

# Alcohol health equity audit series

Alcohol consumption and estimated need

West Sussex Public Health

December 2023



## Acknowledgements

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This project would also not have been possible without the kind support of the following people and organisations:

Dr Kate Bailey: Consultant in Public Health (Educational Supervisor)

Dan Barritt: Public Health Lead

Holly Yandall: Public Health Lead

Philippa Gibson: Senior Commissioning Manager, Substance Misuse Services

Change Grow Live, particularly Mandy Rutherford (Data analyst) and Ian Dunster (Regional Director)

HumanKind, particularly Cait Molineux, Felicity Simpkin and the data team

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## Introduction

Alcohol misuse remains a leading risk factor for premature mortality, morbidity, and disability in England<sup>1</sup>. It is a causative factor for over 200 health conditions and injuries and is associated with important social consequences such as unemployment, crime, and relationship and family issues<sup>2</sup>. These health and social impacts can also adversely affect the families, partners, friends, and communities around the person who drinks. Alcohol, along with tobacco and overweight/obesity, has been highlighted as one of the key public health issues that should be prioritised in West Sussex.

Long-term surveys exploring the prevalence of risky drinking have reported an increase in the UK since the Covid-19 Pandemic. Deaths from causes directly linked to alcohol, have also increased in 2020, having been previously stable since 2012.

The West Sussex Alcohol Health Equity Audit (HEA) was carried out in 2022 and sought to understand the picture of people drinking at hazardous, harmful, or probable dependent levels. The HEA was undertaken due to data indicating the significant harms associated with alcohol misuse, including its contribution to health inequalities.

Where possible, we explored the impact of alcohol use and harms on a range of demographic and environmental factors. These include all those listed under the Equality Act 2010 (age, disability, gender reassignment, marriage/civil partnership status, pregnancy/maternity, ethnicity, religion/belief, sex, sexual orientation and deprivation). We looked at these alongside other characteristics of interest, based on known inequalities in the research base or via local intelligence (deprivation, housing issues, employment status, involvement with criminal justice team and presence of a mental health condition).

This report is a chapter in the West Sussex Alcohol HEA Series. It outlines the development of a population model which estimates and describes the characteristics of alcohol consumption and outcomes of harmful drinking we might expect in West Sussex.

Further information on other chapters of the HEA Series is available in the following reports:

- Health Care & Mortality
- Commissioned Alcohol Services
- The Alcohol Landscape

There are also a number of interactive and downloadable resources available to support strategic work at a local level in our Alcohol Health Equity Audit resource library on the West Sussex JSNA site.

This document describes how we measure risky alcohol consumption, how consumption nationally has changed over time and how we used national alcohol consumption estimates along with population figures from the Office for National Statistics (ONS) to create a population model of increasing and higher risk drinking in West Sussex.

Later chapters describe how data on a range of demographic characteristics (e.g., age, sex, ethnicity, and deprivation) were obtained from early intervention and specialist services in West Sussex. Service data were compared to the population model to understand if there were more or less episodes of activity in services from some population groups than might be expected.

It is intended that the information collated in the Health Equity Audit will support the development of a strategic approach to alcohol in West Sussex, as well as future plans for the Supplementary Substance Misuse Treatment & Recovery Funding grant allocation in 2023/24 and 2024/25.

## The national picture

### How much and what is risky drinking?

In the England, four in five adults drink some alcohol, with the around half of those aged 16+ drinking at least once per week<sup>3</sup>.

There is no definitively 'safe' lower limit of drinking, however, the UK Chief Medical Officers (CMOs) advise that adults should not regularly drink more than 14 units of alcohol per week<sup>4</sup>.

National surveillance measures frequency and volume of units consumed whilst services supporting people with alcohol misuse typically use the Alcohol Use Disorders Identification Test (AUDIT) screening tool, which was developed by the World Health Organisation (WHO).

#### The Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT screening tool moves away from a measure of risk based purely on the amount of alcohol consumed per week to a more comprehensive consideration of behaviours around drinking (such as feeling unable to stop drinking, reliance on alcohol, feelings of guilt or remorse after drinking, and own or others' concerns about the persons drinking).

There are 10 questions around alcohol consumption, drinking behaviours and alcohol related problems to understand alcohol consumption and harm. This gives a score between 0 and 40.

