalist health care professionals in the community setting e.g. Community Psychiatric Nurses or from community based specialist alcohol services. There is no routine data collection from NHS community services on alcohol misuse.

The Scottish prison health service is currently reviewing its information system.
d) Local Data from NHS Primary/Community Care

Undertaking the postal survey has provided valuable indication that data is available at local level across Scotland. The content of datasets is specific to each local area but generally data seems to cover routine patient data and staff activity. A number of Primary Care Trusts, particularly those providing alcohol and substance misuse services (outpatient, inpatient and community based) report having substance misuse databases including Borders, Tayside, Forth Valley, Dumfries and Galloway Primary Care Trusts and Fife Home Detoxification Service. A number of respondents reporting local data included copies of forms or a note of the data items with their completed questionnaires. Ayrshire and Arran Primary Care Trust provided a set of guidance documents on the Common Addictions Database. This is the central database for agencies providing alcohol services in Ayrshire and Arran. Grampian Primary Care Trust Substance Misuse Service is aiming to provide their alcohol services with the system used in collecting drug misuse information in the near future.

Two ad-hoc studies on prevalence of alcohol problems in primary care were reported (Glasgow and Highland).

2.2.2 Perceived Information Gaps

Many of the information gaps mentioned in the survey apply not just to NHS data but to the alcohol field in general. Some of the gaps apply to multi-disciplinary working and to Social Care (see below).

Gaps specifically relating to NHS derived data:

- local data
- (SMR) data is episode not patient based
- absence of linked data
- lack of links with other agencies
- referrals
- outpatients data not diagnostic
- data from A&E (large proportion of attendees will have alcohol involved)
- outcome data
- information from GPs-prescribing/contacts
- overall numbers using health services
- distinction of alcohol from drugs
- under recording of alcohol diagnoses
- addiction severity

Information on specific conditions:

- dual diagnosis
- alcohol related accidents
- foetal alcohol syndrome
- alcohol and fire data
More generally:
- a directory of services
- levels of training of workers (for alcohol problems)
- core data set with medical and social history
- multi disciplinary data
- national alcohol database

2.2.3 Key Issues

One of the main issues for hospital in-patient data is the likely under reporting of alcohol related diagnoses. This can be due to lack of detection or lack of perception of alcohol problems as a ‘diagnosis’ to be recorded for SMR. Training and services such as brief intervention will be identified in the Alcohol Services Inventory currently underway\textsuperscript{16}.

Existing information is well used but there is a clear desire to have this reported to local level.

Definition of a national set of codes defining ‘alcohol related ill-health and harm’ (see also Deaths), would allow local analyses to make national comparisons and would improve consistency in reporting at national level.

Data linkage of SMR data would allow analysis by individuals as well as some tracking of pathways (within the SMR scheme). Given the multi-agency nature of alcohol services, tracking pathways between and through key services is not possible nationally at present. One example of a local data scheme that enables this is the Ayrshire and Arran Common Addictions Database. Development of patient pathways would also have to consider referral information.

A major issue is the absence of any alcohol misuse information from A&E departments in hospitals, where alcohol misuse is well known to play a major role in reason for attendance. There is no national routine data collection at present but any such development should consider the value of recording alcohol misuse.

Paucity of outcome information was highlighted. There are no existing national outcome indicators for alcohol misuse at present in Scotland. Development of nationally agreed outcome indicators would assist evaluation of services. The UK Clearing House for Health Outcomes reviewed potential health outcomes for alcohol misuse\textsuperscript{18}.

The lack of information from the primary care setting is being addressed through the development of CMR and Primary Care Nurse Data Collection. Development of a national set of Read codes defining ‘alcohol related ill-health and harm’, mapping to ICD 10 codes, would allow local areas to make national comparisons. There is still a need for development of an information system for the community mental health services\textsuperscript{19} which are increasingly delivering services, e.g. home detoxification, to those with alcohol problems.

There was a clear desire from respondents for, at minimum, a standard core dataset for use by those delivering alcohol services. Many suggested the establishment of a national alcohol misuse database similar to the Scottish Drug Misuse Database. Given the widespread treatment of alcohol problems by those in generalist services, careful consideration would
have to be given to issues of coverage/definition of an ‘alcohol service’/training etc.

2.2.4 Deaths

Death statistics have been collected since the 1840’s. All deaths are required by law to be registered. Data is computerised at point of collection and returned to the Registrar General’s Office (GRO). Data is published in an Annual Report by the Registrar General. Regular routine returns are made to Health Boards with Statutory weekly returns to Directors of Public Health.

