



# **Alcohol Deaths Reviews in Scotland**

**2025**

# Alcohol Death Reviews in Scotland: Full Report

## Executive Summary

This summary report provides a national-level overview of alcohol death reviews conducted across Scotland. By synthesising findings from six regional reviews, it examines the analysis undertaken, key findings identified, and where opportunities for intervention are being missed. Across the reviews, three fundamental aims of the alcohol death reviews consistently emerge: understanding patient journeys and service engagement, identifying risk factors, and generating learning to improve systems. While the sample is limited, the patterns observed are clear and carry important implications for prevention, service delivery, and policy.

### Key Findings from the Alcohol Death Reviews

Across all reviews, a consistent profile of alcohol-related deaths emerged:

#### *Who Is Dying and Why*

- Most individuals were middle-aged, with men overrepresented, although women tended to die at younger ages.
- Alcoholic liver disease accounted for roughly two-thirds of deaths, reinforcing the prolonged and preventable trajectory of harm.
- Social isolation and deprivation were recurring features, with many individuals living alone and residing in the most deprived areas.
- Comorbidities were prevalent, with one review reporting an average of three chronic conditions per person. Mental health comorbidities in particular were nearly universal.

#### *Service Contact and Intervention*

- There were substantial delays between the onset of alcohol problems and formal recognition in clinical records - often inferred from discrepancies between patient history and first documentation - with average lags of 2–5 years.
- Most individuals had repeated contact with health services, particularly emergency departments and acute care, yet engagement with specialist alcohol services was inconsistent or poorly sustained.
- Mental health diagnoses were frequently recorded months or years before death, yet alcohol was not routinely discussed during appointments.
- Many experienced unplanned or unsupported detoxification, limiting opportunities for stabilisation and recovery.
- Abnormal liver function tests were frequently recorded years before death, but rarely followed by structured intervention, suggesting that warning signs were recognised but not acted upon.

- Screening, recording, and referral practices were inconsistent, with multiple tools in use (FAST, PAT, SADQ) and no standard approach to actioning concerning results.
- Information sharing across primary care, acute services, mental health, and addiction teams was fragmented, resulting in disconnected care and lost continuity.

### Collective Learning from Alcohol Death Reviews

Despite methodological variations between the six reviews, the process of reviewing the individual reports alongside ongoing liaison with the Alcohol Death Researchers Network reveals clear common themes. These recurring patterns - in risk factors, service engagement, and missed opportunities - are sufficiently consistent to be synthesised and shared to inform future prevention efforts and service improvements. These are not abstract statistics, but actionable intelligence that can guide targeted interventions and strengthen multi-agency awareness.

### Limitations

The findings presented should be interpreted with caution. The analysis is based on only six publicly available alcohol death reviews, representing a limited sample of alcohol-specific deaths nationally. The reviews examined alcohol-specific deaths only; the broader category of alcohol-related deaths - where alcohol was a contributing rather than primary cause - would substantially increase the number of deaths considered. Reviews also employed varied methodologies, analytical approaches, and timeframes, and accessed different combinations of available data sources, making direct comparisons challenging. These limitations expose gaps in the evidence base and underscore the importance of establishing more consistent approaches going forward.

### A Framework for Action

The five thematic categories of recommendations emerging from these reviews provide a comprehensive framework for improving alcohol-related harm prevention, early intervention, treatment and support across Scotland's health and care systems:

- **Early Identification and Recording** addresses the fundamental need to recognise alcohol problems when individuals present to any service, document this accurately and consistently, and communicate it effectively across the care system.
- **Service Processes and Early Intervention** tackles the fragmentation and poor coordination between services that allows individuals to fall through gaps despite multiple contacts, and creates clear pathways and connections.
- **Withdrawal Support and Psychological Care** ensures that when individuals are ready to address their drinking, effective, evidence-based treatment is available and accessible, with proper aftercare to sustain recovery.
- **Priority and Vulnerable Groups** recognises that alcohol harm is not evenly distributed and that effective prevention requires targeted approaches addressing specific needs of highest-risk populations.
- **Monitoring, Reporting and Strategic Development** creates the infrastructure for ongoing learning and improvement, ensuring that alcohol harm remains visible and prioritised at strategic level.

Together, these recommendations, derived from systematic analysis of deaths that might have been prevented, provide a roadmap for reducing alcohol-related mortality across Scotland. Their implementation, monitored through ongoing surveillance and periodic repeat reviews, offers the best prospect for ensuring that future deaths are prevented through learning from past losses.

### Scotland's Implementation Gap and the Case for Action

Despite their demonstrable value, alcohol death reviews remain underutilised. While every Alcohol and Drug Partnership (ADP) has a drug death review group, only around one in four reported having an alcohol harms group - and just 7% conducted alcohol death reviews in 2022/23, even as alcohol-specific deaths reached a 15-year high. The contrast with drug death reviews is stark; while drug-related fatalities receive intensive scrutiny, alcohol-related mortality continues to receive less structured attention, despite causing over 1,200 deaths per year. This implementation gap represents a profound missed opportunity to prevent harm and save lives. Following the publication of Alcohol Focus Scotland's practical guidance around completing alcohol death reviews in 2020, the Scottish Government recommended that ADPs should be seeking to complete a review every 3 years; a recommendation we believe still stands and that the national Alcohol Deaths Researchers Network supports, with the caveat that this process is adequately resourced.

Alcohol death reviews bridge the gap between national statistics and local service delivery, providing detailed insights into patient journeys, service breakdowns, and intervention opportunities. They provide a structured mechanism for local systems to see where interventions failed or arrived too late, enabling health boards and ADPs to identify where their resources would have the greatest preventive impact. They restore humanity to statistics, reveal lives behind the numbers, and challenge complacency in current approaches. Evidence from this report provides a clear roadmap for what comprehensive implementation could achieve.

### Conclusion

The evidence is clear: alcohol death reviews are one of Scotland's most powerful yet underused tools for preventing alcohol-related mortality. The question is no longer *whether* to expand their use, but *how quickly*. Every death that occurs without systematic review is a loss - not only to families and communities, but to our collective understanding of how to prevent future tragedies. The time for action is now; the tools are available, the evidence is clear, and systematic expansion of alcohol death reviews must form a cornerstone of Scotland's alcohol harm prevention strategy. While these reviews cannot save those who have died, systematically examining their journeys ensures their deaths are not in vain, turning loss into learning and providing a mandate for change.

## Contents

<b>Executive Summary</b> .....	<b>2</b>
<b>Introduction</b> .....	<b>7</b>
<b>Alcohol Harm in Scotland Today</b> .....	<b>7</b>
<b>Health Inequalities and Service Access Crisis</b> .....	<b>7</b>
<b>Scottish Government Expectation/ADP Funding Letter</b> .....	<b>7</b>
<b>Availability of Guidance – AFS Guidance</b> .....	<b>8</b>
<b>Existence of the Alcohol Deaths Researcher Network (ADRN)</b> .....	<b>8</b>
<b>Addressing the Knowledge Gap</b> .....	<b>9</b>
<b>What are Alcohol Death Reviews?</b> .....	<b>9</b>
<b>Core Aims of Alcohol Death Reviews</b> .....	<b>9</b>
<b>Limitations and Scope</b> .....	<b>10</b>
<b>Anonymity and Confidentiality</b> .....	<b>10</b>
<b>Collaborative Approach and Common Themes</b> .....	<b>10</b>
<b>Reviews Included in This Analysis</b> .....	<b>10</b>
<b>Analytical Approach</b> .....	<b>12</b>
<b>Review Results by Theme</b> .....	<b>13</b>
<b>Risk Factors</b> .....	<b>13</b>
Key Risk Factor Profile: The Evidence for Targeted Prevention.....	13
Age & Gender: Critical Demographic Patterns.....	13
Location: Geographic Concentration of Risk .....	13
Marital Situation & Family History: Social Isolation and Family Breakdown .....	14
Housing Status at Time of Death .....	14
Employment Status.....	14
Police and Fire Service .....	15
Comorbidities .....	15
<b>Mortality Statistics</b> .....	<b>15</b>
Cause of Death .....	15
Contact with Services .....	16
Recorded Alcohol History.....	18
Screening Tools.....	21
Emergency Department & Hospital Attendance .....	24

Outpatient Appointments.....	26
Inpatient Appointments .....	29
Mental Health Appointments .....	32
<b>Interventions .....</b>	<b>36</b>
Context: Evolving Treatment Landscape.....	36
Alcohol Brief Interventions (ABIs).....	37
Community Addiction Teams .....	38
Substance Use & Addiction Liaison .....	40
Detoxification.....	42
Relapse Prevention Medication .....	44
<b>Access to Services .....</b>	<b>46</b>
Social Work.....	46
Non-Statutory Alcohol Services.....	47
<b>Healthcare Costs .....</b>	<b>49</b>
<b>Alcohol Death Review Recommendations .....</b>	<b>49</b>
<b>AFS Conclusion .....</b>	<b>53</b>

# Introduction

## Alcohol Harm in Scotland Today

Scotland faces an alcohol harm crisis of significant proportions. With the highest rate of alcohol-specific deaths in the UK, Scotland recorded 1,277 alcohol-specific deaths in 2023—representing a 15-year high that followed the Scottish Government's recognition of alcohol harm as a public health emergency in 2021<sup>i</sup>. In 2024 there were 1,185 alcohol-specific deaths registered in Scotland, a decrease of 92 deaths from 2023, however numbers remain high<sup>ii</sup>.

These figures represent only the tip of the iceberg. Public Health Scotland estimates that the total number of deaths caused by alcohol is likely to be more than double the alcohol-specific statistics, as these figures only capture deaths from conditions caused by alcohol alone, such as alcohol-related liver disease and alcohol dependence syndrome<sup>iii</sup>. Most alcohol-related deaths result from wider causes including cancers, heart conditions, stroke, and accidental injuries.

The COVID-19 pandemic has exacerbated Scotland's alcohol problem, with increased harmful drinking and reduced service access driving increased harm. If current consumption patterns persist, modelling suggests this will lead to approximately 7,500 additional deaths and 70,000 more hospitalisations by 2040, costing £82.2 million in hospital costs alone<sup>iv</sup>.

This inequality is compounded by a significant decline in treatment access, with specialist alcohol treatment uptake falling by 40% from 2013/14 to 2021/22, reaching its lowest level in a decade<sup>v</sup>.

## Health Inequalities and Service Access Crisis

Scotland's alcohol problem disproportionately affects the most deprived communities, where individuals are over four times more likely to die due to alcohol and six times more likely to be hospitalised compared to those in the wealthiest areas<sup>vi</sup>.

The impacts extend beyond individual deaths to encompass alcohol-related diseases, accidents, violence, unemployment, family breakdown, domestic abuse, child neglect, and fetal alcohol spectrum disorder. These cascading effects compromise people's right to health and create widespread harm across communities and families.

## Scottish Government Expectation/ADP Funding Letter

The Scottish Government has established clear expectations for Alcohol and Drug Partnerships (ADPs) regarding alcohol death reviews. Within the ADP Funding Letter for 2025/26<sup>vii</sup>, there is a specific requirement for ADPs to enhance their alcohol death review processes:

***"ADPs are required to update and implement plans to carry out death reviews to help drive service improvements aimed at reducing deaths from alcohol and drugs. There are fewer alcohol death reviews carried out at present than drug death reviews. To help deliver on the Audit Scotland recommendation to increase focus on alcohol, ADPs are asked to enhance their alcohol death review process in 2025/26."***

This directive reflects recognition that alcohol death reviews have been underutilised compared to drug death reviews, despite Scotland's significant alcohol mortality rates. The expectation emphasises using reviews to drive service improvements and aligns with broader recommendations to increase focus on alcohol harm prevention and response.

## Availability of Guidance – AFS Guidance

Alcohol Focus Scotland has developed [comprehensive guidance](#) to support teams undertaking alcohol death reviews. This guidance is intended for use by Alcohol and Drug Partnerships and NHS Public Health teams concerned with alcohol deaths prevention, serving as a reference manual for teams at any stage of planning alcohol death reviews, from initial consideration through to publication.

The guidance draws on best practice from those who have previously completed Alcohol Death Reviews. It is kept under review and continues to be updated as more areas undertake death reviews, with stakeholders from ADPs across Scotland sharing what worked well, what could be learned, and what they would do differently if repeating their reviews. We seek and gather supportive tools and resources from areas, where these can be accessed and adapted by other localities.

The guidance sections mirror the practical concerns and thinking required at all stages of review. Recognising that local teams have varying priorities, interests, and resources, the guidance provides a general overview of how alcohol death reviews can be carried out while leaving space for ADPs and NHS Public Health teams to develop their own approaches as appropriate to their circumstances.

The guidance forms one element of AFS's comprehensive support for teams concerned with alcohol deaths prevention. Teams can access the most recent guidance through Alcohol Focus Scotland's resources and receive ongoing project support from the AFS team as reviews are planned and undertaken.

## Existence of the Alcohol Deaths Researcher Network (ADRN)

Alongside the guidance, Alcohol Focus Scotland has established the Alcohol Deaths Researchers' Network (ADRN) to facilitate communication, support, and information sharing between people involved in reviews. This network currently meets every three months and welcomes active and former researchers or analysts from across Scotland.

The ADRN serves as a vital platform for knowledge exchange, enabling practitioners to share experiences, discuss challenges, and develop best practices in alcohol death review methodology. The network addresses the isolation that individual teams might otherwise experience when undertaking these complex and sensitive reviews. The collaborative approach fostered by the ADRN ensures that lessons learned from individual reviews contribute to improved practice across Scotland's alcohol death review landscape.

The network represents a crucial infrastructure supporting the expansion and enhancement of alcohol death reviews across Scotland, providing both practical support and professional development opportunities for those engaged in this important work.

If you would be interested in learning more about the network, please contact: [enquiries@alcohol-focus-scotland.co.uk](mailto:enquiries@alcohol-focus-scotland.co.uk)

Through both the network and death review guidance, we want to increase consistency in approaches across localities. This would in turn, make them easier to compare and to understand trends across Scotland.

## Addressing the Knowledge Gap

One of the major obstacles to preventing alcohol deaths in Scotland is limited knowledge around how services might help people at risk of dying by alcohol, and the course of addiction through people's lives before they die. While annual National Records of Scotland statistical information is available, little else is reported at the local or service level.

Reviews provide a platform for examining the lives of people who have died to generate information that can inform service design and strategic approaches to prevent future deaths. Those who have undertaken reviews describe them as uniquely helpful in framing an issue that can seem too large to tackle, providing a full account of the challenges and barriers facing people with alcohol problems and a starting point to alleviate them.

By generating useful data, reviews enable understanding of how people interact with services, identify areas where practice could be improved, highlight new services that may help, and inform strategic approaches that can address problems before they become fatal. They also allow evaluation of the impact of changes made and better planning for the future.

## What are Alcohol Death Reviews?

Reviews of alcohol deaths study information about a person's life and death in order to evaluate what opportunities could be taken in future to prevent other people dying in similar ways. Reviews of alcohol deaths involve gathering quantitative and qualitative information to understand how alcohol played a role in a person's life and eventual death.