A score of 0-7 indicates low risk. **Scores above 8 denote increasing and higher risk drinking.** Specifically, a score between 8 and 15 denotes potentially hazardous risk levels of drinking. Harmful risk levels of drinking are indicated by AUDIT scores of 16-19 and a score of 20 or more is indicative of probable dependence.

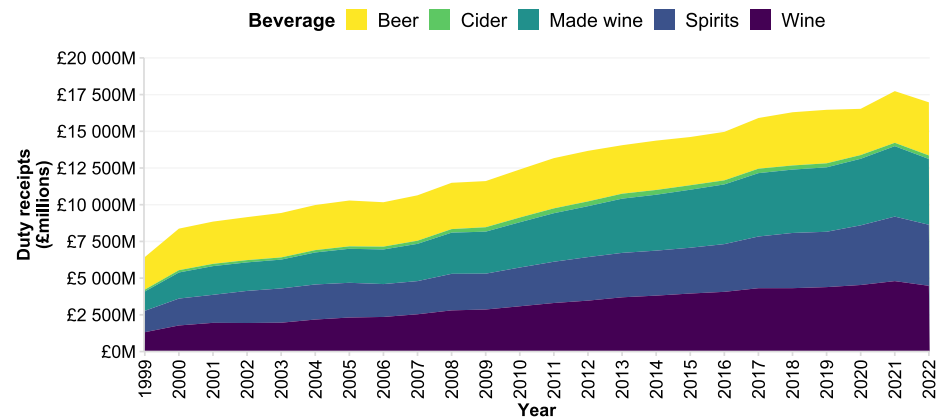
## Changes in drinking patterns over time - sales

It is important for stakeholders to have access to good quality data on supply and demand in their areas in order to reduce alcohol related harms, not least through licencing activities. However, much of the information on sales is commercially sensitive and not available in the public domain with the exception of high-level national summaries.

UK clearances report from HM Revenue and Customs<sup>5</sup>, shows when excise goods are released (cleared) onto the UK market for consumption. This is when goods pass a 'duty point', as payment of duty to HMRC is required once goods are cleared. It is not the point of consumption.

The figure below shows total duties paid by beverage type from 1999 to 2022. There is a steady increase over the last two decades until 2020 and 2021 when there was a modest (around 5%) decrease in duty receipts.

Duty receipts (£millions) by beverage type  
United Kingdom; 1999 - 2022



Source: HM Revenues and Customs Alcohol Bulletin, June 2023.

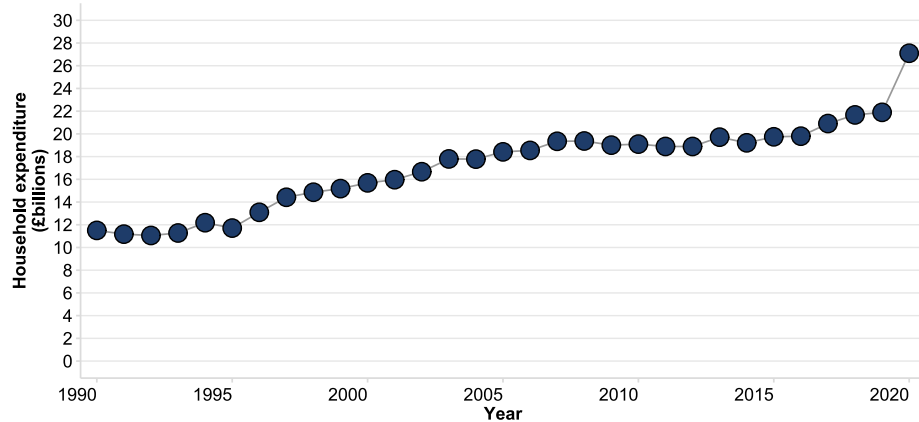
Duty receipts do not distinguish alcohol bought for consumption on premises and off premises and do not take inflation into account.

The UK household expenditure on 'off trade' alcohol (alcohol beverages purchased for consumption) from supermarkets and off licences was £27.1 billion in 2020.

The Living Costs and Food Survey for the UK indicated that average real terms (adjusted for inflation) spending on 'off trade' alcoholic drinks rose by 19.6% from £4.03 per person per week in 2017/18 to £4.82 in 2020/21, whilst alcoholic drinks bought for consumption outside the home fell by 81.3% from £3.42 to £0.64<sup>6</sup>.