The main cause of death is recorded with a further 3 underlying causes possible. Diagnoses are coded to the World Health Organisation’s International Classification of Diseases 10th Revision (ICD 10). For analysis by the GRO in Scotland, there is a set of codes that define ‘alcohol related death’.

Some validation is carried out by ISD against Scottish Morbidity Records (SMR) data. ISD routinely links death data to the national linked SMR01 and SMR04 datasets. The GRO statistics provide trend data over long periods of time and it is possible to make comparisons through use of international coding. Details include the individual’s postcode thus allowing geographical analysis.

A limitation of GRO statistics as an indicator of the harm associated with alcohol misuse is that alcohol related diagnoses are likely to be under-recorded, either due to lack of awareness of the problem by the certifying clinician (for example, if a post mortem is carried out, there is more chance of alcohol involvement being detected through a police report or toxicity levels) or reluctance to record alcohol problems on a death certificate which will be seen by relatives.

Ad-hoc studies have shown the extent of under estimation of deaths where alcohol is involved. In Australia, the National Alcohol Indicators Project has calculated the proportion of death and hospital admissions due to high risk drinking utilising an ‘aetiologic fraction’ formula.

2.2.5 Perceived Information Gaps

Alcohol related mortality was mentioned as an information gap in the postal survey.

2.2.6 Key Issues

The key issue is of completeness of recording of alcohol involvement. The GRO does produce a training pack with guidance on certification but it is uncertain to what extent this is applied. There also may be lack of awareness of the set of alcohol related codes for analysis. It was suggested by GRO that more emphasis on this topic in medical training would be useful.
2.3 ALCOHOL MISUSE INFORMATION: SOCIAL CARE

Social care for people with alcohol problems is delivered by both the statutory and non statutory sector by a variety of agencies. Care can be provided by either specialist or generic services. From the responses to the postal survey it is clear that the amount of data collection varies between agency type.

a) Social Work, Housing and Community Services

Those people who are recipients of social work services due to their alcohol problem are recorded on local social work information systems. Summary data are provided to the Scottish Executive and to Audit Scotland. Information on alcohol misuse may therefore be available within or from social work departments but due to limitations in local recording systems this may be confined to cases where alcohol is the main presenting problem. If alcohol misuse is not seen as the main problem, alcohol misuse as a factor may not be systematically recorded. This limits availability of knowledge on the extent to which alcohol is a contributory problem in peoples’ attendance at social work, and the level of alcohol misuse in the community.

Local research has recently been carried out in Central and South Aberdeenshire Social Work Departments on the prevalence of alcohol abuse in social work caseloads.

Looked After Children (LAC) i.e. children in care, have detailed data collected using standardised instruments. This may include details of alcohol misuse. Inspection reports of children’s homes are collected and these may include details of alcohol misuse. These reports are published by the Scottish Executive. Dumfries and Galloway conducted a survey in 1997/8 of children on a child protection register where alcohol was a significant factor.

A national return is made to the Scottish Executive by Councils on the number of residential care beds for alcohol/drug misuse. Beds for those with alcohol problems e.g. brain damage secondary to alcohol misuse are not identified separately.

ISD collects data from private nursing homes registered under the terms of the Private Nursing Homes Registration (Scotland) Act or the Mental Health Act. Information is available on the number of residents with alcohol related problems by health board and local council areas.

There is no routine data nationally on alcohol misuse problems among homeless people. A UK survey was conducted in 1996. In response to questionnaire items on data collection Glasgow, Edinburgh and Falkirk Councils replied that they record data in accordance with the Rough Sleepers Initiative (RSI). However, the dataset was designed to meet the information needs of the RSI and does not necessarily record items that are the most useful on alcohol misuse. Edinburgh and Glasgow both reported continuous data collection since 1998 on incidence of alcohol abuse in their rough sleeping populations. A local survey of homeless persons in Glasgow was carried out in 1999 showing a high prevalence of hazardous drinking. Local surveys were carried out in 1996 and 2000 in Glasgow of the
incidence of alcohol abuse of those living in hostels.

Data collection is more likely to be based on paper systems among voluntary organisations. Of the four voluntary residential care organisations that responded to the survey, three collect data on their clients, of which only one collection is computerised.

Daycare services are primarily provided by voluntary organisations, either self funded or contracted by the statutory sector. Of the seven organisations that responded to the postal survey, some collected data that was paper based, some had no data collection and one had a computer based collection scheme. All used different methods for collection.

b) Specialist Addiction Services

Social Work

Some social work departments have dedicated social workers for drug and alcohol services (e.g. Glasgow). Other departments have established or are establishing specialist teams. Substance misuse databases have been developed e.g. East Renfrewshire; Carefirst (Aberdeenshire/West Dunbarton); Christo Inventory for Substance Misuse Services (CISS) (Dundee). Some information on alcohol misuse may be reported to the Scottish Drug Misuse Database from specialist substance misuse teams where alcohol is reported as well as drug use (see section 2.2.1c for more details).