## Core Aims of Alcohol Death Reviews

Across the reviews included in this summary, three fundamental aims consistently emerge:

### 1. Understanding Patient Journeys and Service Engagement

- Investigating trends over time and variations by gender, age, deprivation, and geographical area
- Identifying patterns of engagement with services and where they break down
- Assessing service pathways and the effectiveness and impact of services

### 2. Identifying Key Risk Factors

- Analysing risk factors emerging from comprehensive data analysis
- Understanding the complex interplay of social, health, and personal factors contributing to alcohol-related deaths

### 3. Generating Learning Points for System Improvement

- Informing potential early interventions to prevent alcohol-related deaths
- Developing effective support for end-of-life care
- Identifying areas for priority action and strengthening multi-agency awareness
- Improving population-level outcomes through evidence-based recommendations

This report synthesises findings across these three core areas to support Alcohol and Drug Partnerships (ADPs), NHS Public Health teams, and other stakeholders in developing targeted strategies to address alcohol-related mortality across Scotland.

## Limitations and Scope

This summary report has several important limitations that must be acknowledged. The analysis is based on only six publicly available alcohol death reviews conducted across Scotland, representing a limited sample of the alcohol-related deaths occurring nationally. The reviews employed varied methodologies, analytical approaches, timeframes, and accessed different combinations of available data sources, making direct comparisons challenging.

The reviews were completed over different time periods and examined deaths occurring across various years, with some focusing on 12-month periods while others examined data spanning up to three years. The range and quality of data sources varied considerably between reviews, from comprehensive multi-agency record linkage to more limited case note reviews. These methodological differences mean that findings should be interpreted with appropriate caution when considering their broader applicability.

## Anonymity and Confidentiality

Throughout this report, maintaining the anonymity and confidentiality of individuals whose deaths were reviewed remains paramount. No identifying information has been included, and care has been taken to present aggregate findings in ways that protect individual privacy while still enabling meaningful analysis of patterns and trends.

## Collaborative Approach and Common Themes

Despite the methodological variations outlined above, the process of reviewing available information alongside ongoing liaison with members of the Alcohol Death Researchers Network has revealed significant commonalities across the reviews. These shared themes and patterns are sufficiently consistent and important to warrant synthesis and dissemination to inform future prevention efforts and service improvements.

The convergence of findings across different geographical areas, time periods, and methodological approaches strengthens confidence in the key themes identified and suggests they reflect genuine patterns in alcohol-related mortality rather than localised anomalies.

## Reviews Included in This Analysis

This summary incorporates findings from six alcohol death reviews completed between 2003-2021 (see Table 1). The reviews examined deaths occurring over periods ranging from 12 months to 3 years, with cohort sizes varying from 20 to 147 individuals. It is important to note that the terms used to describe the main cause of death vary across reviews. For the purpose of this report, we have used the term(s) that were used in each individual review.

Review Number	Time Period Reviewed	Number of Individuals in Cohort	Data Sources	Main Cause of Death
1	2013 to 2015	147 (all alcohol-specific deaths)	SMR01, SMR04, SMR00, A&E2 Datamart, Prescribing Information System	Alcoholic Liver Disease (58.5%)
	1982 to 2016	N/A – 25-year analysis of alcohol-specific deaths (to provide an up-to-date epidemiological summary of deaths)	Routinely available sources and data from a mortality dataset provided by the National Records of Scotland (NRS) and ISD Scotland	Alcoholic Liver Disease (53% over the last 10-year period)
2	2003	65 (representative sample of all alcohol-specific deaths)	Unclear	All Alcohol Liver Disease (82%)
3	2010	65 (representative sample of all alcohol-specific deaths)	Unclear	All Alcohol Liver Disease (64.6%)
4	2013	56 (representative sample of all alcohol-specific deaths)	Unclear	All Alcohol Liver Disease (56%)
5	2021	20 (all alcohol-specific deaths)	SMR01, SMR04, SMR06, SMR00, SMR01-E/SMR50, A&E Attendance Data, Prescribing Information System	Alcoholic Cirrhosis of Liver; Mental and Behavioural disorders due to alcohol dependence syndrome; Alcoholic Hepatic Failure; Alcoholic Liver Disease, Unspecified (80%)
6	2020	69 (all alcohol-specific deaths)	SMR01, SMR04, SMR00, A&E2 Datamart, Prescribing Information System	Alcohol Liver Disease (65%)

**Table 1. Characteristics of Included Reviews**

The reviews utilised diverse data sources including GP case notes, addiction team records, clinical portals, electronic health records, social work records, national datasets (Scottish Morbidity Records, Prescribing Information System, A&E2 Datamart), and information from third sector organisations. Some reviews employed comprehensive record linkage methodologies, while others focused on targeted case note analysis or specific service pathway examination. Cases of alcohol-specific and alcohol-related deaths used all or some of the ICD-10 codes (ICD-9 codes prior to 2000) as detailed in Table 2.

ICD10 code	Description
E24.4	Alcohol-induced pseudo-Cushing's syndrome
F10	Mental and behavioural disorders due to use of alcohol
G31.2	Degeneration of nervous system due to alcohol
G62.1	Alcoholic polyneuropathy
G72.1	Alcoholic myopathy
I42.6	Alcoholic cardiomyopathy
K29.2	Alcoholic gastritis
K70	Alcoholic liver disease
K73	Chronic hepatitis, not elsewhere classified
K74.0	Hepatic fibrosis
K74.1	Hepatic sclerosis
K74.2	Hepatic fibrosis with Hepatitis sclerosis
K74.6	Other and unspecified cirrhosis of liver
K85.2	Alcohol-induced acute pancreatitis
K86.0	Alcohol induced chronic pancreatitis
Q86.0	Fetal induced alcohol syndrome (dysmorphic)
R78.0	Excess alcohol blood levels
X45	Accidental poisoning by and exposure to alcohol
X65	Intentional self-poisoning by and exposure to alcohol
Y15	Poisoning by and exposure to alcohol, undetermined intent

**Table 2. ICD-10 Codes**

## Analytical Approach

This summary report adopts a thematic approach to presenting findings, leading with the overarching conclusions drawn from cross-review analysis before examining specific themes in detail. Information is presented under headings aligned with those commonly used across the individual reviews, enabling comparisons where methodologically appropriate while acknowledging important caveats regarding direct statistical comparisons.

Where possible, quantitative findings are presented alongside ranges to reflect the variation between reviews. Qualitative themes are synthesised to highlight consistent patterns while noting areas where reviews diverged in their findings or emphasis. This approach aims to maximise the utility of available evidence while maintaining transparency about its limitations.

The report structure moves from broad themes and conclusions to detailed examination of specific aspects of the patient journey, service engagement patterns, and intervention opportunities, concluding with recommendations from AFS for system improvement based on the collective insights from all reviews.

## Review Results by Theme

### Risk Factors

Risk factors represent the personal, social, and clinical characteristics that increase an individual's likelihood of experiencing alcohol-related death. Analysis across the six reviews reveals consistent patterns that not only identify who is most at risk but also highlight critical missed opportunities for intervention within Scotland's health and care systems.

### Key Risk Factor Profile: The Evidence for Targeted Prevention

The reviews consistently demonstrate that **alcohol deaths disproportionately affect middle-aged men, though women tend to die at younger ages**. This demographic pattern, combined with high levels of social isolation and deprivation, creates a clear target population for enhanced prevention efforts.

#### The typical risk profile emerging across all reviews includes:

- Men aged 45-64 years (peak risk group)
- Women dying 1-11 years younger than men on average
- High levels of social isolation (45-63% lived alone)
- Residence in areas of multiple deprivation
- Complex mental health comorbidities (70-83% had mental health service contact)

### Age & Gender: Critical Demographic Patterns

Across all reviews, men aged 45-64 years old were consistently identified as the highest-risk demographic for alcohol-related death. Where data was available, the average age of men at death ranged from 54-59 years, while women died at consistently younger ages (48-57 years). The average age of women who died of alcohol-related causes was consistently lower than men, with the average difference ranging from 1 year up to 11 years over respective years.

One review noted that the peak age of alcohol-related deaths for females was 20 years younger than males in their area. This pattern observed across reviews reflects the wider evidence indicating that women face higher risks, including earlier occurrence of alcohol-related problems and problems which emerge even when consuming lower amounts of alcohol.<sup>viii, ix</sup> This research demonstrates that **equal alcohol consumption may produce disproportionate harm in women**, yet current service provision often fails to account for these biological differences in screening, intervention timing, and treatment intensity.

### Location: Geographic Concentration of Risk

**Rates of alcohol deaths were consistently higher in areas of greater deprivation** across all reviews.

One review noted that, despite some narrowing of gaps over the previous decade, mortality rates in the most deprived communities remained **three times higher** than in the least deprived areas. This is

similar to the national average where mortality rates are four times higher in the most deprived areas.

One review found that 33% of deaths occurred in the most deprived quintile compared to 14% in the least deprived quintile. Using the Scottish Index of Multiple Deprivation (SIMD), another review observed that the majority of individuals lived in SIMD 2 and SIMD 3 areas, with **none living in SIMD 5 (the most affluent areas)**.

This geographic concentration suggests that **targeted prevention efforts in specific communities could yield disproportionate benefits**, while also highlighting the complex relationship between poverty, social stress, and alcohol-related harm.

## Marital Situation & Family History: Social Isolation and Family Breakdown

**Social isolation emerges as a critical risk factor across all reviews**, with 45-63% of individuals living alone at the time of death and 31-66% reported as socially isolated. Whether this social isolation existed prior to, or emerged after, alcohol difficulties began, this appeared to lead to increased vulnerability.

Family breakdown was extensive, with at least half of individuals in two reviews being separated or divorced, potentially as a result of their alcohol consumption. Only one review observed that a higher number of people lived with someone else at 55%, with over half of these individuals married, in a civil partnership or co-habiting. Another review highlighted that 43% of individuals in one year had a close friend or family member who also had an alcohol problem.

One review found that just over a third of the cohort (35%) were recorded on their death certificate as being married at the time of their death with a similar proportion (36%) divorced and 20% were single/never married. Differences were seen between males and females in the cohort with more males being divorced or single compared to females. From reviewing case notes, seven individuals reported that their parent(s) were alcohol dependent and four reported alcohol dependence in their siblings, there were also mentions of partners with alcohol dependence.

**The domestic violence connection** was noted across two reviews, with women more likely to be victims than perpetrators. One review also noted that **child neglect was more common in those who were heavy drinkers**, and it had hindered the development of relationships with children under 16 years old, where some had been taken into care because of alcohol problems. Within one review, a higher percentage of women (6%) were recorded as neglecting children compared to men (2%).

## Housing Status at Time of Death

Housing problems were common across reviews, though the majority of individuals lived in their own homes at death. There were also a number of deaths occurring in acute hospitals and community hospitals. Very few deaths occurred within care homes, but a higher number involved homeless people in temporary accommodation such as bed and breakfasts or hostels, indicating **housing instability as both a risk factor and consequence** of severe alcohol dependency.

## Employment Status

**Employment patterns varied significantly between reviews**, ranging from high unemployment rates to 60% employed in routine occupations in some areas. While most reviews found that most of their

respective cohorts were either unemployed or retired, another found that 60% of individuals were employed in routine or semi-routine occupations. One review reported that the majority of employed individuals worked in higher professional or lower managerial roles. Another highlighted that 6 individuals had a background of working in roles with a drinking culture, including working at sea. Some had also lost their jobs due to their drinking. A further review observed no patterns in occupation, with 47 separate occupation codes recorded across 61 individuals.

## Police and Fire Service

Contact with criminal justice systems was more common among men, with 6-19% having prison records over three-year periods compared to 15% of women over one year. In one review, **40% had documented police contact** either as perpetrators or victims of crime. Some had multiple contacts with the police over many years.

Social work notes within another review showed that just over a fifth of the cohort had contact with Criminal Justice Social Work on at least one occasion. For around half (7 of 15) there were reports of offending that was directly related to alcohol use.

**The relationship between alcohol and fire incidents was notable**, with 9% of individuals in one review having fire service contact due to alcohol-related incidents.

## Comorbidities

**Mental health comorbidities were nearly universal**, with reviews showing most individuals having co-existing mental health problems. The mean number of comorbid conditions was 3 per person in one review, indicating **complex multi-system disease requiring integrated care approaches**.

Where alcohol was not discussed during appointments, the most common conditions reported were depression, anxiety, hypertension and obesity. Depression was the most frequently recorded mental health condition, with individuals often prescribed antidepressants and anxiolytics. One review observed that **all mental health diagnoses were recorded more than 6 months before death**, indicating lengthy periods where intervention opportunities existed but were not fully utilised.

Self-neglect was recorded within some individuals' case notes. Another review found that just over half (n=35) of the cohort had reported mental health conditions at least once, noted at many contacts with services over numerous years for most individuals. About a quarter of the subset (n=18) reported chronic pain, which left some unable to work or with mobility issues. Reports of chronic pain were also associated with higher rates of mental health conditions. In one review, 3 individuals had a cancer diagnosis however this was not relating to the liver. **Three individuals showed signs of alcohol-induced brain damage**, one of which had a confirmed diagnosis.

## Mortality Statistics

### Cause of Death

Across all reviews, **the majority of deaths were as a result of alcoholic liver disease at an estimated 65.6% of cases**. The other most frequent causes of deaths varied across reviews and location, but ranged from:

- Alcohol Dependence Syndrome,

- Mental and behaviour disorders due to use of alcohol,
- Alcoholic cirrhosis of the liver,
- Alcoholic fibrosis of the liver,
- Alcoholic hepatic failure,
- Alcoholic liver disease, unspecified,
- Acute intoxication,
- Alcohol poisoning,
- Withdrawal Syndrome,
- Acute myocardial infarction,
- Alcoholic cardiomyopathy,
- Alcohol ketoacidosis.

**One review found that a higher proportion of people aged >65 years old died from fibrosis and cirrhosis of the liver** compared to younger people, whereas **deaths due to acute intoxication and alcohol poisoning were more common in people aged <44 years old**. Another observed that individuals had a **medical history of diagnoses attributable to alcohol recorded in their case notes, of which 82% were recorded more than 6 months prior to death**. One review noted differences between males and females, with a **greater proportion of males dying from alcoholic liver disease** (72% compared to 54% of females).

## Contact with Services

A key focus of the reviews conducted was to assess individuals' contact with services prior to their death and the nature of that contact. The table below summarises the topics considered within the reviews and displays the range/variation across reviews where possible, highlighting the key findings. RAG scoring is applied to indicate completion rates in relation to documentation of alcohol problems, advice provision, screening and referrals made, where Red = 24% or below, Amber = 25-74%, and Green = 75% or above. Descriptive components of the table which would not be appropriate to apply RAG scoring to have not been colour-coded.