#### Household expenditure on 'off trade' alcohol adjusted for current prices

United Kingdom; 1990 - 2020



Source: Consumer Trends (codes ADIT, ABJQ). The Office for National Statistics.

The sharp increase on previous years of 'off trade' sales likely reflects a shift from purchasing 'on trade' alcohol (from restaurants and bars) as a result of these venues closing during the national response to COVID-19. For most households, supermarkets and other food and drink retail outlets were the only place to buy alcohol for consumption at home.

The overall volume of duty paid alcohol was down just 1.2% from 2019/20 to 2020/21<sup>7</sup>.

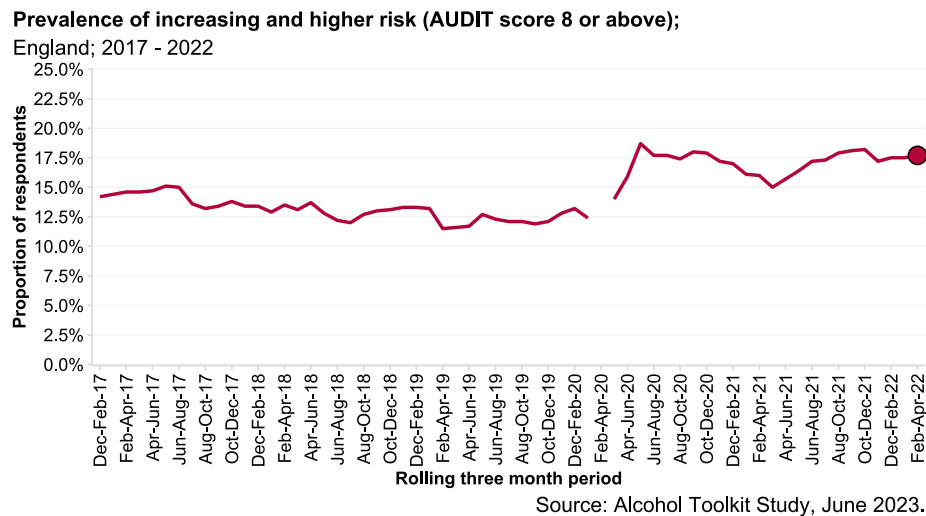
Analyses of volume sold, duties paid, or household expenditure on alcohol, only go so far as a proxy for consumption patterns. Sales duty data exclude unrecorded alcohol (e.g. untaxed, duty free, or illegal alcohol), and of course it may include alcohol which is bought but not consumed.

Moreover, it is not clear from the sales information alone, who is consuming alcohol, and at what frequency and volume. As such, it is impossible to say whether any changes (or stability) in sales data represent drinkers consuming less alcohol or whether this reflects rising levels of abstinence in the population displaced by some drinkers drinking more.

## Changes over time - consumption

As noted above, consumption of alcohol is usually estimated using self-report measures from household surveys such as the Health Survey for England, a survey covering a range of healthy lifestyle behaviours as well as the Alcohol Toolkit Study<sup>8</sup>, which specifically asks respondents to complete the AUDIT screening tool as a measure of risk of harm.

The figure below shows a sharp increase in the prevalence of increasing risk drinking (AUDIT scores of 8 or more) from the start of 2020 (although data is missing in March 2020 due to initial response to the COVID-19 pandemic).



The step change, in the context of many on-premises venues closing in response to the pandemic, according to the UK Government report on monitoring alcohol consumption and harm during COVID-19<sup>7</sup>, represented a polarisation in drinking.

Whilst the majority of respondents to a nationwide sample of consumer purchasing reported drinking the same volume and frequency of alcohol before the pandemic, roughly the same proportion of drinkers reported reducing consumption as increasing it.

Where pre pandemic history data was available, it indicated that those who reported heavier drinking tended to increase drinking as the pandemic commenced.

## Inequalities

The prevalence of risky drinking and the harms associated with alcohol consumption are not seen evenly across society. Health inequalities are often avoidable, unfair, and systemic differences in health amongst different groups of people<sup>9</sup>. Analyses of inequalities in health commonly explore patterns by age, sex, ethnicity, occupation, and sexual identity as well as measures of socioeconomic and environmental inequalities such as household income and neighbourhood deprivation.

There are substantial differences in the harms associated with alcohol use which are covered in more detail in our accompanying report on health care and mortality. In summary here, the rate of alcohol-specific deaths (those which are recorded as being caused as a direct consequence of alcohol) in males is more than double the rate for females (19.0 and 9.2 deaths per 100,000 people in 2020 respectively) [6] and the age group with the highest crude rate of deaths is the 55-59 year olds.