Local Councils on Alcohol (LCAs)

LCAs are the main voluntary groups providing dedicated alcohol services across Scotland. They are affiliated to the Scottish Council on Alcohol (SCA). In order to obtain information for managing services to clients the LCAs developed a computerised management information system (COMIS). The SCA is currently overseeing a review of the information system. The main purpose of the review is to move away from the existing DOS based system. COMIS collects data on all new contacts: demographic details, drinking patterns, number of contacts, referral source, progress (review every 4 sessions) which includes consumption and outcome. Main case notes are not recorded on COMIS. The current data content was felt to be reasonable by those LCAs responding to the postal survey, although ability to measure follow up and time spent with clients were mentioned as potential improvements. Statistics are collated nationally by SCA (aggregated summaries only) and fed back to the LCAs.

2.3.1 Perceived Information Gaps

The following were reported as gaps in social care information on alcohol misuse:

- extent of social work activity in response to alcohol related issues
- effects of parental alcohol abuse on children
- number and age of children living with a problem drinker
- information for parents on handling children
- extent of problems in young people
- links between alcohol misuse and behavioural problems
- housing needs of those with alcohol problems
numbers of people who need rehabilitation/supported accommodation/designated place
residential care placements, community care assessments, child care for those with alcohol misuse
lack of data from those attending voluntary organisations. (other than LCAs). No common methodology for data collection
standardised outcome measures
length of time in (counselling) service, number of sessions attended
integrated data from different services within local authorities e.g. housing/Social Work/criminal justice etc. needed.
accurate community workload indicators for social work, health and voluntary agencies.
consistent, accurate and objective method of data collection to enable targeting and delivery of good quality services

2.3.2 Key Issues

Alcohol problems are likely to be a contributory factor in much of the caseload of social workers. However information will not be likely to be recorded unless alcohol abuse is considered the primary care factor. Where information is sought on alcohol misuse, clients themselves may be ambivalent about disclosing alcohol problems because of concern about possible consequences. Care workers may not be able to record alcohol misuse as a problem because of limitations in information systems which do not facilitate reporting of contributory problems. In some areas a local substance misuse database has been developed. However, not all areas were able to identify drug and alcohol problems separately from their database. There are no common data standards and definitions underpinning these databases.

A report to the Social Work Services Inspectorate in 1995 to assess progress in implementing community care arrangements for people with drug and alcohol problems touched on the need to collect hard data on client contact in order to enable service effectiveness to be assessed. It also recommended compiling databases in order that inter-agency comparison is possible.

A major review is underway by the Social Work Information Review Group for social work information. ‘Local and National Information Requirements for Social Work In Scotland’ sets out future action to achieve better information for social work for both local and national information needs. Alcohol misuse is mentioned in one National Objective (CC3). It is likely that as the proposed work is implemented possibilities will arise for improving information on alcohol misuse. The review may also bring closer together information needs in the social work arena and the health arena.

Housing needs are likely to be a major consideration for those with more severe alcohol problems. The alcohol related problems of those with housing needs are not always known to housing departments. Again there are issues relating to disclosure. It is difficult to assess the prevalence of those with alcohol related brain damage in residential care. Prevalence of problems of the homeless in the RSI projects are being measured. Reporting of this could be made more available.
LCAs play a significant role in the provision of specialist alcohol services across Scotland. They also provide a useful source of information locally. The review of COMIS may want to take into account any information developments in the wider alcohol field.

Although COMIS exists as a data collection scheme for a significant part of the voluntary sector, other voluntary organisations do not have standardised data collection. Some organisations do not collect any data at all. More investigation of the data collected by voluntary organisations may be necessary.

Respondents expressed the wish to be able to integrate data between Local Council services and other statutory and non-statutory agencies. Integration is not well developed at present. As within the health sector, client pathways through different care settings are often difficult to follow. Concern about confidentiality is a significant issue that would need to be addressed.

The LA/voluntary sector would like to see the development of outcome indicators which could be used by alcohol services.
2.4 ALCOHOL MISUSE INFORMATION : CRIME AND CRIMINAL JUSTICE

a) National Crime

Although alcohol is known to be a contributory factor in many crimes committed, there are very few offences that are alcohol specific. These include:

- Drunk and disorderly
- Drunk and incapable
- Driving under the influence of alcohol
- Drunk in charge of a child
- Licensing offences (selling alcohol to the under age, buying for the underage, buying as under age).