Review Aspect	Range/Variation Found	Key Findings
GP Documentation of Alcohol Problems	85-98% across four reviews	High awareness but terminology inconsistent
Alcohol Advice Provision	89-91% across five reviews	Consistently high across reviews
Abstinence Advice	79-85% across five reviews	Good coverage, provided median 6 years before death
Screening for Hazardous Drinking	17-41% across five reviews	Significant variation - major gap identified
Referrals to Specialist Services	45-80% across four reviews	Wide variation suggests system inconsistencies

Review Aspect	Range/Variation Found	Key Findings
Gender Differences	Total number of presentations: Male (24) vs Females (5) in one review	Clear disparity in service utilisation patterns
Service Contact Duration	Average 7.9 years in one review	Long-term engagement before death

**TABLE 3. Contact with Services**

Key themes identified across reviews included:

### 1. High Awareness of Alcohol Use but Variable Recording Across Services and Documentation

- Alcohol problems were consistently well-recognised at primary care level (95-98% documented in some reviews), but inconsistent terminology was used to describe drinking behaviours ('dependent', 'social drinking', 'intoxication'), and discrepancies existed between full case notes (100% recording) and GP notes (85% recording) for the same individuals.
- Recording methods varied considerably across services and practitioners, with some recording consumption in units, others using general descriptions of type and quantity consumed, and others using vague terms like "drinking heavily" without quantification, making it difficult to track changes over time or compare information across different service contacts.

### 2. Extensive Service Contact Patterns

- Data across all reviews often indicates high levels of contact with multiple services throughout individuals' lives (social services, A&E, outpatient/inpatient services, mental health services), with an average of 7.9 years of documented attendance at outpatient and GP appointments prior to death in one audit, demonstrating sustained long-term engagement.
- Gender differences in presentation patterns were evident, with men averaging 24 presentations over the lifespan compared to 5 for women in one cohort, and contacts with secondary care increasing dramatically in the years immediately prior to death while primary care and social work contacts often occurred much earlier.

### 3. Variable Delivery of Advice and Follow-Through with Brief Interventions

- Advice around alcohol use was given to the majority (89-91% of cases), with specific advice to abstain provided to 79-85% (median 6 years prior to death), demonstrating good awareness among healthcare professionals, though some individuals may have underreported consumption, affecting appropriate advice delivery.
- Formal Alcohol Brief Interventions (ABIs) showed much greater variability in delivery (6-25% across cohorts; see section below) despite screening indicating need in many more cases, representing a significant implementation gap between screening and intervention.

#### 4. Screening and Referral Inconsistencies

- Wide variation existed in screening rates for hazardous drinking using validated tools (17-41%), suggesting inconsistent implementation of screening protocols despite national guidance recommending screening in priority settings.
- Referral rates to specialist services varied dramatically (45-80% across areas), with main services referred to including community addiction teams, counselling, and Alcoholics Anonymous, though not all referrals were accepted or resulted in sustained engagement (55% referred to substance use liaison while in hospital in one area, but not all accepted).

#### Critical areas requiring attention:

- **Standardisation of screening protocols:** There is an urgent need for consistent implementation of validated screening tools across all priority settings (primary care, emergency departments, and antenatal services).
- **Consistency in referral pathways:** Referral rates to specialist services ranging from 45-80% across areas suggest significant system inconsistencies that cannot be explained by differences in patient populations alone.
- **Terminology standardisation for alcohol use disorder documentation:** The use of varied and sometimes vague terminology ('dependent', 'social drinking', 'intoxication', 'drinking heavily') without clear definitions hinders effective communication between services and makes it difficult to track changes in an individual's condition over time.
- **Gender-specific intervention strategies:** The notable gender differences observed in service contact patterns, referral rates, and engagement require targeted responses.

#### Recorded Alcohol History

The completed reviews explored the recorded alcohol history of individuals, including what was documented and how this information was recorded. The table below summarises what was recorded within the reviews and displays the range/variation across reviews where possible, highlighting the key findings.

Review Aspect	Findings/Range	Key Observations
<b>Age at Problem Recognition</b>	32% by age 25 in one review; average age of 38 years (range 18-78) in another review	Early adult onset common
<b>Gender Differences - Males</b>	40% identified problems by age 25 in one review; earlier onset (32-37 years) in another review	Earlier recognition in males
<b>Gender Differences - Females</b>	53% identified by age 35 in one review; later onset (36-39 years) in another review	Later recognition pattern

Review Aspect	Findings/Range	Key Observations
<b>Documentation Time Lag</b>	2-5 years average across two reviews; median 13 years prior to death in another review	Substantial delays in recording
<b>Weekly Consumption - High End</b>	>900 units maximum recorded in one review	Extremely severe consumption
<b>Weekly Consumption - Average</b>	200-220 units median across three reviews	Consistently high levels
<b>Weekly Consumption - Range</b>	50-99 units (lowest) to >900 units	Wide variation in severity
<b>Abstinence Periods</b>	55% had abstained at some point in one review	Significant attempt at recovery
<b>Alcohol Types Consumed</b>	Wine (70%), Spirits (60%), Beer/Cider (50%) in one review	Wine most common preference

**TABLE 4. Recorded Alcohol History**

Key themes identified across reviews included:

### 1. Early Onset with Gender Differences in Identification or Reporting of Alcohol Problem

- Problematic alcohol use often began in early adulthood, though age at first identification varied considerably (32% reporting problems by age 25 in one review, average age 38 but ranging 18-78 years in another), suggesting variable timing of problem development or recognition.
- Consistent gender differences showed males typically reporting or being identified with problematic drinking at younger ages (40% by age 25 in one review, average 32-37 years in another) compared to females (53% by age 35 in one review, average 36-39 years in another), potentially reflecting biological factors, social factors, or help-seeking behaviours.

### 2. Substantial Delays in Recognition and Documentation

- Significant time lags existed between when individuals first experienced alcohol problems and when these were formally recognised and documented, with average delays of 2-5 years between problem development and case note recording. The term “social drinker” was often used prior to problem recognition. Within another review a median of 13 years was observed between first recorded problems and death.
- Additionally, there was an average 2-year delay between patients presenting with alcohol-related conditions and alcohol consumption being recorded as a concern in GP notes, with most individuals reporting long histories of heavy drinking (commonly 10-20 years) by the time of documentation.

### 3. Inconsistent and Variable Recording Practices Relating to Type and Amount of Alcohol

- Recording methods varied considerably with some using standard units, others using general descriptions (“one litre of vodka”, “28 units”, “drinking heavily”), and some patients having

very limited documentation, highlighting need for better and more consistent history-taking practices.

- Recording was particularly variable across different consultations and services for the same individual, with alcohol consumption sometimes discussed and recorded in one specialty but not in others treating the same person, and reliance on self-reporting likely leading to underestimation of actual consumption.

#### 4. Very High Consumption Levels with Gender Differences

- Extremely high consumption levels were documented, with one review recording maximum consumption over 900 units per week, lowest 50-99 units per week, and average maximum 288.3 units weekly (median across three audits: 200, 200, and 220 units), far exceeding low risk drinking guidelines of 14 units weekly.
- Men consistently consumed more than females across reviews, with some men consuming considerably more than average, though even women's consumption levels were extremely high and well into dependent drinking ranges, and most patients were noted to be regular daily drinkers rather than binge drinkers.

#### 5. Complex Drinking Patterns and Abstinence Attempts

- Despite severity of dependence, 55% of individuals in one review had achieved periods of abstinence at some point, with around half of these supported by specialist services and often receiving medications such as Acamprosate or Disulfiram during abstinence periods.
- One review detailed alcohol types consumed: wine (70%), spirits (60%, mostly vodka), and beer/cider (50%), with most drinking two types and some consuming all three, though ultimate outcome of alcohol-specific death indicated abstinence periods were not sustained.

#### Critical areas requiring attention:

- **Standardised recording protocols:** Implementation of consistent, standardised methods for recording alcohol consumption across all healthcare settings is essential. This should include mandatory recording of consumption in standard units; specified timeframes for recording (e.g., typical weekly consumption); consistent documentation of drinking patterns (daily, binge, etc.); and standardised terminology for describing severity of alcohol use disorders.
- **Early intervention strategies to target younger demographics:** Given that problematic alcohol use often began at an early age, there is a clear need for enhanced screening and early intervention approaches targeting younger adults.
- **Improved case notes systems and better clinical processes:** The substantial time lags between problem development and formal documentation (median 13 years prior to death in one review) indicate systemic failures in clinical processes.
- **Gender-specific approaches:** Services should develop targeted screening and treatment approaches that account for different presentation patterns in men and women, addressing specific barriers to disclosure and treatment-seeking in each gender.

- **Enhanced history-taking training:** The inconsistent and sometimes inadequate recording of drinking patterns suggests a need for improved training in comprehensive alcohol history-taking for all healthcare professionals.

It is important to note that there were **strengths identified** within the completed reviews, including the **recognition of abstinence attempts** and **appropriate medication support**. Findings also indicate an **awareness of extremely high consumption levels** requiring intensive intervention which should have resulted in onward referral to specialist services. There was however, significant variability in whether onward referral occurred.

## Screening Tools

A key focus of the reviews conducted was to understand the use of tools which assessed the amount of alcohol which individuals consumed, the type of alcohol, and the impact of alcohol on various biochemical markers. The table below summarises the topics considered within the reviews and displays the range/variation across reviews where possible, highlighting the key findings. RAG scoring is applied to indicate completion rates in relation to drink diary usage, screening and factors relating to ultrasound, where Red = 24% or below, Amber = 25-74%, and Green = 75% or above. Components of the table which do not highlight completion rates and would therefore not be appropriate to apply RAG scoring to, have not been colour-coded.

Screening Aspect	Findings/Range	Key Observations
<b>Drink Diary Usage</b>	2% → 6% → 13% (improving over time within one locality)	Significant underutilisation but gradual improvement
<b>FAST/PAT Screening</b>	32% - 35% screened across two reviews	Moderate usage in primary care
<b>FAST Score Follow-up</b>	3/5 individuals with score ≥3 received ABI in one review	Incomplete adherence to guidance
<b>Physical Dependence Evidence via Biochemical Markers</b>	57-78% across three reviews	High prevalence documented
<b>Cognitive Impairment</b>	13-31% prevalence across three reviews	Significant minority affected
<b>Hepatitis C Screening</b>	26-59% across two reviews	Wide variation in implementation
<b>Abnormal LFTs</b>	82% - 95% outside normal range across four reviews	Near-universal biochemical evidence
<b>Liver Ultrasound</b>	80% completion rate in one review	Good adherence to SHAAP Guidance <sup>x</sup> (stating all abnormal liver scores should result in a liver ultrasound scan)

Screening Aspect	Findings/Range	Key Observations
	However, time from abnormal LFT to Ultrasound in this review was 2 to 6 years	Long wait between both tests
<b>Time from Abnormal LFT to Death</b>	Median 6 years in one review	Long-term evidence of liver damage
<b>Time from Abnormal Scan to Death</b>	Median 1.5 years in one review	Accelerated deterioration after scan

**TABLE 5. Screening Tools**

Key themes identified across reviews included:

### 1. Inconsistent Implementation of Recommended Screening

- Screening tools were used inconsistently across reviews despite recommendations and requirements detailed in guidance, with the three priority settings (Primary Care, A&E, Antenatal) not systematically implementing screening protocols. It should be noted that only two reviews were completed since the current guidance for good practice from SHAAP<sup>x</sup> was published.
- Secondary care showed no evidence of documented screening tool use in some reviews, representing a significant missed opportunity given the high frequency of hospital contacts among those who died.
- NHS Boards and Alcohol & Drug Partnership (ADP) partners should ensure that screening is carried out in priority settings using an appropriate screening tool, followed by an ABI where required, but implementation remains patchy and variable across Scotland.

### 2. Underutilisation of Drink Diaries

- Drink diaries (issued to patients to facilitate accurate collection of the quantity of alcohol consumed and recommended within the latest version of the UK Clinical Guidelines for Alcohol Treatment [*draft for consultation*]<sup>xi</sup>) were rarely used, with only 2% of one cohort having these recorded initially.
- There has been gradual improvement over time in some areas, with usage increasing from 2% to 6% to 13% across subsequent cohorts in one locality, and high completion rates (100%) when offered, suggesting patient acceptance.
- Despite this improvement, drink diaries remain significantly underused as a tool to aid identification of problem drinking and support accurate assessment, with no mention of their use within most reviews completed.

### 3. Variable Application of Formal Screening Tools

- Multiple validated screening tools were in use across areas (FAST, PAT, SADQ), with 32-35% of individuals screened in some cohorts, though rates varied considerably between areas and settings.

- Gaps were apparent between screening results and appropriate referral actions. While screening tools should inform whether an ABI is delivered and whether onward referral to specialist services is needed, in practice this was variably implemented, with some individuals with high scores not receiving appropriate next steps.

#### 4. Delayed Recognition Through Biochemical Markers

- Biochemical markers indicating physical alcohol dependence or harm were widely present (57-78% across three audits showing evidence of dependence, 82-95% having abnormal liver function tests across four reviews), but follow-up investigations were inconsistent.
- Long intervals existed between abnormal results and death, with one review finding that the first abnormal liver function test was recorded a median of 6 years prior to death, and for those who had abnormal ultrasound scans, these occurred a median of 1.5 years before death.
- While SHAAP Guidance<sup>x</sup> states that patients with abnormal liver biochemistry associated with excess alcohol consumption should have a liver ultrasound scan, this occurred in only 80% of cases in one review which was conducted after the publication of this guidance, with the time between abnormal blood tests and ultrasound scans varying from within 2 years to over 6 years.

#### Critical areas requiring attention:

- **Standardised screening implementation across priority settings:** There is an urgent need for consistent implementation of screening protocols in the three priority settings (primary care, emergency departments, and antenatal services) where national guidance mandates screening.
- **Bridge gap between screening and intervention delivery:** The finding that individuals with high screening scores did not consistently receive appropriate next steps (ABIs or specialist referrals) indicates a key area of concern.
- **Address absence of documented screening in secondary care settings:** The lack of evidence of screening tool use in secondary care represents a major missed opportunity given the high frequency of hospital contacts among individuals who died from alcohol-related causes.
- **Hepatitis C screening consistency:** Wide variation in Hepatitis C screening rates (26-59% across two reviews) despite high co-infection rates (16-24% positive when tested) indicates inconsistent application of best practice guidelines.

It is important to note that there were **strengths identified** within the completed reviews, including **high completion rates when screening tools are offered**. There was **good adherence to liver investigation guidelines** and **comprehensive documentation of physical evidence** of alcohol harm.

## Emergency Department & Hospital Attendance

A key focus of the reviews conducted was to assess individuals' contact with hospital and emergency departments prior to their death and the nature of that contact. The table below summarises the topics considered within the reviews and displays the range/variation across reviews where possible, highlighting the key findings. RAG scoring is applied to indicate instances where alcohol was recorded where Red = 24% or below, Amber = 25-74%, and Green = 75% or above. Components of the table which do not highlight completion rates and would therefore not be appropriate to apply RAG scoring to, have not been colour-coded.