In terms of consumption in different age groups, younger adults are the least likely age group to drink. However, when they do drink, it appears that they are more likely to consume more alcohol than older people.

On the next few pages, we highlight some of the differences in alcohol consumption from the Health Survey for England (HSE) in 2021 (published December 2022) and Alcohol Toolkit Study. It should be noted that these use a variety of definitions of risky drinking such as the frequency of drinking in the past year and the average number of units consumed per week, as well as the more comprehensive measure of risky drinking from the AUDIT tool.

The 2021 HSE survey indicated that half of those aged 16+ drank alcohol at least once per week (see figure below), with the proportion of females slightly lower (42.6%) compared to males (56.7%).

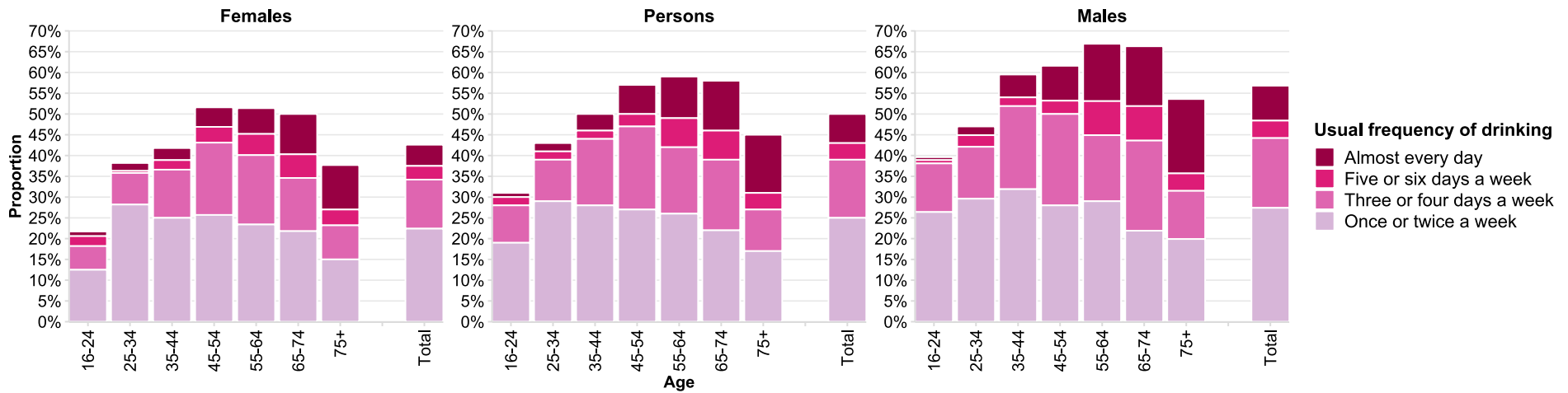
The prevalence of at least weekly drinking increases with age for both males and females and tends to level off at around 50% for females and 65% for males after the age of 55-64 years before falling among those aged 75 and over.

One in four adults reported drinking three or more times a week. This ranges from one in ten aged 16-24 to one in three aged 55-64.

**Proportion of adults (aged 16 and over) drinking three or more times per week in the last year; England**

Age group	Females	Males	Persons
16-24	9.2%	13.2%	12%
25-34	10%	17.4%	14%
35-44	16.8%	27.6%	22%
45-54	25.9%	33.6%	30%
55-64	28%	37.9%	33%
65-74	28.2%	44.4%	36%
75+	22.7%	33.7%	28%
Total	20.2%	29.4%	25%

**Estimated proportion of adults drinking alcohol at least once per week; England; adults aged 16+; 2021**



Source: Health Survey for England, 2021.