Data on these offences are collected at police force level and returned nationally to the Scottish Executive. They are not a reliable indicator of all alcohol specific crime as not all arrests for these offences are necessarily prosecuted or convicted.

Details on all vehicle accidents involving death or injury are reported on STATS 19 which are returned to the Scottish Executive and the Department of Transport. This includes recording whether or not a breath test has taken place along with the result. Also recorded are data on casualties by nature of injury (fatal, serious or slight) for both drivers and/or pedestrians. Some forces (e.g. Lothian) carry out breath tests on all moving offences. Both data on drink-drive accidents and breath testing involve a degree of under-reporting.

There are many other offences where alcohol is a significant contributory factor but this information is not routinely reported at national level. Some police forces do record alcohol involvement in crime (Strathclyde/Fife/Lothian/Dumfries and Galloway) though this information will not be recorded for every crime. There are no national definitions of what constitutes a ‘contributory factor’.

Scottish Crime Survey

This national survey has been conducted every three years since 1993. There are two questions relating to alcohol misuse. Respondents are asked whether they think alcohol abuse is a problem for Scotland in general and secondly drink driving appears in a list of possible priority offences for action for police forces. It is based on a sample size of 5000 people aged 16 and over.

b) Local Crime

There can be local offences that are alcohol specific such as offences against local bye-laws of drinking in public places.

Two designated places exist in Scotland. Data on alcohol misuse was reported as being collected
c) Social Work Criminal Justice Services

There are a number of schemes whereby Procurator Fiscals may divert alcohol-using offenders to Social Work or Voluntary Agencies. Social Work Departments complete return information on diversion from prosecution to the Scottish Executive. There is no national collation on alcohol misuse from these at present. In some areas Social Work are assisted in monitoring clients’ attendance at services by means of ratification of attendance data collected by Alcoholics Anonymous. This may also be used by other Social Work teams where attendance at AA services is required.

Social Work National Standards require that alcohol use in relation to offending behaviour is assessed in Social Enquiry Reports (SER1s). Returns of SER1s are made to the Scottish Executive. Stirling Social Work Department regularly monitors Social Enquiry Reports/caseloads to determine alcohol misuse in offending. Ayrshire and Arran are doing a snapshot survey of Social Enquiry Reports and reporting of alcohol misuse as a problem.

Probation orders can have alcohol treatment/counselling registered as a requirement but usually only in high tariff cases (where the offender is at high risk of custody). They are subject to different practice in different areas. Data is available nationally by gender only. Aberdeen Criminal Justice Social Work Department reports collection of data in relation to alcohol.

Alcohol use is routinely assessed by supervising social workers for through and after care and addressed in statutory reports e.g. Parole Home Background Reports returned to the SE.

d) Licensed premises

There is no national data collection specifically linking crime to licensed premises. Aberdeenshire collects data on alcohol misuse incidents in licensed premises that lead to hospital admission or fatality.

2.4.1 Perceived Information Gaps

The following are reported gaps in relation to crime information:

- alcohol and public disorder
- involvement of alcohol in crime
- alcohol related injuries linked to place of injury and licensed premise
- alcohol related crime and licensed premises

2.4.2 Key Issues

Statistics on alcohol specific offences are collated nationally. However, alcohol misuse is known to play a major part in many other offences but this is not quantified routinely.

There may be potential to collect data on alcohol misuse from social work criminal justice reporting. As with generic social work however, there may be issues of disclosure e.g. if alcohol treatment is part of a probation order and the client fails to attend, the offender runs the risk of not complying with the order.
Laws concerning underage drinking are difficult to enforce. Police have no power to detain someone in order to establish their age nor compel them to disclose it. Recent trends in the increase in drinking of young people are of concern.

2.5 HEALTH EDUCATION / PROMOTION

Health Education Material

The postal survey identified the following two organisations as being the key providers of health education resources in Scotland: the Health Education Board for Scotland (HEBS) and the Scottish Council on Alcohol. The Centre for Alcohol and Drug Studies (CADS) at the University of Paisley and the Scottish Drugs Training Project at the University of Stirling were mentioned as important sources of information to support training and education. A considerable amount of information is generated by the national Drinkwise campaign co-ordinated through HEBS and the SCA.

Frequent use is made of the internet as a source of information on alcohol misuse. Sites mentioned included dedicated sites such as Alcohol Concern (England), the SCA site and general sites such as Medline, HEBS and the Scottish Executive. A list of nationally produced health education materials on alcohol misuse that are in current use will also be a product of the Inventory of Services.