Review Aspect	Findings/Range	Key Observations
<b>Emergency Department Rates (3 years prior)</b>	88.4%-95% of individuals across two reviews	Near-universal ED contact
<b>Average Attendances (6 years)</b>	8 times per person in one review	High frequency repeat usage
<b>Median Attendances (3 years)</b>	4 per person (range 1-11) in one review	Consistent pattern across reviews
<b>Alcohol Recorded as Factor</b>	16-27% of attendances across two reviews	Significant under-recording
<b>First Alcohol-Related Contact</b>	Average 2.7 years before death (range 9.3 years and 20 days) in one review	Relatively recent recognition
<b>Most Common Discharge Diagnosis</b>	Alcoholic liver disease (5.5%) in one review	End-stage organ damage prevalent
<b>Second Most Common</b>	Acute alcohol withdrawal (5%) in one review	Higher withdrawal presentation rates
<b>Common Specialties</b>	General medicine, surgery, gastroenterology, orthopaedics, respiratory	Multi-system involvement

**TABLE 6. Emergency Department Attendances**

Key themes identified across reviews included:

### 1. Escalating Contact Patterns Approaching Death

- There was a clear temporal relationship between hospital presentations and proximity to death across multiple reviews, with dramatic increases in service contact during the final 12 months of life; one review showed 80.3% of people experienced a hospital admission in this period.
- High frequency of repeat attendances was evident, particularly in final years, with some individuals attending emergency departments 10 or more times, and only 4.8% of people having no recorded service contacts in the three years prior to death in one cohort.

- Over a six-year period, one audit found each person attended an emergency department around 8 times on average, while another review showed 95% of individuals attended emergency departments in the last three years of life with a median of 4 admissions (ranging up to 11 for one individual).

## 2. Universal or Near-Universal Emergency Department Contact

- The vast majority of individuals (88.4%-95% across reviews) had attended emergency departments in the years prior to death, indicating near-universal contact with acute services that represented multiple opportunities for intervention.
- More than half of individuals (39 in one cohort) had their first contact with emergency departments for any reason 5 years or more prior to their death, demonstrating long-term patterns of emergency service use that could have triggered earlier preventive interventions.
- The majority (64/68 or 94% in one review) of individuals had attended an emergency department at least once in the time period examined, with 85% of attendances occurring at hospitals within the health board area of residence.

## 3. Inconsistent Alcohol Recognition and Recording

- Significant variation existed in recording alcohol as a contributory factor, with only 16-27% of emergency department attendances having alcohol documented despite the individuals ultimately dying from alcohol-specific causes.
- Alcohol was often unrecorded even in the final months before alcohol-related death; one review found alcohol was not recorded in 26% of instances, including in the 3-month period prior to death in some cases.
- Where alcohol-related or alcohol-involved attendances were recorded, the majority of first such attendances occurred less than 5 years prior to death (average 2.7 years, ranging from 9.3 years to 20 days), suggesting delayed recognition of alcohol as a factor even when individuals had been attending emergency departments for other reasons for much longer.

## 4. Complex Presentation Patterns and Comorbidities

- Individuals presented with a wide range of complaints beyond direct alcohol-related issues, including superficial head injury, falls (specified and unspecified), feeling unwell, fractures, pain, seizures, collapse and intoxication, demonstrating the multi-system impact of alcohol.
- The most common discharge diagnoses were alcoholic liver disease (5.5%) followed by acute alcohol withdrawal (5%), with services most often accessed including general medicine, general surgery, gastroenterology, orthopaedics, and respiratory medicine.
- Multiple medical specialties were involved in care, reflecting the complex health needs of individuals with severe alcohol problems, though coordination between these specialties regarding alcohol issues was often poor.

### Critical areas requiring attention:

- **Documentation gaps:** The finding that alcohol was documented as a contributory factor in only 16-27% of emergency department attendances for individuals who ultimately died from alcohol-specific causes represents an important learning point in clinical assessment and recording.
- **Missed opportunities with high emergency department attendance rates but inconsistent recognition of alcohol difficulties:** With 88.4%-95% of individuals attending emergency departments and an average of 8 attendances per person over six years, there were multiple opportunities for intervention that were not taken.
- **Relatively high service usage from small cohorts:** The concentration of emergency department attendances among individuals with alcohol problems (some attending 10+ times) places significant demands on emergency services.

It is important to note that there were **strengths identified** within the completed reviews, including **high service accessibility and engagement**. There were also details of **multi-specialty care**, providing support to individuals across disciplines.

### Outpatient Appointments

The completed reviews assessed individuals' contact and engagement with outpatient departments prior to their death and the nature of that contact. The below tables summarise the topics considered within the reviews and displays the range/variation across reviews where possible, highlighting the key findings.

Review Aspect	Findings/Range	Key Observations
<b>Overall Attendance Rates</b>	45%-91% of cohorts (mean 79.8%) across five reviews	Near-universal outpatient contact
<b>Appointment Intensity</b>	402 appointments for 20 individuals, with 4 individuals accounting for 50% of total appointments (one cohort over a 9-year period)	Very high service usage
<b>Median Appointments</b>	6-15 per person across two reviews	Significant variation between reviews
<b>Attendance in Final 180 Days</b>	11% of total appointments in one review	Increased contact near death
<b>Attendance in Final 3 Months</b>	14.3% attended an appointment in one review	Greater end-of-life contact
<b>Long-term Engagement</b>	33% first appointment 7+ years before death in one review	Extended care relationships

TABLE 7. Outpatient Attendance Patterns

Specialty/Condition	Frequency/Notes	Clinical Context
<b>Gastroenterology</b>	Most common (33% in one review) to least common in another	Liver disease management
<b>General Psychiatry</b>	Common across reviews	Mental health comorbidity
<b>Trauma/Orthopaedics</b>	Frequently accessed	Fall and injury presentations
<b>Respiratory Medicine</b>	Regular attendance	Alcohol-related respiratory issues
<b>Most Common Conditions</b>	Alcohol-related liver disease, alcohol dependence syndrome, harmful use	Advanced disease presentations

**TABLE 8. Specialty Distribution and Conditions**

Key themes identified across reviews included:

### 1. High-Intensity Service Usage with Concentrated Demand

- Very high appointment volumes were generated by relatively small numbers of individuals, with one cohort of 20 people generating 402 appointments over 9 years, and just 4 individuals accounting for 50% of the total appointments.
- Long-term engagement patterns spanning multiple years were evident, with 33% having their first outpatient appointment 7 or more years before death in one review, and around half having their last appointment in the same year as their death.
- Significant variation existed in attendance patterns between individuals within cohorts; over the final 180 days of life in one review, 5 individuals had no outpatient appointments and 8 had low rates, but 1 individual had 50% of their total appointments during this period.

### 2. Universal or Near-Universal Outpatient Contact with Varied Engagement

- The overwhelming majority of individuals (mean 79.8% across five reviews, ranging from 45%-91%) attended outpatient services at least once, with high median appointment numbers (6-15 per person) indicating sustained engagement over time.
- One review found 91% had at least one outpatient appointment with a median of 15 appointments, while another saw around 40% attendance but noted some individuals were lost to follow-up due to non-attendance at subsequent appointments.
- In one review, 85% of the cohort attended one or more outpatient appointments between 2009 and 2020, with the majority (91%) of appointments attended being in hospitals within the health board area of residence, indicating good local service accessibility.

### 3. Systematic Failures in Cross-Specialty Communication

- Alcohol consumption was discussed inconsistently across different medical specialties treating the same individuals, with examples of problem alcohol use being recorded in one specialty but not discussed in appointments with other specialties that occurred within the same time period or subsequently.
- Information silos existed between departments, with some individuals being asked about alcohol consumption when first referred to a service and reporting problem use, but then not being asked again at subsequent appointments with that specialty or related specialties.
- In secondary care case notes reviewed (n=24 in one audit), three quarters (n=18) had documentation of alcohol consumption being discussed with individuals at least once across all outpatient appointments, but this meant a quarter had no such documentation despite attending multiple appointments.

### 4. Variable Documentation and Recording Practices

- Inconsistent methods existed for recording alcohol consumption across specialties, with different timeframes and measurement approaches used (some recording weekly units, others describing patterns like "heavy drinker," and others using vague terms).
- One-off discussions about alcohol were often not followed up in subsequent appointments, with no evidence of ongoing monitoring or repeated brief interventions to support behaviour change.
- The lack of standardised documentation meant that when individuals attended different specialties for conditions that could all be alcohol-related (liver disease, repeated falls, mental health problems), there was no consolidated picture of their alcohol use informing care planning.

### 5. Diverse Specialty Involvement with Gastroenterology Prominence

- Multiple medical specialties were involved in care, with gastroenterology being most frequently accessed in some reviews (accounting for a third of all outpatient appointments in one area) and least common in another, suggesting different local referral patterns.
- The most common specialties attended varied between reviews but typically included general psychiatry (mental illness), gastroenterology, trauma and orthopaedic surgery, respiratory medicine, ophthalmology, and general medicine.
- Where stated, the most common reasons for attendance included alcohol-related liver disease, alcohol dependence syndrome, harmful use of alcohol, and obesity, though many appointments in specialties like orthopaedics were ostensibly for other conditions that may have had alcohol as a contributing factor.

### Critical areas requiring attention:

- **Alcohol information not shared between departments treating same individuals:** The siloed nature of information about alcohol consumption across specialties represents a fundamental system failure.
- **One-off discussions not followed up in subsequent appointments:** The pattern of alcohol being discussed once then not revisited in subsequent appointments suggests missed opportunities for repeated brief interventions, which evidence shows are more effective than single conversations.
- **Different recording methods across specialties creating fragmented care:** The use of different measurement approaches, timeframes, and terminology for recording alcohol consumption across specialties makes it impossible to track changes over time or identify escalating problems.

It is important to note that there were **strengths identified** within the completed reviews, including **high outpatient engagement rates** (patients attending at least one appointment) and **good initial alcohol screening** at referral. There were examples of **extended care relationships** spanning multiple years and **strong local service accessibility**.

### Inpatient Appointments

A key focus of the reviews conducted was to assess individuals' contact and engagement with inpatient departments prior to their death and the nature of that contact. The tables below summarise the topics considered within the reviews and displays the range/variation across reviews where possible, highlighting the key findings.

Review Aspect	Findings/Range	Key Observations
<b>Overall Admission Rates</b>	78%-100% of cohorts (mean 88%) across all six reviews	Near-universal inpatient contact
<b>Total Episodes (10 years)</b>	297 episodes for one cohort	High volume concentrated usage
<b>Admission Range</b>	1-84 admissions per person in one review	Extreme variation in intensity
<b>Emergency Admissions</b>	56-80% of total admissions across two reviews	Predominantly unplanned care
<b>Final 180 Days Concentration</b>	31% of total episodes in one review	Dramatic end-of-life intensification
<b>First Admission Timing</b>	>50% within 5 years of death in one review	Relatively late disease recognition

Review Aspect	Findings/Range	Key Observations
<b>Alcohol-Related Admissions</b>	75% within 5 years of death in one review	Even later alcohol-specific recognition
<b>Admission Span Duration</b>	Median 5.5 years (range 1-39) in one review	Long-term episodic care relationships

**TABLE 9. Admission Patterns and Volumes**

Clinical Category	Frequency/Details	Disease Progression Indicators
<b>Primary Diagnosis</b>	Alcoholic liver disease (most common across all reviews)	Advanced hepatic damage
<b>Secondary Conditions</b>	Alcohol withdrawal, ascites, gastritis, cirrhosis	Multi-system complications
<b>Severe Complications</b>	Encephalopathy, haematemesis, deranged LFTs	End-stage presentations
<b>Hepatitis C Co-infection</b>	16% of males and 24% of women positive when tested in one review	Additional liver damage risk
<b>Drug Use History</b>	95% no illegal drug use history in one review	Primarily alcohol-related pathology

**TABLE 10. Clinical Presentations and Diagnoses**

Key themes identified across reviews included:

### 1. Escalating Admission Patterns with End-of-Life Intensification

- Clear concentration of admissions occurred in the final months of life, with 31% of total inpatient episodes occurring within the final 180 days of individuals' lives in one review, demonstrating accelerated deterioration as death approached.
- The majority of admissions (56-80%) occurred via emergency routes rather than planned care, indicating crisis-driven rather than proactive healthcare engagement and missed opportunities for earlier, planned interventions.
- Dramatic end-of-life intensification was evident, with volume of inpatient episodes remaining regularly low until late in the disease course, then peaking significantly; one review showed 112 episodes in 2021 compared to much lower volumes in preceding years.

### 2. High Admission Volumes with Significant Variation

- Universal or near-universal inpatient contact was demonstrated (mean 88% across six reviews, ranging from 78%-100%), with 432 total inpatient admissions recorded for 57 individuals in one review (median 4, ranging from 1 to 84 admissions per person).

- Significant variation in admission frequency between individuals was evident, with some having only 1-2 admissions while others had 10 or more, and one individual accumulating 84 admissions between 2009 and 2020.
- Small numbers of high-intensity users generated disproportionate admission volumes; 10 individuals accounted for all admissions over 10 times in one cohort, while 17 individuals had 5 or more alcohol-related admissions.

### 3. Alcoholic Liver Disease as Dominant Presentation

- Consistent pattern existed across all reviews of alcoholic liver disease as the primary diagnosis for the majority of admissions, followed by alcohol dependence syndrome and seizures due to alcohol.
- Progressive complications of liver disease were documented including ascites (fluid accumulation), encephalopathy (brain dysfunction), haematemesis (vomiting blood), and hepatitis, reflecting advanced organ damage.
- Late-stage presentations were typical, with over half of individuals having their first inpatient admission within 5 years of death, and 75% having their first alcohol-related admission within 5 years of death, suggesting delayed recognition or presentation of severe alcohol problems.

### 4. Inconsistent Hepatitis C Screening and Management

- Variable screening rates existed across reviews (26-57% tested). Guidelines state that all patients with liver disease should be assessed for hepatitis, representing inconsistent application of best practice, however it should be noted that multiple reviews occurred prior to the publication of this guidance.
- Significant Hepatitis C co-infection rates were found when testing occurred (16-24% positive when tested), indicating an important additional risk factor for accelerated liver damage.
- Apparent association with concurrent drug use was noted in the minority of cases, though one review found that the majority (95%) did not have a history of illegal drug use, suggesting Hepatitis C risk factors extended beyond injecting drug use.

### 5. Limited Access to Liver Transplant Services

- Very few individuals were referred for liver transplant assessment across all reviews despite advanced liver disease presentations - only 3 patients referred in one review, 3 in another, with none referred at all in a third.
- Multiple barriers existed to transplant consideration including six-month abstinence requirements, medical unsuitability due to other comorbidities, and patients dying before scheduled assessment appointments could occur.
- In one review, no patients were referred for assessment for liver transplant, although three individuals had notes mentioning discussions around the possibility; these were not progressed due to individuals' history, current medical condition, and inability to maintain required abstinence periods.