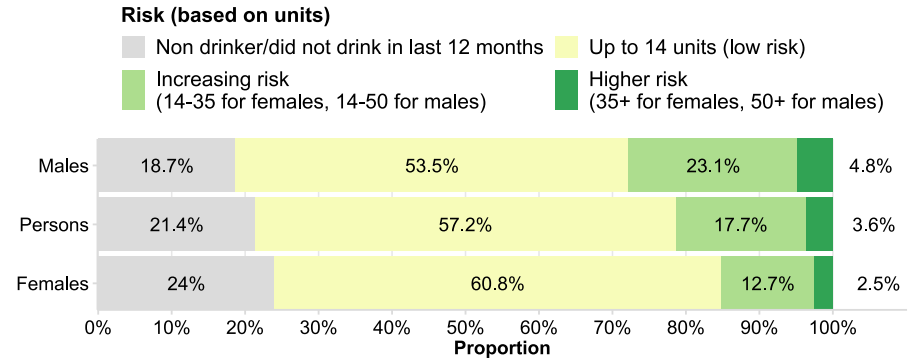
The highest proportion was among males aged 65-74 in which 44.4% said they drank at least three times per week.

The HSE also shows the average number of units of alcohol consumed each week, for males and females. Alcohol consumption in the HSE is reported in terms of units of alcohol; one unit of alcohol is 10ml by volume of pure alcohol. Note that increasing risk is defined as 14-35 units for females and 14-50 units for males.

The figure opposite shows that the proportion of non-drinkers and low risk drinkers (as defined as consuming up to 14 units per week) is higher among females compared to males.

The figure below shows the increasing and higher risk drinking (based on weekly units consumed) by age and sex. Almost double the proportion of males were estimated to have increasing or higher risk weekly consumption of alcohol compared to females.

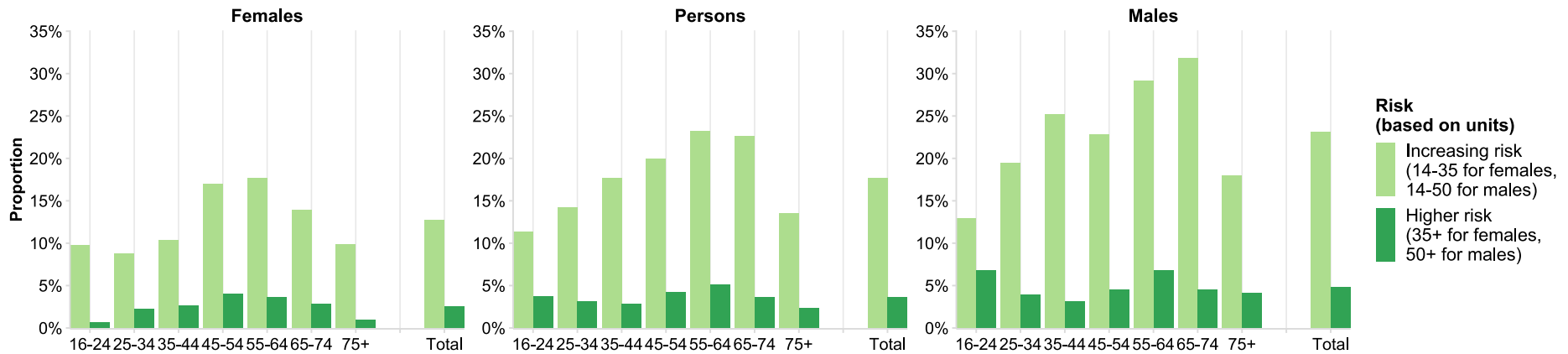
**Estimated average weekly consumption of alcohol**  
England; adults aged 16+; 2021



Definitions for increasing and higher risk are different for men and women.  
Source: Health Survey for England, 2021.

Moreover, 4.8% of males, compared to 2.5% of females were estimated to be drinking at higher risk levels. Of note is the higher risk drinking among 16-24 year olds; particularly males. The same proportion (6.8%) of males aged 16-24 and aged 55-64 were estimated to drink 50 or more units per week (higher risk drinking).

**Estimated average weekly consumption of alcohol (increasing and higher risk drinking) by age and sex**  
England; adults aged 16+; 2021



Definitions for increasing and higher risk are different for men and women.  
Source: Health Survey for England, 2021.



The HSE 2021 also shows that increasing and higher risk alcohol consumption (drinking 14 or more units per week) becomes more prevalent as household income increases (see figure opposite).