Primary and secondary education national data

The first Joint Scottish Executive/COSLA/HEBS/Survey of Health Promotion and Drug Education in primary, secondary (including independent schools) and special schools was carried out in January 2000\textsuperscript{28} by the Scottish Executive to determine how many schools were undertaking substance misuse education, including alcohol misuse, in line with national advice\textsuperscript{29-32}. The survey also contains information on the number of schools with written procedures for managing incidents of drug misuse (including alcohol) in line with national and/or local council advice.

A major project was carried out by the Scottish Council for Research in Education between 1996-1999\textsuperscript{33}. This assessed the extent and nature of school based drug education (including alcohol); pupils attitudes and behaviours concerning substance misuse; pupils views on their drug education and the effectiveness of school based drug education.

Aberdeenshire Council Education and Recreation Department collect data at establishment level on alcohol misuse incidents which results in exclusion from school or community education establishments.

Health Education in Local Councils

A bi-annual survey is undertaken at local council level (part of the Scottish Executive schools survey described above) that covers a range of questions about council policy and practice in relation to health promotion, including information on alcohol misuse.

2.5.1 Perceived Information Gaps
A wide range of topics regarding health promotion in alcohol misuse:

- perceptions about safe drinking
- impact of alcohol education in schools
- comparison of attitudes towards alcohol and drug misuse
- factors affecting beginning of alcohol misuse
- videos on alcohol misuse and of those who have successfully overcome addictions
- attitudes to proof of age cards/ID schemes
- parental attitudes
- rural attitudes to alcohol
- prevention and education effectiveness
- greater use of media e.g. theatre, video
- better training for teachers
- more information in shops, pubs, off licenses

2.5.2 Key Issues

One of the key issues mentioned is the need for more understanding regarding attitudes to use of alcohol, particularly by young people.

Another area highlighted is the effectiveness of health education on alcohol. Provision of alcohol education in schools is being addressed through recent surveys. Publication of these findings more widely would be advantageous.

The effect of alcohol misuse by young people on their schooling cannot at present be quantified at national level.

Little information was identified on provision of alcohol education in other settings such as Further and Higher Education.
2.6 OTHER ALCOHOL MISUSE INFORMATION

2.6.1 COSTS

There is no routine data on the costs of alcohol misuse in Scotland although SACAM has recently commissioned such work to be carried out. Lanarkshire AMCC has commissioned a project by GGHB Health Economics Unit. Argyll and Clyde Health Board have undertaken work on alcohol services and costs.

Both information on advertising expenditure (by type of beverage) and the expenditure of alcohol as a percentage of disposable personal income are published for the U.K.

Perceived Information Gaps

- indirect costs to society (e.g. absenteeism, vandalism)
- costs of alcohol misuse to agencies (e.g. health/social services; police)
- resources expended on alcohol misuse broken down by type of intervention

Key Issues

Information on costs is usually carried out as ad-hoc pieces of research. Of particular importance are the costs to agencies dealing with the consequences of alcohol misuse. Strategic planning and policy need to be able to identify what existing resources are being utilised on alcohol services (both in the generic and specialist settings).

2.6.2 OCCUPATIONAL HEALTH

There is no routine data on absences related to alcohol misuse.

Perceived Information Gaps

Only a few direct references were made to lack of information on occupational health.

- Data on work absences related to alcohol misuse geographically
- Employment and health

Key Issues

Although not highlighted by many as a key area in terms of the information scope, alcohol misuse in the workplace is an important issue. Many workplaces have alcohol policies and occupational health services will deal with alcohol related problems. Many occupational health services are funded by industry. More details on these services may be provided by the Service Inventory. The workplace setting has huge potential for delivery of health promotion messages.
2.6.3  RESEARCH

A by product of the postal survey was information about some local research. A number of respondents described research projects undertaken in their area and in some cases sent copies of research reports. The projects mainly concern estimating prevalence and needs of users and carers, outcomes of interventions and costs. Some of the gaps in information availability identified by respondents suggest both new research or better dissemination of existing research material. These are summarised below. It is stressed that this is not intended to be a fully comprehensive assessment of research needs in the alcohol field.

Perceived Research Gaps
  o  patterns of alcohol use in rural areas
  o  new proven interventions
  o  model for planning, monitoring and evaluation
  o  behaviour of young people in relation to use of alcohol
  o  value of leisure/sports provision
  o  publication of research findings on regular basis

Several respondents indicated that they wished to know of research on effective interventions for alcohol services. Although such research can be found through searching the various databases of published literature; from national publications such as the Effectiveness Bulletin or through the assistance of libraries, this can be time consuming and can involve duplication of effort. It would be possible to post onto a website new and relevant publications as they became known but this would involve considerable resource in terms of searching and upkeep. However, work commissioned by SACAM on effective interventions could be published once completed.