## 6. Fragmented Discharge Planning and Continuity

- Adequate inpatient withdrawal management occurred where required, with Clinical Institute Withdrawal Assessment (CIWA)<sup>xii</sup> procedures carried out appropriately and medication provided to manage withdrawal symptoms safely.
- Poor discharge follow-up was evident however, with limited evidence of GP handover or community service referrals in medical records, and for some individuals support stopping at discharge with no onward referral or aftercare recorded.
- Even when follow-up appointments were arranged, these were often limited in number and resulted in discharge with no further follow-up, suggesting inadequate planning for the long-term support needed to maintain recovery after acute treatment.

### Critical areas requiring attention:

- **Majority of admissions occurred within 5 years of death suggesting missed early intervention opportunities:** As severe problems often went unrecognised or unaddressed for many years, earlier identification and intervention could potentially have prevented progression to crisis admissions.
- **Adequate inpatient care not followed by appropriate community support:** The pattern of good acute care during admission followed by inadequate discharge planning and community follow-up represents a critical gap in care pathways.
- **Very low transplant referral rates despite advanced liver disease presentations:** With only 0-3 patients per cohort being referred for transplant assessment despite the majority having advanced liver disease, there appears to be either lack of awareness of referral criteria, therapeutic nihilism about outcomes for people with alcohol problems, or legitimate barriers related to inability to maintain abstinence.
- **Variable Hepatitis C screening despite high co-infection risks:** With 16-24% testing positive when screened but only 26-57% being offered testing, there is substantial missed opportunity for identifying and treating a condition that significantly worsens liver disease prognosis.

It is important to note that there were **strengths identified** within the completed reviews including **high inpatient service accessibility**. There were **good withdrawal management protocols (CIWA)**, **appropriate specialist referrals to gastroenterology** and **strong local service utilisation patterns**.

## Mental Health Appointments

The completed reviews assessed individuals' contact and engagement with mental health departments prior to their death and the nature of that contact. The tables below summarise the topics considered within the reviews and displays the range/variation across reviews where possible, highlighting the key findings. Table 13 also details the accessibility and availability of mental health services as detailed in reviews. RAG scoring is applied to indicate contact rates and availability/usage of services where Red = 24% or below, Amber = 25-74%, and Green = 75% or above. Descriptive

components of the table which do not highlight contact rates or service availability and would therefore not be appropriate to apply RAG scoring to, have not been colour-coded.

Service Category	Contact Rates	Gender Differences	Key Observations
Non-Addiction Mental Health	70-75% across two reviews	65% male, 85% female	Higher female engagement
Addiction-Specific Mental Health	39% in one review	35% male, 54% female	Significant gender gap
General and Alcohol-Specific Psychiatric Services (Under 25s)	67-83% across two reviews	Not specified	Very high youth referral rates
General Psychiatric Referrals	62-75% across two reviews	Women > Men (general services)	Consistent gender disparities
Clinical Psychology	0-18% across four reviews	Higher female referrals	Very limited access

TABLE 11. Mental Health Service Contact Rates

Review Aspect	Findings/Range	Clinical Significance
Certificate of Incapacity	65% enacted at least once in one review	High cognitive impairment rates
Attendance at All/Most Appointments	Only 11% in one review	Very poor engagement rates
Compliance with Interventions	~50% in men, higher in women as seen in one review	Gender-specific engagement patterns

TABLE 12. Service Utilisation Patterns

Service Type	Availability/Usage	Access Issues
Community Mental Health Teams	Widely available	Good accessibility
Crisis Teams	Available when needed	Crisis-reactive service
Psychological Therapies	Limited (0-18% referrals)	Significant access barriers
Residential Rehabilitation	Very limited (0-14%)	Major service gaps
CAMHS	No contact recorded	Age-appropriate service gaps
Child/Family Psychiatry	Minimal (trauma cases only)	Historical trauma unaddressed

TABLE 13. Service Access and Availability

Key themes identified across reviews included:

### **1. High Mental Health Comorbidity with Universal Service Contact**

- The overwhelming majority of individuals (67-83% across reviews) had contact with mental health services, reflecting the near-universal presence of mental health comorbidity in people dying from alcohol-related causes.
- Complex presentations requiring multiple different mental health teams were common, with individuals accessing support from community mental health teams, crisis teams, psychological therapies, substance use liaison, liaison psychiatry teams, and addiction psychological therapy services.
- High prevalence of severe cognitive impairment was documented, with 65% of one cohort having a certificate of incapacity enacted at least once (some up to 3 times), most commonly due to alcohol withdrawal, hepatic encephalopathy and/or delirium, indicating legal recognition of their compromised decision-making capacity.

### **2. Shifting Referral Patterns from Addiction-Specific to General Mental Health**

- Stepwise reduction in the proportion of patients referred to addiction psychiatry who died of alcohol use disorders was observed over time in one area, alongside an increase in referrals for other mental health issues particularly depression and anxiety.
- One review noted that the proportion of patients attending psychiatric services for addiction-specific issues in earlier audits was much higher than in later years, suggesting a shift in service model from specialist addiction mental health to generic mental health management.
- Questions arise about whether this shift represents appropriate integration of alcohol and mental health care or potentially problematic dilution of specialist addiction expertise, with reviewers recommending analysis of referral and attendance rates for specific alcohol services in future audits.

### **3. Gender Differences in Engagement and Referral**

- Women consistently showed higher engagement with mental health services across all categories (70-75% overall contact vs 65% for males, and 85% female vs 65% male contact with non-addiction mental health in one review).
- Better compliance with psychological interventions was observed amongst females, with around 50% compliance in men but higher rates in women, and women described as more amenable to "talking therapies" as part of their treatment.
- Gender-specific preferences for different intervention modalities were evident, though engagement remained challenging across both genders, with particularly poor male attendance at addiction-specific mental health services (35% male vs 54% female in one review).

#### 4. Poor Attendance and Compliance Rates

- Consistently low attendance at psychiatric appointments was documented across reviews, with only 11% attending all or most appointments in one review, despite high referral rates.
- High referral rates did not translate into sustained engagement, with the median number of appointments offered being 3 (ranging from 1-33 in one review), but many appointments not attended or completed.
- Particular challenges with male engagement in psychological services were evident, alongside general difficulties retaining both genders in treatment; one review noted lower rates of referral to addiction psychiatry combined with poor attendance meant few patients benefited from the service.

#### 5. Complex Bidirectional Relationship Between Alcohol and Mental Health

- Alcohol was commonly used as a coping mechanism for stress, depression, and anxiety, with individuals reporting they drank to manage difficult emotions or life circumstances, creating a self-perpetuating cycle.
- Mental health symptoms were frequently exacerbated during alcohol withdrawal, with individuals experiencing depression and anxiety when cutting down or stopping drinking, making abstinence difficult to maintain.
- Multiple opportunities for intervention existed through frequent mental health contacts, but these were not always well-utilised to address alcohol problems. Mood-related conditions like depression, anxiety, stress, or low mood required regular primary and/or secondary care attendance, providing opportunities to discuss alcohol use that were sometimes missed.

#### 6. Limited Access to Specialist Psychological Services

- Very low referral rates to clinical psychology existed (0-18% across four reviews), with geographic and resource variations in service availability between areas.
- Where referrals occurred, limited numbers of individuals engaged. In one review only 5 individuals had records of clinical psychology support more than 6 months prior to death, and another review found 7 out of 18 referred attended at least one appointment.
- No contact with Child and Adolescent Mental Health Services (CAMHS) was recorded across reviews despite many individuals having long histories of alcohol problems dating back to adolescence or early adulthood, and only minimal contact with child and family psychiatry (for past trauma in one case).

#### Critical areas requiring attention:

- **Shift from addiction-specific to general mental health services may reduce specialist expertise:** The observed move away from specialist addiction psychiatry towards management in general mental health teams raises concerns about maintenance of specialist knowledge and skills in alcohol treatment.

- **Consistently poor male engagement across all mental health services:** With lower male engagement rates despite equally high levels of mental health comorbidity, gender-specific barriers need to be addressed.
- **Access inequalities for psychological and residential rehabilitation services:** Very low referral rates to clinical psychology (0-18%) and residential rehabilitation (0-14%) suggest either lack of availability of these services or lack of awareness of their value.
- **High referral rates but very low sustained attendance:** The pattern of good initial referral rates not converting into sustained engagement suggests problems with appropriateness of services offered not matching patient needs or preferences; lack of assertive outreach when appointments are missed; insufficient attention to practical barriers (transport, childcare, competing priorities); and need for more flexible delivery models including home visits, telephone/video appointments, or community-based delivery.

It is important to note that there were **strengths identified** within the completed reviews including **high mental health service awareness and referral rates**, plus **good crisis response capabilities**. There was **greater female engagement** with services and **multiple opportunities for intervention through existing contacts**.

## Interventions

### Context: Evolving Treatment Landscape

Scotland's approach to alcohol interventions is currently undergoing significant development. The UK Government is preparing to publish comprehensive Alcohol Treatment Guidelines that will provide:

- A detailed framework for specialist service providers to support high-quality alcohol treatment
- Guidance for commissioners to inform service specifications and quality assessment
- Clear consensus on good practice for implementing NICE-recommended interventions
- Frameworks for managing treatment pathways between hospitals and community, and prisons and community
- Reference standards for national regulatory bodies when inspecting alcohol treatment services

These guidelines aim to develop clear consensus on good practice and help services implement interventions for harmful drinking and alcohol dependence that are recommended by the National Institute for Health and Care Excellence.

### Alcohol Brief Interventions (ABIs)

Recent national policy developments have significant implications for ABI implementation. On 29 October 2024, Public Health Scotland published a comprehensive review of the Alcohol Brief Intervention programme in Scotland, documenting recommendations for the programme's future direction.

The PHS review proposed three overarching recommendations for The Scottish Government to consider:

- **Reaffirm commitment** to the programme and its reorientation to flexible, evidence-informed conversations about alcohol
- **Set out steps** by which the vision of embedding conversations about alcohol can be achieved over 10 years
- **Seek engagement and leadership** from the Chief Medical Officer, Chief Nursing Officer, Royal College of Midwives and other relevant professional organisations to normalise conversations about alcohol

## Alcohol Brief Interventions (ABIs)

A key focus of the reviews conducted was to assess delivery rates of Alcohol Brief Interventions (ABI). The table below summarises the key findings. RAG scoring is applied to indicate screening completion and ABI delivery rates where Red = 24% or below, Amber = 25-74%, and Green = 75% or above.

Review Aspect	Findings/Range	Clinical Significance
Alcohol screening completion	17%-41% of patients across 5 reviews	Low rates of screening
ABI delivery rates	6%-25% across cohorts across 3 reviews	Very low delivery despite requirement for ABIs to be delivered if FAST score of 3 or more

**TABLE 14. Alcohol Brief Interventions**

Key themes identified across reviews included:

### 1. Low Uptake and Implementation Gaps

- ABI delivery varied significantly across reviews, ranging from 6% to 25% of cohorts receiving this intervention, with the majority of individuals who died having no recorded ABI despite FAST scores indicating need.
- Systematic gaps existed in identification and intervention processes, with one review noting that prior to ABI programme introduction, only 34% of patients had ever answered an alcohol screening questionnaire, though there was encouraging increase following introduction, albeit still covering less than half of problem drinkers.
- Coverage remained well below 50% of problem drinkers requiring intervention across all reviews, despite ABIs being a national priority with dedicated training, resources, and targets.

### 2. Missed Intervention Opportunities

- Most individuals were described as being referred for ABIs following the use of screening tools, but actual delivery remained limited, suggesting barriers between identification and intervention.

- Rare documentation of patient refusal existed (only one individual declining an ABI was recorded in one subset of 22 case notes reviewed), suggesting that low uptake was more likely due to system barriers (time, confidence, training) rather than patient unwillingness.

### 3. Target Population and Implementation Challenges

- ABIs were introduced to encourage health care workers to discuss alcohol consumption as part of routine care and encourage patients to decrease their consumption, primarily aimed at people drinking at hazardous levels rather than those already dependent.
- The intervention may have been beneficial for some patients with dependence despite not being the primary target group, though this was not the intended focus of the programme.
- Limited routine discussion of alcohol occurred prior to ABI programme implementation, indicating these programmes successfully increased awareness of the need to discuss alcohol, even if uptake remained suboptimal.

### Community Addiction Teams

A key focus of the reviews conducted was to assess individuals' contact and engagement with Addiction teams (Community Addiction Teams, Addiction Services) prior to their death. It is important to note that the names of such teams vary across localities, and that some of the areas included within this report have changed what they call these services since they published their reviews. The term 'Community Addiction Team' is therefore used as a "catch-all" for the purposes of this summary report. The table below summarises the topics considered within the reviews and displays the range/variation across reviews where possible, highlighting the key findings.

Service Aspect	Positive Indicators	Concerning Patterns
<b>Referral trends</b>	Rising rates across three reviews in one locality: 22% → 32% → 59%	Inconsistent recording across reviews
<b>Engagement</b>	Some planned discharges occurred	85% unplanned discharges in one review
<b>Gender access</b>	80% female referrals in one cohort	0% female attendance in multiple cohorts
<b>Treatment duration</b>	Range 22-401 days available in one review	Average only 123 days
<b>Appointment attendance</b>	Up to 12 appointments in one review (indicating that engagement is possible)	Average 3.4 appointments, 1.3 DNAs per referral
<b>Care coordination</b>	Voluntary agency referrals made	GPs uninformed of patient activity
<b>Service continuity</b>	Some follow-up planned	Limited aftercare, no onward referrals

TABLE 15. Addiction Teams

Key themes identified across reviews included:

### **1. Inconsistent Recording and Rising Referral Rates**

- Information about Community Addiction Team involvement was sporadic across reviews, hindering comprehensive assessment of service engagement and making it difficult to understand the full picture of support offered. This was due to two reviews including no information about such teams (one as a result of this service having not been developed at time of review, and the second did not appear to request this data). The level of detail provided in the remaining four reviews is varied.
- Where adequately recorded, referrals increased substantially over time from 22% to 32% to 59% across three reviews in one locality, thought to be at least in part due to greater joined-up working between agencies/departments and increased awareness of referral pathways.

### **2. High Disengagement and Poor Retention**

- Unplanned discharges were the predominant pattern, with 85% of discharges being unplanned in one review, indicating significant challenges retaining patients in treatment despite initial engagement.
- Average treatment duration was only 123 days (ranging from 22-401 days in one review) with low appointment attendance (average 3.4 appointments), alongside high non-attendance rates (average 1.3 DNAs per referral), demonstrating brief and intermittent rather than sustained engagement.
- Many individuals required repeated referrals (ranging from 2-5 referrals per person in one cohort), suggesting cyclical patterns of engagement and disengagement that were not effectively addressed.

### **3. Gender Disparities and Communication Breakdowns**

- Stark differences in engagement existed, with some cohorts showing no female attendance despite 80% female referrals in one area, while another showed better male engagement rates (54% male vs 80% female referred, but 0% female and 20% male attending).
- Primary care teams received insufficient information about patient attendance, defaulted appointments, and referrals to voluntary agencies, hampering coordinated care and meaning GPs were often unaware of this activity.
- Very little information appeared in primary care notes regarding patients attending the community addiction team or patients defaulting appointments, making it difficult for primary care teams to encourage or support engagement.