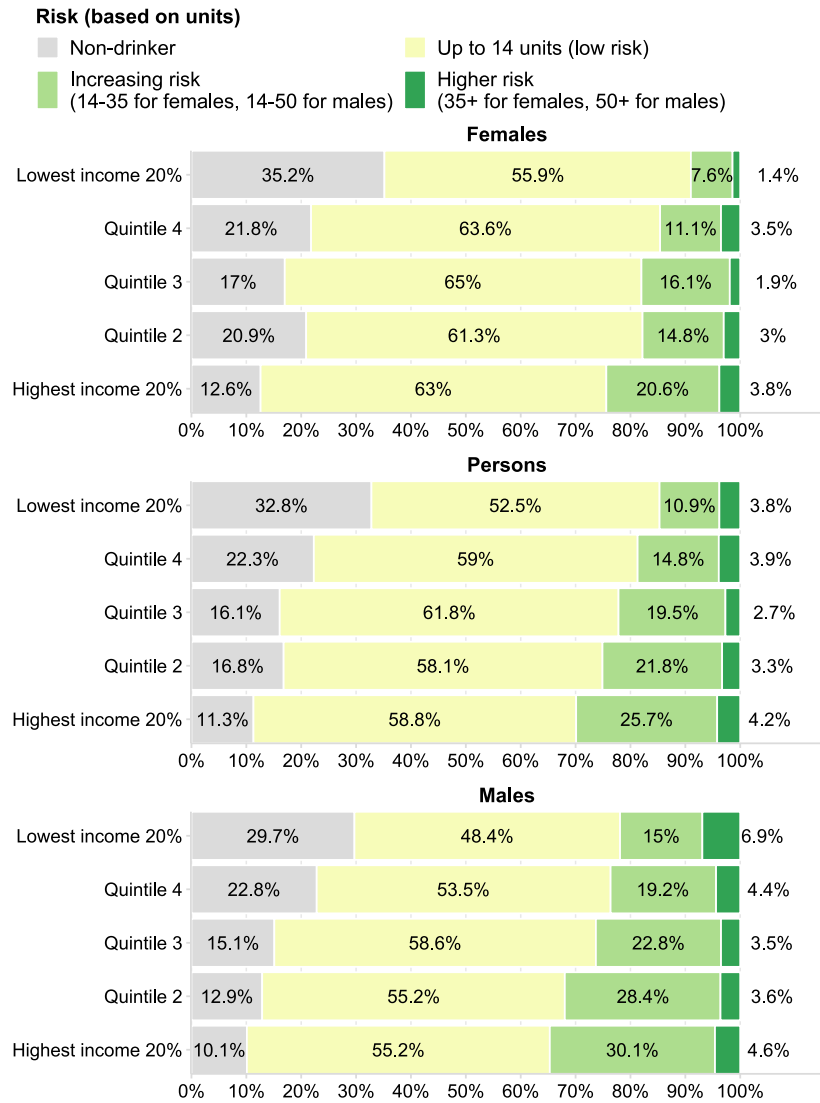
The HSE measure of equivalised household income considers the number of adults and dependent children in the household as well as overall household income. Households are ordered from highest income to lowest and then divided into quintiles (each representing 20% of households) based on this measure. The age profile of the income quintiles has been age-standardised to account for differences in age profiles between households.

Among those living with the lowest 20% of household income, just one in seven were estimated to drink 14 or more units of alcohol per week, compared to almost one in three of those living with the highest 20% of household income.

The consumption at higher levels (drinking 50+ units per week) for males was most prevalent (6.9%) in the lowest equivalised household income quintile with the second highest prevalence (4.6%) in the highest household income quintile. This suggests a perhaps a polarisation of increased risky drinking amongst those in the lowest and highest income groups.