Young people as an ‘at risk’ group were mentioned frequently. Some of the gaps mentioned in Health Education/Promotion such as factors affecting beginning of alcohol use, if not yet covered by existing research, could be a research need.
The information scope has found that surveys are one of the most heavily used sources of information. National surveys are used most by Alcohol Misuse Co-ordinating Committees (AMCCs), Health Boards, Local Authority Education Departments, alcohol services and the Police. Local lifestyle and alcohol surveys are used particularly by all Departments of Local Authorities, Health Boards and AMCCs.

Information from health services (SMR01, SMR04, Scottish Health Statistics, Drug Misuse Bulletin, local service statistics, GRO) is also well used, mainly by health service organisations, AMCCs, alcohol services and Social Work Departments.

Local Councils on Alcohol use information from their own COMIS database for each area and also use the selection of national statistics compiled by the SCA. Local Authority departments also utilise information from Local Councils on Alcohol. This was the second most frequently reported source after local surveys.

Information from the Health Education Board for Scotland is widely used. The main users are Education Departments, followed by Health Boards, some alcohol services and the Police.

Reference was also made to a number of other sources. These sources include Addiction Journals, Alcohol Concern (publications and Web-site), Drinkwise, Medline, statistics from local services, local prevalence studies and need assessment studies, local strategies, community care plans and health improvement programmes, Alcoholics Anonymous, SDF, Scottish Council for Research in Education, Centre for Health Economics, CRAG, OPCS, the Scottish Executive and CBI. Greater Glasgow Alcohol Strategy was used by a number of organisations within Greater Glasgow. Documents such as strategy documents contain data from a range of primary sources.

Information from Social Work information recording systems is used to make reports to Audit Scotland. No other organisations mention reported use of Social Work sources. Information from the RSI projects are used by Local Authorities and Housing Committees.

Crime data is published in Police Force Annual Reports. Although their use was mainly reported by the police, at least one Health Board had also used the reports.

Information is used widely for a variety of purposes (for a summary of the types of use by organisation type see Appendix 4). The most frequent reason reported was “planning”. This was reported by all types of organisation. Non statutory day services rate use of information for service evaluation ahead of planning. Monitoring is the next most frequent use for Health Boards, Local Authorities, Local Councils on Alcohol and non statutory services. Preparation of reports is also a frequent reason for use by all types of organisation, second to planning by Primary Care and Acute Trusts.
2.8 ACCESS TO ALCOHOL MISUSE INFORMATION

There are many different media through which alcohol misuse information can be accessed by services such as paper records; locally held computer databases; national computer databases; routine publications; published literature; on-line (literature or specialised websites).

2.8.1 Expressed Needs

Respondents were asked how access to alcohol misuse information could be improved. The following mentioned:

- review of studies in relation to treatment and prevention to disseminate information on best practice
- reference online
- methods of access that are both quick and cheap
- accessing information from other agencies
- local information/database that can be accessed by all local agencies
- reports disseminated in electronic format
- access to resources for rural areas
- better dissemination to staff

2.8.2 Issues

Searching for and analysing alcohol misuse information can take time and expertise and be costly. The existing resources such as HEBS and dedicated alcohol internet sites such as Alcohol Concern in England are valued. Rural areas will not be able to visit libraries with ease so may find online access more appropriate.

Another issue identified was that of access to information held by different agencies. This presumably refers to data held on individual patients/clients. A major concern will be that of confidentiality. Integration could be on a ‘need to know’ basis.

Alcohol misuse information is collected and published by a variety of individual organisations. Although such information may be available through publications or websites, there was a clear wish to have a ‘one stop shop’ where all such information could be accessed.
PART THREE

3 CONCLUSIONS

3.1 It was clear from the level of interest engendered and from the detailed responses to the survey that there is already considerable demand for reliable, timely and relevant information. At all levels from Scottish Executive and SACAM, AMCC’s in their various forms, through commissioning and funding bodies, to services providers, organisations are concerned to base their decisions on factual evidence whenever possible, to set goals and monitor progress, and compare their own progress against similar services, other areas or against the overall national scene.

3.2 The national strategy for alcohol may signal further needs for information. Some of this might already be available. Some may yet have to be specified, collected and analysed. Certainly it would be inappropriate for any policy strategy to constrain its comment solely to aspects that are immediately and readily supported by existing data. The drawing up of a strategy may indeed contribute further clarity about what information is most important, and what the critical gaps are.