### **4. Poor Aftercare and Service Continuity**

- Limited evidence existed of planned discharge support, onward referrals, or follow-up care when treatment episodes ended, resulting in service gaps at a critical transition point.
- Even when planned discharges occurred, there was little evidence of either aftercare from the addiction team or onward referral to other agencies to provide continuing care, and follow-up appointments, when arranged, were limited and resulted in discharge with no further follow-up.

- Notes from community addiction teams identified a much larger number of referrals to voluntary agencies than was documented in GP notes, indicating GPs were not informed of this activity and could not reinforce or support it.

**Key service pathway concern:** The reviews highlight fundamental problems with care pathways, aftercare provision, referral processes, and inter-service communication that compromise treatment continuity and outcomes. Specifically, there was a consistent gap between primary care/GPs and specialist services, hampering coordinated care.

## Substance Use & Addiction Liaison

The completed reviews assessed individuals' contact and engagement with Substance Use and Addiction Liaison teams prior to their death. Such services were available in two different localities. The table below summarises the topics considered within the reviews and displays the range/variation across reviews where possible, highlighting the key findings. RAG scoring is applied to indicate referral rates where specified with Red = 24% or below, Amber = 25-74%, and Green = 75% or above. Where these details are not available, cells have not been colour-coded.

Service Aspect	Pre-Liaison Team Era	Post-Liaison Team Era
Referral pathways	22% to social work addiction services in one review	35-50% to acute addiction liaison across two reviews
Joint working	17% health/social care collaboration in one review	Not specified
Engagement rates	Not specified	26% of referred patients seen in one review
Contact frequency	Not specified	4.5 contacts per engaged person in one review
Screening practice	Limited documentation	80% asked about drug use (one review)
Substance patterns	Cannabis, benzodiazepines, stimulants	Cannabis (18%), illicit diazepam (14%)
Gender engagement	Not specified	Particularly poor female attendance

TABLE 16. Substance Use & Addiction Liaison

Key themes identified across reviews included:

### **1. Inconsistent Documentation and Variable Screening Practices**

- Documentation of non-alcohol substance use varied significantly across reviews, with mixed evidence of comprehensive assessment practices across different areas making it difficult to understand the true prevalence of poly-substance use.
- One review showed 80% of individuals were asked about drug use during clinical contacts, but overall assessment appeared patchy across reviews, with incomplete recording in clinical notes hampering comprehensive understanding of substance use patterns.

### **2. Poly-Substance Use Patterns and Overdose Presentations**

- Cannabis emerged as the most commonly used additional substance (18% in one review), with illicit benzodiazepines and heroin-diazepam combinations also noted in others, indicating overlap between alcohol and drug use in some individuals.
- Four individuals had overdose records in one cohort (including prescribed medications such as antidepressants and painkillers), with most overdoses appearing intentional based on documented suicidal ideation context, highlighting the intersection of substance use and mental health crisis.
- Women showed proportionately higher rates of additional substance use compared to men in one review (except for tobacco), suggesting gender-specific patterns in poly-substance use, though smoking was common across cohorts with 70% having smoked at some point during life.

### **3. Gender Disparities and Poor Engagement Rates**

- Particularly poor female attendance at liaison services was evident despite referral pathways being available, with women showing proportionately higher rates of substance use but lower engagement with services designed to address it.
- Only 26% of those referred actually engaged with acute addiction liaison services in one review, representing significant lost opportunities for intervention despite identification of need and availability of appropriate services.
- Engagement remained challenging across all groups, limiting intervention opportunities despite available pathways, with multiple contacts per engaged person (4.5 contacts in one review) suggesting intensive support for those who did engage but inability to engage the majority.

### **4. Low Referral Rates and Service Evolution**

- Acute addiction liaison team referrals ranged from 22-50% across reviews, showing considerable variation between areas and suggesting inconsistent identification or referral practices.
- Earlier reviews showed 22% referrals to social work addiction services pre-liaison teams, with evidence of joint working between health and social care in 17% of one sample, demonstrating service development over time from social work to acute liaison models.

- Despite service improvements and the introduction of dedicated hospital-based liaison services, sustained challenges remained with both referral rates and subsequent engagement, suggesting that availability alone is insufficient without addressing barriers to uptake.

## Detoxification

A key focus of the reviews conducted was to assess individuals' contact and engagement with detoxification services prior to their death. They also explored the most common detox settings and medications used. The table below summarises the topics considered within the reviews and displays the range/variation across reviews where possible, highlighting the key findings. RAG scoring is applied to indicate rates of detoxification where specified with Red = 24% or below, Amber = 25-74%, and Green = 75% or above. Where these details are not available, cells have not been colour-coded.

Review	Overall Rate	Male Rate	Female Rate	Most Common Setting	Key Findings
Review 2	42%	48%	24%	Outpatient (supported/unsupported)	Males higher average number
Review 3	63%	60%	73%	Acute inpatient	Women more likely to detox. Concerns that many detoxifications were unplanned or unsupported
Review 4	75%	Not specified	Not specified	GP unsupported	Chlordiazepoxide commonly prescribed
Review 6	1 patient	Not specified	Not specified	Acute inpatient	Due to COVID-19 lockdown the provision of inpatient detox was unavailable during some of 2020, with one individual in the cohort noted as potentially affected by this

**TABLE 17. Detoxification Access**

Key themes identified across reviews included:

### 1. Variable Access and Gender Disparities

- Access to detoxification varied significantly across reviews, with rates ranging from 1 patient in one cohort to 75% in another, reflecting differences in service availability, referral practices, or cohort characteristics.
- Gender differences were inconsistent across areas; women were more likely to undergo detoxification than men in two reviews (73% vs 60%, and 72% vs 60% respectively), while one audit showed higher male access (48% vs 24%), possibly reflecting biological vulnerabilities, treatment-seeking behaviours, or referral biases.

## 2. Setting Variations and Unsupported Detoxifications

- Acute inpatient detoxification was the most common setting in several reviews, providing supervised medical management in hospital, while GP unsupported detoxification (managed in community without specialist supervision) predominated in others, presenting risks of complications going unrecognised.
- A concerning pattern emerged of predominantly unplanned or unsupported detoxifications across multiple reviews, limiting opportunities for comprehensive assessment, psychosocial support, and long-term recovery planning.
- Cases of Wernicke Korsakoff syndrome (alcohol-related brain damage) were more likely to go unrecognised in unsupported settings, and patients were less likely to be comprehensively assessed for comorbidities, nutrition, and psychological needs without professional supervision.

## 3. Multiple Episodes and Pandemic Impact

- Many individuals underwent repeated detoxifications (ranging 2-5 per person in some cohorts), indicating cyclical patterns of dependence and limited long-term abstinence success, highlighting the chronic relapsing nature of alcohol dependence.
- Multiple detoxification attempts without sustained recovery suggest inadequate follow-up support, relapse prevention, and ongoing care after the immediate withdrawal period.
- COVID-19 lockdowns affected inpatient detoxification provision during some of 2020, with at least one individual in one cohort noted as potentially impacted by pandemic service restrictions that limited access to planned, supervised detoxification.

## 4. Medication Prescribing and Clinical Practice Concerns

- Around 66% received medication-assisted detoxification in one review, with chlordiazepoxide being the most commonly prescribed medication for managing withdrawal symptoms and preventing seizures.
- Inconsistent adherence to NICE guidelines existed for Thiamine/Pabrinex documentation and prescribing, despite these being essential to prevent Wernicke Korsakoff syndrome in people undergoing detoxification.
- In line with NICE guidelines, patients undergoing detoxification should be prescribed Thiamine and Pabrinex, particularly where the patient is malnourished or at risk, has decompensated liver disease, is in acute withdrawal, or is in specialist inpatient settings, yet documentation of this was inconsistent.

**Key concern:** The predominance of unplanned or unsupported detoxifications across reviews presents significant risks for treatment outcomes and long-term abstinence maintenance.

## Relapse Prevention Medication

The completed reviews assessed the type of relapse prevention medication used and usage patterns across included individuals prior to their death. The table below summarises the topics considered within the reviews and displays the range/variation across reviews where possible, highlighting the key findings.

Drug Classification	Specific Medications	Usage Pattern	Clinical Notes
<b>Relapse Prevention</b>	Acamprosate calcium	68% of community prescriptions in one review	Preferred NICE recommendation
	Naltrexone	Rarely used	Limited uptake despite evidence
	Disulfiram	Ranged from least to most common drug across three reviews	Variable use
<b>Withdrawal management</b>	Chlordiazepoxide	Most commonly prescribed	GP-led prescribing
	Clomethiazole	Less common	Hospital/specialist use
<b>Vitamin supplementation</b>	Thiamine	Universal (71-88% across two reviews)	NICE guideline compliance
	Folic acid, B12, B compound	Variable (3-28 patients)	Adjunctive treatment

**TABLE 18. Medication Type Distribution**

Key themes identified across reviews included:

### 1. Vitamin Supplementation Predominance Over Evidence-Based Medications

- Vitamin-based treatments (particularly Thiamine) were more commonly prescribed than relapse prevention medications across reviews, with 71-88% receiving Thiamine compared to much lower rates of acamprosate, disulfiram, or naltrexone.
- Low levels of relapse prevention interventions were observed across three audits, whether in the form of prescribed medication (acamprosate, disulfiram, naltrexone), day centres, or residential care, representing missed opportunities to support abstinence.
- While vitamin supplementation is important for preventing complications like Wernicke Korsakoff syndrome, the predominance over medications specifically designed to prevent relapse (like acamprosate) suggests a focus on managing complications rather than preventing return to drinking.

## 2. Community Prescribing Patterns and GPs as First Prescribers of Alcohol-Related Medications

- Over six years in one cohort, 25% received 50 dispensed alcohol-related prescription items in the community, demonstrating ongoing pharmaceutical management but concentrated among a subset of patients.
- The majority of alcohol-related medications were first prescribed by GPs, with evidence of continued GP prescribing following inpatient detoxification discharge, indicating GP leadership in ongoing medical management.
- Acamprosate calcium comprised 68% of dispensed medications in community settings in one review, making it the most commonly used relapse prevention medication where such medications were prescribed at all.

## 3. Inconsistent Prescribing Practices and Medication Choices

- No consistent pattern existed for acamprosate versus disulfiram prescribing across services, with disulfiram ranging from the least to most common drug across three reviews, despite NICE recommending acamprosate as first-line treatment<sup>xiii</sup>
- Patients often received multiple courses of relapse prevention medications over extended periods (one individual prescribed acamprosate monthly for one year, then disulfiram for eight months, another had three courses lasting 3 months, 1 month, and 3 months), suggesting repeated treatment attempts.
- Naltrexone was rarely used in either community addiction teams or primary care across reviews, despite evidence for its effectiveness, indicating either lack of awareness, concerns about prescribing, or preference for other medications.

## 4. Assessment Practices and Clinical Concerns

- CIWA (Clinical Institute Withdrawal Assessment) assessments were carried out in 80% of individuals in one review, indicating good practice in assessing withdrawal severity to guide medication dosing and identify those at risk of complications.
- Missed opportunities existed for maintaining abstinence following detoxification, with the predominance of vitamin supplementation over evidence-based relapse prevention medications suggesting clinical practice gaps.
- Inconsistent prescribing patterns not aligned with NICE guidance preferences (which recommend acamprosate as first-line) indicate need for improved training, formulary development, or shared care protocols to standardise practice.

**Key clinical concern:** The predominance of vitamin supplementation over evidence-based relapse prevention medications suggests missed opportunities for maintaining abstinence following detoxification, with inconsistent prescribing patterns not aligned with NICE guidance preferences.

## Access to Services

The following section highlights themes relating to access to services including social work teams and non-statutory services. RAG scoring is applied to indicate contact rates where Red = 24% or below, Amber = 25-74%, and Green = 75% or above. Descriptive components of the table which do not highlight contact rates and would therefore not be appropriate to apply RAG scoring to, have not been colour-coded.

### Social Work

Review	Social Work Contact	Gender Difference	Specialist Alcohol Referrals	Protection Referrals	Active at Death
Review 1	60%	Not specified	Limited detail	75% → adult/public protection	Not specified
Review 2	45% (44% males, 24% females)	Males: 7.1 contacts vs Females: 1.8	No women in addiction services	Not specified	25% open to addiction team
Review 3	57% (39/68 individuals)	Not specified	14/39 had alcohol service contact	Not specified	21/68 supported at death
Review 4	82%	Not specified	Limited despite documented alcohol problems	Not specified	Not specified

TABLE 19. Social Work Contact

**Note:** The variation in social work involvement (45%-82%) may reflect differences in local service provision, data collection methods, or cohort characteristics across the reviewed studies.

Key themes identified across reviews included:

#### 1. High Prevalence of Social Work Contact with Wide Variation in Engagement

- Social work involvement ranged from 45% to 82% across different reviews, with the majority of individuals who died from alcohol-related causes having had previous social services contact at some point in their lives.
- Long-term involvement often began in teens or early twenties when problematic alcohol use first emerged, with some individuals having contact spanning decades, providing multiple opportunities for intervention and support that were not always fully utilised.
- For many individuals in one review, contact with social work services began when they were in their mid to late teens and early twenties with problem alcohol use often noted at this early stage, though not always acted upon.

## 2. Gender Differences in Service Engagement

- One review showed men averaged 7.1 social work contacts over their lifetime compared to 1.8 for women, a nearly four-fold difference suggesting markedly different patterns of social work involvement or need between genders.
- Gender differences may reflect different pathways to social work engagement (men more likely through criminal justice, women through child protection or domestic abuse), or different help-seeking behaviours and service responses to men versus women with alcohol problems.
- Male over-representation in social work contacts may indicate criminal justice or housing-related referral routes, while women's lower contact rates may mask unmet need if barriers exist to accessing support.

## 3. Early Identification but Limited Specialist Alcohol Referrals

- Alcohol problems were frequently documented in social work records, with 28 of 39 individuals in one cohort (72%) having at least one entry in their social work records noting high levels of alcohol consumption or problem use.
- Despite documentation of alcohol problems, there were inadequate referrals to specialist alcohol services in many cases; only 14 of 39 individuals in one review had at least one mention of contact with or referral to an alcohol support service.
- This gap between problem recognition and appropriate specialist intervention represents critical missed opportunities for early, potentially more effective, intervention through existing social work contacts before problems became life-threatening.

## 4. Protection Concerns and Information Sharing Gaps

- A substantial proportion (75% in one review) were referred for public or adult protection at some point, indicating recognition of vulnerability and risk, though most referrals resulted in no further action (only 2 of most recent referrals progressed as adult protection in one cohort).
- Significant gaps existed in information sharing between social services and primary care, with 77% having a social work file in one area but very little information about this appearing in primary care notes, hampering coordinated care.
- GPs were often unaware of ongoing social work support (40% of patients were involved with social work teams at time of death but this was not documented in 64% of GP notes in one review), compromising their ability to provide coordinated, holistic care and reinforcing support plans.