**Estimated average weekly consumption of alcohol; by household income distribution and sex;**

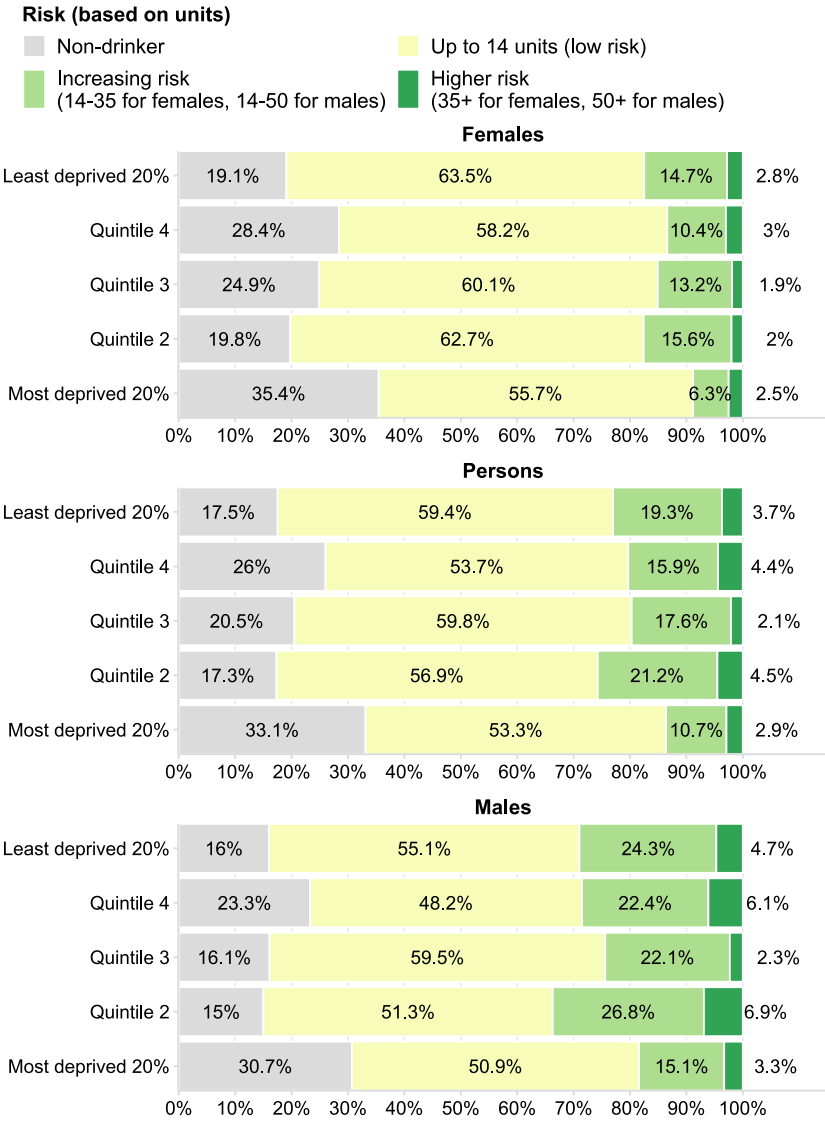
England; adults aged 16+; 2021



Definitions for increasing and higher risk are different for men and women.  
Source: Health Survey for England, 2021.

**Estimated average weekly consumption of alcohol; by neighbourhood deprivation and sex;**

England; adults aged 16+; 2021



Definitions for increasing and higher risk are different for men and women. Source: Health Survey for England, 2021.

Environmental disadvantage is also measured in the HSE using the Index of multiple deprivation; a measure that ranks every residential neighbourhood in England by relative deprivation on seven domains (income, health, education, access to services, employment, crime, and living environment). As with household income, areas are split into five equal groups each representing 20% of neighbourhoods.

Unlike the household income measure, there is no clear gradient in increasing or higher risk drinking. However, the prevalence of increasing and higher risk drinking (as defined by number of units consumed) is still nearly double in the least deprived neighbourhoods on England (23%), compared to the most deprived areas (13.8%).

The HSE is the biggest population level survey offering up to date annual data on a host of health behaviours. However, because of the breadth of topics it covers, apart from age, sex, income, and deprivation, the HSE does not routinely capture data on other known inequalities risk factors for risky drinking.

Tentative evidence suggests that alcohol consumption in LGBTQ+ communities is disproportionately high. A report by Stonewall<sup>10</sup> in 2018 suggested that one in six LGBTQ+ reported drinking alcohol nearly every day, although sampling in these groups typically uses non-probability sampling, increasing the risk of bias<sup>11</sup>. Due to a lack of routine data collection related to sexual orientation and gender identity, it is not clear whether alcohol related harms are greater in these communities.

Marriage has been shown to be a protective factor for alcohol misuse by several studies, with transition to marriage leading to reduced excess drinking and higher remission rate for people with alcohol misuse<sup>12</sup>.

There is limited evidence related to inequalities in consumption and harm by ethnic group. However, a national evidence review noted that people from Black and Minority ethnic backgrounds tend to be under-represented in alcohol treatment services, which may in part be due to higher rates of abstinence among some communities. Although, the review pointed to significant variation across groups, with evidence of high prevalence amongst Sikh males, refugees and asylum seekers and Irish nationals<sup>13</sup>.