3.3 A number of themes have emerged during the course of this information scoping study.

3.4 Firstly it is clear that there is already a wide range of data collected at local and national level but this is not always readily accessible to potential users, nor necessarily presented or disaggregated in the most suitable way for the data to be used effectively. There is also evidence that some information sources would be used more extensively if there was wider knowledge of their existence. The potential use of data may not always be evident to users. The process of this scoping study has encouraged discussion about the range of information that already exists and has revealed the extent to which existing user requirements are not being met.

3.5 Investment in information should be directed towards supporting the development and implementation of Government and local policies. At its core, information should inform the delivery of good quality services for those with alcohol problems. Information collection, compilation and analysis need adequate resources and whilst some developments could be actioned relatively easily, others will take considerable investment and cannot necessarily be achieved quickly. Success may only be achievable where all relevant stakeholders are involved in the development process. Clarity as to the target users (both specialists and generalists) and the potential uses of the data are essential.
3.6 Possible options for development reflect the scale of the challenge if information in the alcohol field is to meet the identified needs of existing and potential users. Meeting this challenge is in practice likely to require an evolutionary approach. A purely piecemeal approach is not recommended. One possibility might be to ensure that the needs of an agreed service model are adequately met. However with services increasingly being provided in community settings and data collection processes in the community relatively less advanced, the scale of the task should not be underestimated.

3.7 Many organisations with joint responsibility for both alcohol and drugs compared the availability of alcohol information unfavourably against information on drugs misuse. Some commented that the sharp distinction between availability of drugs information and alcohol information was often frustrating and unhelpful.

3.8 The use of the World Wide Web as a communication medium struck a particular chord. A website designed as a hub site for professionals in the field, perhaps similar to the drugs misuse approach which links to other key sites in Scotland, UK wide and internationally, and provides access to national statistics and other reports, would be widely welcomed.

3.9 The need to improve coordination arrangements for information collection and dissemination has to be viewed as a cornerstone of any information strategy for the alcohol field. The tasking of a single body or appropriate grouping of bodies to champion this, under the guidance of the Scottish Executive and SACAM, would be a logical first step for such an information strategy. It is suggested that, as a minimum, an information strategy should seek to develop a framework for taking this forward along with the tasks which can be identified as priorities, where the necessary funding is available, and where there is a likelihood of success. The increasing demand to secure access to reliable information on which to base decisions cannot easily be met with the current disparate information landscape.
**Appendix One**

**SURVEY OF ALCOHOL MISUSE INFORMATION**
**BY THE INFORMATION AND STATISTICS DIVISION (ISD)**
**ON BEHALF OF THE SCOTTISH ADVISORY COMMITTEE ON**
**ALCOHOL MISUSE (SACAM)**

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**Introduction**

The aim of this questionnaire is to gather information about the availability, accessibility and use of information on alcohol misuse. The responses received will inform the findings of the scoping review of alcohol misuse information commissioned by SACAM.

There are five sections:

1) Organisation details
2) Data gathered by your organisation
3) Information used by your organisation from other sources
4) New information / accessibility of information
5) Questionnaire / respondent details

Extra copies of Sections Two and Three are attached for use as required.

Please complete the questionnaire in conjunction with the accompanying Notes.
SECTION 1: ORGANISATION DETAILS

Please complete the following details about your organisation:

Q1  Organisation name, address, and postcode

Q2 (a)  What does your organisation do / provide in relation to alcohol use / misuse? (please x all that apply)

- Health services
- Social Work Services
- Counselling
- Health Promotion
- Education
- Research
- Training
- Law Enforcement
- Licensing
- Information
- Planning / Commissioning services
- Other (please specify)

Q2 (b)  Please provide details if appropriate

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
SECTION 2: DATA GATHERED BY YOUR ORGANISATION

Please complete this section if your organisation collects or has collected data on alcohol use / misuse - if not go to Section 3.

Please answer questions 3 - 15 (Section 2) for each separate data collection scheme / research project / survey, etc.
A further copy of Section 2 is enclosed if required.

Q3 Name of data scheme / research project / survey, etc. 

Q4 General description of data scheme / research project / survey, etc.

Q5 Data items (Please enclose a blank data collection form or questionnaire if available.)