## Non-Statutory Alcohol Services

Non-statutory alcohol services are support and treatment services provided by organisations operating independently of government funding and oversight. These include voluntary sector organisations such as charities and community groups, mutual aid groups like Alcoholics Anonymous and SMART Recovery, and private treatment providers. Unlike statutory services delivered by NHS or local authorities, non-statutory services are typically funded through donations, grants, or private

payment, and often provide specialised support such as peer counselling, group therapy, residential programs, and community-based recovery activities. Within the context of alcohol treatment pathways, non-statutory services play a crucial complementary role to statutory provision, though the reviews identified significant challenges in coordination between sectors, including poor documentation of referrals, unclear interface arrangements, and limited outcome monitoring, which compromised the continuity and effectiveness of care for individuals with alcohol problems.

Key themes identified across reviews included:

### **1. Variable Engagement Levels and Gender Disparities**

- Referral rates to non-statutory services ranged widely from 13% to 57% across reviews, suggesting either differences in availability of such services, awareness of them among statutory services, or local practices regarding when and how referrals are made.
- Significant variation existed in attendance and completion rates, with 56% of those referred to Alcoholics Anonymous attending in one review, but only one-third attending other voluntary addiction agencies, indicating different levels of engagement with different service types.
- Notable gender differences existed, with 13% of men but no women referred to Alcoholics Anonymous in one review, potentially indicating barriers to access for females in mutual aid services or lack of gender-appropriate alternatives.

### **2. Limited Follow-Through Support and Poor Timing**

- Referrals often consisted of mere recommendations to engage with services (such as "you should consider attending AA") without additional facilitation support such as arranging first appointments, providing transport, or accompanying individuals.
- Non-statutory services were frequently offered upon discharge or completion of statutory treatment rather than as complementary ongoing support, meaning individuals were transitioning between services at a vulnerable time without continuity.
- Poor attendance rates resulted from this lack of engagement support, with uptake generally poor when clients were transitioning between services, suggesting need for more active bridging and warm handovers.

### **3. Documentation Deficiencies and Service Integration Challenges**

- Primary care notes consistently showed inadequate recording of non-statutory referrals, with one review noting that community addiction team notes identified many more referrals to voluntary agencies than appeared in GP notes, meaning GPs could not reinforce or support engagement.
- Significant uncertainty existed about the role and interface between statutory and non-statutory services, with reviewers highlighting lack of clarity about what non-statutory services provide and how they connect with statutory pathways.
- Unclear treatment pathways and limited understanding of non-statutory service provision existed among statutory service staff, with reviews unable to identify the level of treatment provided by non-statutory services or evidence that referrals were discussed at subsequent consultations.

#### 4. Systemic Issues and Outcome Monitoring Gaps

- Service integration challenges appear systemic across multiple reviews rather than area-specific, suggesting this is a Scotland-wide issue requiring national-level attention rather than local fixes.
- Reviews were unable to identify the level of treatment and care provided by non-statutory services or any outcomes monitoring, making it impossible to assess effectiveness or value for money.
- Lack of evidence existed of ongoing discussion about non-statutory referrals in subsequent consultations, with no routine follow-up about whether individuals attended, found it helpful, or continued engagement, representing a "refer and forget" approach.

##### Critical areas requiring attention:

- **The lack of clarity about non-statutory service provision and their interface with statutory services** appears to be a systemic issue across multiple reviews rather than being area-specific
- **Consistent documentation gaps** suggest widespread information governance challenges
- **Gender disparities in referral patterns** require further investigation and targeted interventions

### Healthcare Costs

One review highlighted the costs associated with the use of healthcare resources within 2 individual years for the cohort of alcohol-related deaths, estimated to be around £4.07 million. The majority of these costs (81.5%) are attributable to the provision of acute hospital care, followed by mental health hospital care (8.3%) and community prescribing costs (5.4%). While these costs are not solely attributable to alcohol consumption, they do indicate where opportunities for intervention care might be prioritised. The costs identified are also likely to be an underestimate as data from specialist alcohol services and adult social care were not available for data linkage and inclusion.

## Alcohol Death Review Recommendations

### The Value of Reviews: From Analysis to Action

A fundamental purpose of alcohol death reviews is their capacity to transform detailed case analysis into actionable recommendations for service improvement. Unlike national statistics, which identify overall trends but provide limited guidance on what to change locally, death reviews create a direct pathway from understanding individual journeys through services to identifying specific, implementable changes that could prevent future deaths.

Each of the six reviews included in this summary report followed a similar trajectory: systematic data collection and analysis revealed patterns in how individuals engaged with services, where opportunities for intervention were missed, and what barriers prevented effective support. This analysis then informed the development of locally-relevant recommendations tailored to each area's

specific service landscape, population needs, and identified gaps. The recommendations emerging from these reviews (**see Appendix 1**) therefore represent not theoretical best practice but evidence-based responses to documented missed opportunities in real cases.

The process of developing recommendations varied across areas but often involved multi-agency collaboration. In one area, recommendations were developed through a workshop process facilitated by the Alcohol and Drugs Partnership. Workshop participants were invited to test the findings of the alcohol-related death review and to develop a list of recommendations for action, to form the basis of an action plan to contribute to reducing harm and mortality associated with alcohol through a facilitated process. The workshop included representatives from agencies including the NHS, mental health crisis team, public health, pharmacy, Alcohol and Drugs Partnership; statutory and third sector alcohol support services, Alcohol Focus Scotland, and the Scottish Government. This collaborative approach ensured recommendations were grounded in operational reality and had buy-in from those responsible for implementation. Notably, screening tool usage improved dramatically following implementation of recommendations from this review, demonstrating the tangible impact reviews can have on practice.

In another area, the review process catalysed ongoing system change beyond the initial recommendations. A multi-agency group continues to meet post-review to monitor implementation and address emerging issues. A GP alcohol liaison service test of change has been initiated based on review findings. Service mapping work is underway to better understand pathways and identify gaps. This sustained momentum demonstrates how reviews can serve as a catalyst for continuous quality improvement rather than one-off exercises.

### **Categories of Recommendations: Common Themes Across Reviews**

While each review produced recommendations specific to local context, analysis across all six reviews reveals five overarching themes that consistently emerged. These themes reflect the common patterns identified in the findings sections of this report and demonstrate how systematic analysis of deaths reveals system-level issues requiring attention across Scotland's alcohol care pathways.

#### **1. Early Identification and Recording of Alcohol-Related Harm**

The substantial delays between problem development and formal recognition (median 13 years in one review), combined with inconsistent recording practices across services, generated recommendations focused on improving how alcohol consumption and alcohol-related harm are identified, documented, and communicated. Reviews consistently recommended: enhancing training for health and care professionals in opportunistic alcohol assessment and recording; standardising terminology and recording methods across services; implementing systematic prompts in electronic health records; improving information sharing between departments and agencies; and promoting awareness of low-risk drinking guidelines among staff and the public.

The emphasis on early identification reflects the finding that individuals typically had extensive service contact years before death, representing multiple missed opportunities for intervention. Recommendations in this category aim to ensure that when individuals do engage with services, their alcohol use is recognised, accurately recorded, and acted upon, regardless of which service or professional they encounter.

## **2. Service Processes and Early Intervention**

The fragmented nature of care pathways, poor communication between services, and inconsistent referral practices identified across reviews generated extensive recommendations for improving how services work together to identify and support people with alcohol problems. Key recommendations included: developing clear referral pathways between services; creating dedicated roles (such as alcohol liaison nurses in emergency departments) to facilitate connections; implementing assertive outreach for individuals who disengage; enhancing multi-agency working through joint protocols and information sharing agreements; and developing communication materials to raise awareness of available services among referring professionals.

Several reviews highlighted the need to address social isolation and connect with non-health services that encounter vulnerable individuals, recommending liaison with housing associations, collaboration with employers, and engagement with educational settings. The emphasis on early intervention and multi-agency working reflects the finding that individuals often came to attention of multiple agencies (social work, housing, criminal justice) before their alcohol problems were adequately addressed.

## **3. Withdrawal Support and Psychological Care**

The finding that many individuals underwent unplanned or unsupported detoxifications, combined with limited access to relapse prevention medication and psychological therapies, generated recommendations focused on improving the quality and comprehensiveness of treatment. Reviews recommended: mapping current service provision against NICE guidelines; improving access to planned, supported detoxification in appropriate settings; ensuring availability of relapse prevention medications (particularly acamprosate and naltrexone); enhancing discharge planning and aftercare; developing shared care protocols between specialist services and primary care; and increasing access to psychological therapies.

Several reviews emphasised the need to develop long-term harm reduction pathways for individuals not ready for abstinence, and to conduct research with people with lived experience to understand barriers to engagement and what would make services more acceptable. The predominance of vitamin supplementation over evidence-based relapse prevention medications in several reviews prompted specific recommendations to review prescribing practices and promote appropriate use of anti-craving medications.

## **4. Priority and Vulnerable Groups**

The consistent demographic patterns identified across reviews (middle-aged men at highest risk but women dying younger; concentration in deprived areas; high levels of social isolation and mental health comorbidity) generated recommendations for targeted approaches to high-risk groups. Reviews recommended: developing methods to proactively identify individuals at highest risk of alcohol-specific death; creating gender-specific pathways recognising different patterns of harm and help-seeking; establishing integrated pathways addressing both physical and mental health needs; implementing family-inclusive approaches; and developing specialised support for complex cases with multiple needs.

The particularly poor engagement of men with mental health and addiction services in several reviews prompted recommendations for male-specific interventions, while the finding that women died at younger ages despite lower consumption generated recommendations for enhanced screening and earlier intervention for women. The near-universal presence of mental health

comorbidity led to recommendations for better integration between addiction and mental health services.

### **5. Monitoring, Reporting and Strategic Development**

Recognition that alcohol death reviews themselves remain rare (only 7% of ADPs conducting them in 2022/23) generated recommendations for enhanced monitoring and strategic oversight of alcohol harm at local and national levels. Reviews recommended: developing routine ADP reporting frameworks on alcohol-related morbidity and mortality; undertaking comprehensive service mapping and gap analysis; monitoring impact of national strategies such as Minimum Unit Pricing on local death statistics; exploring integrated commissioning frameworks for alcohol and drug services; and ensuring consistency in data collection and reporting across services.

Several reviews emphasised the value of repeating death reviews at regular intervals to monitor trends, evaluate impact of changes made, and identify emerging issues. The concentration of healthcare costs in acute hospital care (81.5% in one review) prompted recommendations to reorient resources toward prevention and early intervention.

### **The Evidence-to-Action Pathway**

What distinguishes death review recommendations from general best practice guidance is their grounding in detailed case analysis of local deaths. When a review documents that 95% of individuals had abnormal liver function tests a median of 6 years before death, the recommendation for better follow-up of abnormal results carries particular weight. When analysis shows that alcohol was recorded in only 16-27% of emergency department attendances for people who ultimately died of alcohol-related causes, the recommendation for improved emergency department screening becomes an urgent priority with clear baseline data for measuring improvement.

Similarly, when reviews identify that 85% of community addiction team discharges were unplanned, or that only 11% attended all or most psychiatric appointments despite high referral rates, these specific findings point directly to where service redesign is needed. The recommendations emerging from reviews are therefore not generic exhortations to "do better" but targeted responses to documented system failures, with clear metrics for assessing whether changes have made a difference.

### **Implementation and Impact**

The true value of death review recommendations lies not in their documentation but in their implementation. The examples from reviews included in this summary demonstrate that recommendations can and do lead to tangible change when properly resourced and monitored. Dramatic improvements in screening tool usage in one area, establishment of ongoing multi-agency groups in another, and initiation of service innovation such as GP alcohol liaison services in a third, all demonstrate the practical impact reviews can have.

However, implementation requires commitment, resources, and sustained attention. With only a small number of ADPs conducting alcohol death reviews, this suggests that many areas are missing the opportunity to generate this evidence-to-action pathway. The recommendations emerging from the six reviews analysed here provide a framework that could guide action across Scotland, but are most powerful when derived from and tailored to local data on local deaths.

## A Framework for Action

The five thematic categories of recommendations emerging from these reviews provide a comprehensive framework for improving alcohol-related harm prevention, early intervention, treatment and support across Scotland's health and care systems:

- **Early Identification and Recording** addresses the fundamental need to recognise alcohol problems when individuals present to any service, document this accurately and consistently, and communicate it effectively across the care system.
- **Service Processes and Early Intervention** tackles the fragmentation and poor coordination between services that allows individuals to fall through gaps despite multiple contacts, and creates clear pathways and connections.
- **Withdrawal Support and Psychological Care** ensures that when individuals are ready to address their drinking, effective, evidence-based treatment is available and accessible, with proper aftercare to sustain recovery.
- **Priority and Vulnerable Groups** recognises that alcohol harm is not evenly distributed and that effective prevention requires targeted approaches addressing specific needs of highest-risk populations.
- **Monitoring, Reporting and Strategic Development** creates the infrastructure for ongoing learning and improvement, ensuring that alcohol harm remains visible and prioritised at strategic level.

Together, these recommendations, derived from systematic analysis of deaths that might have been prevented, provide a roadmap for reducing alcohol-related mortality across Scotland. Their implementation, monitored through ongoing surveillance and periodic repeat reviews, offers the best prospect for ensuring that future deaths are prevented through learning from past losses.

## AFS Conclusion

This summary report demonstrates unequivocally that alcohol death reviews represent one of Scotland's most powerful yet underutilised tools for preventing alcohol-related mortality. The evidence presented across six reviews reveals a consistent and compelling picture; alcohol deaths often follow similar patterns, occur among identifiable high-risk populations, and represent the culmination of multiple missed opportunities for life-saving intervention.

### The Evidence for Action

While we cannot draw major conclusions from such a small number of reviews, the audits examined in this report have uncovered critical insights that would otherwise remain hidden in national statistics. We can see that alcohol deaths disproportionately affect middle-aged men while women die at younger ages; that social isolation and deprivation create concentrated vulnerability; and that the majority of individuals had extensive contact with health services, averaging 7.9 years of engagement before death. These are not abstract statistics but actionable intelligence that can transform how Scotland responds to alcohol harm.

Most significantly, the reviews reveal a healthcare system that recognises alcohol problems but struggles to act effectively upon this knowledge. While 95-100% of individuals had their alcohol problems documented in primary care, only 17-41% received appropriate screening for hazardous drinking. Despite 89-91% receiving alcohol advice, systematic gaps in follow-through meant that

opportunities for intervention were repeatedly missed. These findings point not to individual failings but to systemic issues that can be addressed through targeted improvements.

### **The Untapped Potential**

The consistency of findings across different geographical areas, time periods, and methodological approaches strengthens confidence that these patterns reflect genuine, Scotland-wide phenomena rather than localised anomalies. The reviews have identified specific intervention points where different approaches could save lives including earlier recognition of abnormal liver function tests (with a median six-year window before death), better coordination between emergency departments and addiction services, improved discharge planning following detoxification, and enhanced engagement with mental health services where 70-83% of individuals had contact.

Perhaps most importantly, the reviews demonstrate that alcohol-related deaths are not inevitable outcomes but preventable tragedies. The evidence shows individuals actively seeking help - 55% had periods of abstinence with specialist support, many underwent multiple detoxifications, and there was near-universal contact with health services. The system was engaging with these individuals; it was the quality and coordination of that engagement that failed them.

### **Scotland's Concerning Implementation Gap**

Despite their demonstrable value, alcohol death reviews remain concerningly underutilised across Scotland. Only 7% of Alcohol and Drug Partnerships conducted formal reviews in 2022/23—a decrease from previous years. This represents a profound missed opportunity at a time when Scotland has faced a 15-year high in alcohol-specific deaths and the Scottish Government has recognised alcohol harm as a public health emergency.

The contrast with drug death reviews is particularly stark. While drug deaths rightly receive intensive scrutiny through systematic review processes, alcohol deaths - which in 2023 claimed 1,277 lives with the true total likely being more than double - receive far less systematic attention. This disparity cannot be justified by the scale of harm, the preventability of deaths, or the availability of interventions.

### **The Case for Urgent Expansion**

The Scottish Government's inclusion of enhanced alcohol death review requirements in the 2025/26 ADP Funding Letter represents crucial recognition of this gap. However, the ambition must extend beyond compliance to embrace the transformative potential these reviews offer. The evidence from this summary report provides a roadmap for what comprehensive implementation could achieve.

Areas that have completed reviews describe them as "uniquely helpful in framing an issue that can preoccupy our minds but seem too large to tackle." They provide clarity where there was confusion, specific targets where there were broad concerns, and actionable recommendations where there was previously only general aspiration to improve. The reviews transform alcohol deaths from incomprehensible tragedies into understandable patterns with identifiable solutions.

### **A Strategic Investment in Prevention**

The financial argument for alcohol death reviews is compelling. One review estimated healthcare costs of £4.07 million for a single cohort over two years, with 81.5% attributable to acute hospital care. These represent the costs of system failure; expensive crisis interventions when prevention and early intervention would have been both more effective and more cost-efficient. Reviews enable health boards and ADPs to identify where their resources would have the greatest preventive impact.

The recommendations emerging from reviews - ranging from improved screening protocols to enhanced discharge planning - represent investments with multiple returns. Better early identification reduces emergency admissions. Improved care coordination prevents the cycling between services that characterises so many of the cases reviewed. Enhanced mental health integration addresses the near-universal comorbidity that complicates treatment.

### **The Moral Imperative**

Beyond the practical arguments lies a moral imperative. Every alcohol death reviewed represents someone who was known to services, who had sought help, and whose death might have been prevented with different approaches. The individuals described in these reviews were not invisible to the healthcare system, they were frequent users of multiple services whose needs were recognised but inadequately met.

The reviews restore humanity to statistics, revealing lives behind numbers and highlighting both the complexity of alcohol dependency and the multiple points where compassionate, coordinated intervention might have changed outcomes. They challenge any complacency about current approaches and demand that we do better.

### **Alcohol Focus Scotland's Commitment**

Alcohol Focus Scotland remains committed to supporting the expansion of alcohol death reviews across Scotland. Through our comprehensive guidance, the Alcohol Deaths Researchers' Network, and ongoing project support, we provide the infrastructure necessary for successful implementation. The establishment of the ADRN has created a community of practice that ensures knowledge sharing and continuous improvement in methodology.

Guidance and support alone, however, are insufficient. What is required is a fundamental shift in how Scotland approaches alcohol-related mortality, from reactive statistical reporting to proactive systematic review, from individual tragedy to systemic learning, from isolated local initiatives to coordinated national effort.

### **The Path Forward**

The evidence presented in this report demonstrates that alcohol death reviews work. They identify patterns, reveal intervention opportunities, and generate recommendations that can prevent future deaths. The question is not whether Scotland can afford to expand these reviews but whether it can afford not to.

Every month that passes without comprehensive implementation represents missed opportunities to save lives. Every ADP that has not yet undertaken a review is missing crucial intelligence about how to better serve their most vulnerable populations. Every death that occurs without systematic review is a loss not just to families and communities but to our collective understanding of how to prevent future tragedies.

Scotland has the opportunity to lead internationally in systematic alcohol death review implementation. The foundations are in place through AFS guidance, the ADRN network, and Scottish Government expectations. What is needed now is the commitment to treat alcohol death reviews not as an additional burden but as an essential component of a comprehensive response to alcohol harm.

The individuals whose deaths are documented in these reviews cannot be saved, but their experiences can save others. Alcohol death reviews ensure that their lives have meaning beyond their deaths and that their stories contribute to preventing similar tragedies. This is both the promise and the responsibility that systematic alcohol death review implementation offers Scotland.

The time for action is now. The evidence is clear. The tools are available. Scotland's response to its alcohol mortality crisis must include the systematic expansion of alcohol death reviews as a cornerstone of prevention strategy.

<sup>i</sup> National Records of Scotland. (2024). Alcohol-specific deaths. Retrieved from:

<https://www.nrscotland.gov.uk/publications/alcohol-specific-deaths-2023/>

<sup>ii</sup> National Records of Scotland. (2025). Alcohol-specific deaths. Retrieved from:

<https://www.nrscotland.gov.uk/publications/alcohol-specific-deaths-2024/>

<sup>iii</sup> Public Health Scotland. (2024). Alcohol consumption and harms dashboard. Retrieved from:

<https://publichealthscotland.scot/publications/alcohol-consumption-and-harms-dashboard/alcohol-consumption-and-harms-dashboard-20222023/>

<sup>iv</sup> Angus, Colin & Morris, Damon & Leeming, Grace & Chen, Ryan & Wilson, Luke & Stevely, Abigail & Holmes, John & Brennan, Alan & Gillespie, Duncan. (2023). New modelling of alcohol pricing policies, alcohol consumption and harm in Scotland. 10.15131/shef.data.21931386.

<sup>v</sup> Alcohol Focus Scotland (26 July 2023). Newly published figures reveal 40% drop in alcohol treatment in Scotland over 10 years. *Alcohol Focus Scotland*. <https://www.alcohol-focus-scotland.org.uk/news/news/decline-in-alcohol-treatment-in-scotland/>

<sup>vi</sup> Public Health Scotland (2023). Alcohol-related Hospital Statistics Scotland 2021/22. Retrieved from: <https://publichealthscotland.scot/publications/alcohol-related-hospital-statistics/alcohol-related-hospital-statistics-scotland-financial-year-2021-to-2022/>

<sup>vii</sup> Scottish Government. (2025). Alcohol and Drug Services delivery support 2025-2026: letter to Alcohol and Drug Partnerships. Retrieved from: <https://www.gov.scot/publications/supporting-delivery-alcohol-drug-services-2025-26-funding-allocation-programme-government-funding-ministerial-priorities/>

<sup>viii</sup> Yale SCORE Program on Sex Differences in Alcohol Use Disorder. (2025). Women's Brains on Alcohol: Insight into the Science of Sex-Based Risks. Retrieved from: <https://medicine.yale.edu/news-article/womens-brains-on-alcohol-insight-into-the-science-of-sex-based-risks/>

<sup>ix</sup> Erol, A., & Karpyak, V. M. (2015). Sex and gender-related differences in alcohol use and its consequences: Contemporary knowledge and future research considerations. *Drug and alcohol dependence*, 156, 1–13. <https://doi.org/10.1016/j.drugalcdep.2015.08.023>

<sup>x</sup> Scottish Health Action Against Alcohol Problems. (2018). Alcohol-related Liver Disease: Guidance for Good Practice. Retrieved from: <https://www.shaap.org.uk/wp-content/uploads/2025/03/ald-report-v2018.pdf>

<sup>xi</sup> Office for Health Improvement & Disparities. (2023) UK clinical guidelines for alcohol treatment - draft for consultation. London: Office for Health Improvement and Disparities.

<sup>xii</sup> Sullivan, J.T., Sykora, K., Schneiderman, J., Naranjo, C.A., & Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction* 84:1353-1357, 1989.

<sup>xiii</sup> NICE. (2011a). *Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. Quick reference guide*. National Institute for Health and Clinical Excellence. Retrieved from: <https://www.nice.org.uk/guidance/cg115/resources/alcoholuse-disorders-diagnosis-assessment-and-management-of-harmful-drinking-highrisk-drinking-and-alcohol-dependence-pdf-35109391116229>

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## Appendix 1. Alcohol Death Review Recommendations

The following recommendations emerged from the six Alcohol Death Reviews detailed within this report. These are categorised under five broad themes. These recommendations provide a comprehensive framework for improving alcohol-related harm prevention, early intervention, treatment and support across Scotland's health and care systems.

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### 1. Early Identification and Recording of Alcohol-Related Harm

#### Core Objectives

- Increase awareness of the importance of identifying and recording alcohol use across all services
- Develop effective and consistent approaches, particularly at early stages of alcohol-related harm
- Enable cross-departmental and cross-service review capabilities

#### Specific Actions

##### For Health and Care Professionals:

- Communicate the importance of opportunistically asking about and recording alcohol units consumed
- Provide advice and support regarding harmful alcohol use, including Alcohol Brief Interventions (ABIs)
- Target clinical teams identified as having greatest contact with those who died from alcohol-related causes
- Promote awareness of low-risk drinking guidelines among both staff and the general public
- Enhanced training on screening tool selection and appropriate ABI delivery techniques

##### Recording and Documentation:

- Support professionals to record units consumed through effective approaches and easy calculation methods
- Improve consistency of liver function test (LFT) recording with interpretation to support non-clinical staff

- Identify methods for recording alcohol units via Patient Information Systems, visible across NHS electronic records
- Include questions around social isolation, familial alcohol use and onset of drinking in assessments
- Establish consistent alcohol recording practices and documentation standards across all departments and presentations
- Implement quality assurance through regular audit of alcohol discussion continuity across specialties

**System Improvements:**

- Further promote guidance on early detection through alcohol screening and ABIs in primary care
- Research potential barriers to detection and treatment from patient and professional perspectives
- Improve understanding and recording of alcohol-related A&E admissions
- Review IT systems and information-sharing processes (referrals, case notes, consumption details, appointments)
- Better linkage between screening results and clinical actions
- Regular audit of screening implementation across all settings
- Ensure adequate staffing and time allocation for comprehensive screening

**2. Service Processes and Early Intervention**

**Housing and Community Support**

- Liaise with housing associations to identify at-risk individuals
- Develop strategies to tackle loneliness and create social opportunities
- Reduce risk of alcohol-related harm and exploitation for vulnerable groups

**Clinical Pathways and Access**

- Improve understanding and implementation of current SHAAP guidance throughout care pathways
- Research access models for alcohol treatment services, especially for those with Alcoholic Liver Disease who decline attendance
- Create dedicated emergency department space for substance use liaison nurse clinics

- Review options for follow-up and assertive outreach services for hard-to-reach individuals
- Implement systematic alcohol screening for frequent emergency department attenders
- Develop early intervention strategies specifically targeting repeat emergency department attenders
- Create emergency admission prevention strategies through early intervention
- Develop specialist alcohol liaison roles across departments for care coordination

### **Training and Workforce Development**

- Review training needs for social work services, ensuring awareness of referral pathways
- Develop alcohol awareness training for social work support staff
- Provide awareness and education sessions for emergency department staff on screening and referral pathways
- Work with employers to support staff with alcohol problems at risk of losing employment

### **Service Development**

- Develop long-term harm reduction pathways for those not motivated to abstinence
- Review approaches between community mental health teams and alcohol services
- Update eligibility criteria and pathways to access support
- Create communication materials promoting addiction services to GPs and healthcare professionals
- Use outpatient settings to promote self-referral through health promotion materials
- Consider co-location of addiction specialists within general mental health teams
- Offer flexible delivery options (individual, group, peer support)

### **Multi-Agency Working**

- Develop cross-organisational policies and protocols for information sharing (GDPR-compliant)
- Create trauma-informed approaches to information collection and sharing
- Review connections between A&E, outpatients, inpatients and ADP services
- Collaborate with educational settings and workplaces for prevention and early intervention
- Support national efforts including availability measures and minimum unit pricing
- Implement cross-specialty integration with shared care protocols for alcohol-related conditions

- Develop systematic GP handover and community referral protocols for discharge planning

#### **Non-Statutory Services**

- Assess services provided by non-statutory providers, particularly for NHS-referred patients
  - Audit data on referrals, attendance rates and treatment outcomes
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### **3. Withdrawal Support and Psychological Care**

#### **Treatment Access and Options**

- Map and review current alcohol service processes against NICE guidelines
- Improve access to detoxification services (planned/unplanned; hospital/outpatient/home-based)
- Enhance access to medicines for alcohol dependence
- Increase access to psychological therapies
- Increase investment in clinical psychology services and residential rehabilitation
- Utilise frequent mental health contacts for alcohol screening and intervention

#### **Medication and Prescribing**

- Develop Tier 1 and 2 treatment guidance for primary care prescribing and supported detox
- Review thiamine prescribing guidance for patients with alcoholic liver disease
- Examine shared care protocols between specialist services, GPs and community pharmacies

#### **Post-Treatment Support**

- Review after-care and follow-up support following discharge
- Provide relapse prevention medication and recovery-orientated care planning
- Define clear pathways for individuals post-detox, including third sector services
- Consider pharmacy roles in prevention and community treatment management

#### **Service Models and Research**

- Conduct research with individuals with lived experience on alcohol-specific services
  - Understand stigma associated with alcohol use in service access
  - Explore collaborative approaches between third sector and primary care
-

## 4. Priority and Vulnerable Groups

### Risk Identification and Engagement

- Develop methods to identify individuals at high risk of alcohol-specific death
- Establish ways to support engagement and retention across all alcohol services
- Create specialised pathways for complex and high-risk individuals
- Implement multi-agency risk assessment protocols
- Develop male-specific engagement strategies tailored to male preferences and barriers
- Implement mandatory Hepatitis C screening for all alcohol-related admissions

### Tailored Approaches

- Establish integrated pathways addressing both physical and mental health needs
- Create tailored pathways for priority groups including women and those experiencing bereavement and domestic abuse
- Implement family-inclusive care models with resources for family members
- Better coordination between addiction and mental health services for dual diagnosis presentations
- Implement comprehensive trauma-informed care addressing historical trauma
- Review transplant pathway assessment criteria and address referral barriers

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## 5. Monitoring, Reporting and Strategic Development

### Data and Reporting

- Develop routine and robust ADP reporting frameworks on alcohol and alcohol-related harms
- Focus particularly on alcohol-related morbidity and mortality
- Monitor impact of national strategies such as Minimum Unit Pricing on local death statistics
- Implement regular quality assurance audits across all service areas

### Service Planning

- Undertake thorough alcohol service mapping and gap analysis exercises
- Explore single commissioning and monitoring frameworks for alcohol and drug services
- Ensure consistency in information requirements from each service



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