Q6 Data type (please state)

Q7 Method of data collection / research project / survey, etc. (please state)
<table>
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<th>Q8 Method of storing data</th>
<th>On paper</th>
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<td>Other (please specify)</td>
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<td>'One-off'</td>
<td>Other (please specify)</td>
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<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
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<td>If yes, please give details</td>
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<th>Q11 Are the data subject to external quality assurance?</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
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<td>If yes, please give details</td>
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Q12 (a) Are the data which is collected used by your organisation? Yes [ ] No [ ]

Q12 (b) If yes, how are the data used? (please x all boxes that apply)

- Planning services [ ]
- Staffing [ ]
- Monitoring [ ]
- Preparation of annual report [ ]
- Performance targets [ ]
- Patient / client outcomes [ ]
- National statistics [ ]
- Patient / client care management [ ]
- Research [ ]
- Service evaluation [ ]
- Reports to joint planning [ ]
- Other (please specify) [ ]

Please give further details if appropriate

_________________________________________________________________________

_________________________________________________________________________

Q12 (c) Are the data published? Yes [ ] No [ ]

If yes, please name publication

_________________________________________________________________________
Q13  Are the data sent elsewhere for collation?  
Yes  ☐  No  ☐  
If yes, please state where it is sent  
__________________________________________  
__________________________________________  
__________________________________________  
__________________________________________  

Q14  In your view are there any limitations to the data / research / survey, etc?  
Yes  ☐  No  ☐  
If yes, please describe  
__________________________________________  
__________________________________________  
__________________________________________  
__________________________________________  
__________________________________________  

Q15  Are there any improvements to the data scheme / research project / survey (etc.) you would like to see?  
__________________________________________  
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SECTION 3: INFORMATION USED BY YOUR ORGANISATION FROM OTHER SOURCES

Please complete this section if your organisation uses data/information collected or produced by other organisations - if not go to Section 4.

Q16 Please list the name of each information source or publication used

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<th>Name</th>
<th>Description of information source or publication</th>
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Please answer questions 17 - 20 for the main information source used. A further copy of these questions is enclosed if required.

Q17 Name

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<th>Description of information source or publication</th>
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Q18 How is the information used by your organisation? (please x all boxes that apply)

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<th>Planning services</th>
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<th>Monitoring</th>
<th>Preparation of annual report</th>
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<th>Reports for joint planning</th>
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Q19 In your view, are there any limitations to the information? Yes □ No □
If yes, please describe

Q20 Are there any improvements you can suggest? Yes □ No □
If yes, please describe
SECTION 4 : NEW INFORMATION / ACCESSIBILITY OF INFORMATION

Please complete this section if you can identify a need for information on alcohol misuse which is not currently met. (For example, information which is not currently collected, or is collected but is not readily accessible.)

Q21 Thinking about the needs of your organisation, in your view, is there any new information which you would find useful.
(Please list and describe and attach additional pages if required.)

<table>
<thead>
<tr>
<th>New Information Required</th>
<th>Potential Use</th>
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Q22 Do you have any views on ways of making more accessible information which currently exists?
(Please list and describe and attach additional pages if required.)

<table>
<thead>
<tr>
<th>Improved Accessibility of Existing Information</th>
<th>Potential Use</th>
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SECTION 5 : QUESTIONNAIRE / RESPONDENT DETAILS

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<td>E-mail Address</td>
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<td>Date</td>
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<td>Survey Completed By</td>
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</table>

Thank you for completing this questionnaire.

Please return it to either Margaret Davies or Martin Hunter at the addresses below by the 31st August.

Margaret Davies  
ISD  
Trinity Park House  
South Trinity Road  
Edinburgh  
EH5 3SQ  
TEL : 0131 551 8901  
E-MAIL : Margaret.Davies@isd.csa.scot.nhs.uk

Martin Hunter  
ISD  
Trinity Park House  
South Trinity Road  
Edinburgh  
EH5 3SQ  
TEL : 0131 551 8851  
E-MAIL : Martin.Hunter@isd.csa.scot.nhs.uk

Any comments or information you would like to add should be noted below.
### Postal Survey Recipients and Response

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Appendix Three

Interviewees

Mr Bill Anderson Central Scotland Council on Alcohol
Mr Ken Barrie The Alcohol Studies Centre University of Paisley
Mr Brian Cole Scottish Executive Social Work Criminal Justice
Professor John Davies University of Strathclyde
Ms Morag Hamil COSLA
Stephen Hatcher Lanarkshire Alcohol Development Officer
Ms Sally Haw Health Education Board for Scotland
Mrs Elizabeth Hill Tayside Substance Misuse Action Team
Mr G Jackson GRO Scotland
Mr Jack Law Scottish Council on Alcohol
Mr Stevie Lydon Ayrshire Common Addictions Database
Mr Alistair Munro Scottish Executive
Ms Gill Ottley Scottish Executive Social Work
Mr Harvey Stalker Scottish Executive HMI
Mr Charles Steele (with Mr Ian Paisley and Ms Winnie Currie) Alcoholics Anonymous
Ms Justine Walker COSLA
Ms Moira Wilson Scottish Executive Education Department
Mr Tom Woods Lothian Police
## Use made of information from data collected by type of organisation

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References

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