Additionally, there is also evidence that whilst groups that follow a religion that prohibits alcohol and drug use have lower rates of substance misuse and dependence, there can also be barriers for people seeking support for alcohol related issues as addiction can be highly stigmatised by some religious communities<sup>14</sup>.

Further to this, research shows that overall, people with learning disabilities are less likely to misuse substances including alcohol. However, some groups of people with learning disabilities are more likely to misuse substances including alcohol, such as those with mild learning disabilities and with additional mental health needs<sup>15</sup>. Additionally, there are additional barriers in these groups accessing services to support them with their alcohol use.

Access to alcohol is also an important factor for alcohol misuse, and some evidence has found a far higher concentration of shops selling alcohol in more deprived areas<sup>16</sup> though this doesn't necessarily translate to patterns of consumption as seen in the HSE 2021 report.

As noted from the outset, whilst national surveillance surveys typically ask a limited number of questions on alcohol consumption such as volume and frequency of drinking, services tend to use the AUDIT score as an indicator of patient need and outcome (often using a reduction in AUDIT score as a measure of successful treatment completion).

## AUDIT as a measure of risk

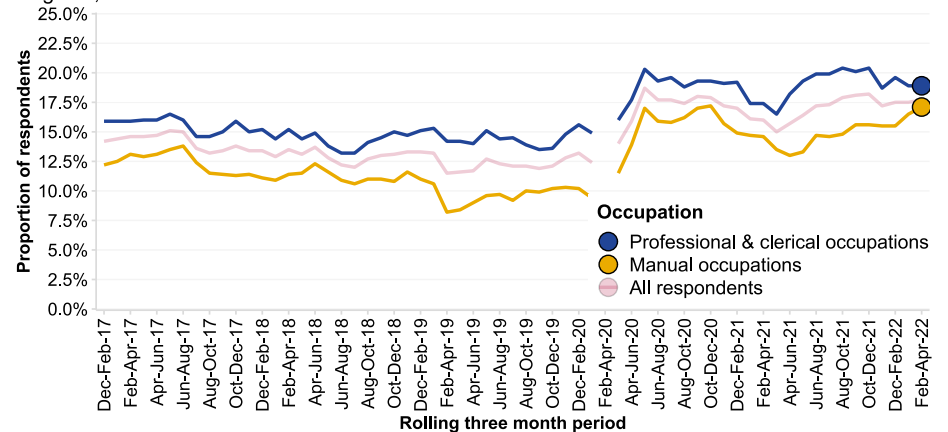
The AUDIT tool is more comprehensive than a single measure of how often or how much someone drinks alcohol as it explores a variety of behaviours and consequences around drinking.

However, there is limited up to date local or national population level estimates of alcohol consumption based on this measure of risk.

The Alcohol Toolkit Study<sup>8</sup> represents the most up to date surveillance of consumption in this way and shows that the prevalence of increasing risk (defined by AUDIT scores of 8 or more) drinking was higher in professional to clerical occupations than in manual occupations consistently in recent years and follows broadly the same increasing trends we saw in the earlier overall Alcohol Toolkit Study prevalence.

**Prevalence of increasing and higher risk (AUDIT score 8 or above); by occupation**

England; 2017 - 2022



Source: Alcohol Toolkit Study, June 2023.

However, the Alcohol Toolkit Study does not publish data on many risk factors (other than occupation).

The most recent AUDIT based national prevalence figures capturing characteristics associated with inequalities is an NHS Digital analysis, based on the Adult Psychiatric Morbidity Survey 2014.

Although these estimates are almost a decade old, these are the most robust estimates available for age, ethnicity, employment status, and household type (all by sex) to enable us to consider how risky alcohol consumption varies amongst these groups with the aim to use this information to consider if services are reaching those in need equitably.

The Adult Psychiatric Morbidity Survey is conducted roughly every seven years, with the next iteration (the 2022 survey) results expected in 2024. It is unclear whether the 2022 APMS will contain AUDIT based prevalence, but any new figures on prevalence will be used to update any population modelling.

The national data indicates that almost one in five (19.7%) of people are drinking at risky levels:

- 16.6% are drinking at hazardous levels (AUDIT score of 8-15)
- 1.9% are drinking at harmful levels or are mildly dependent (AUDIT score of 16-19)
- 1.2% are drinking at probable dependent levels (AUDIT score of 20+)

Confidence intervals from the national dataset for prevalence estimates were not always available for individual risk categories.

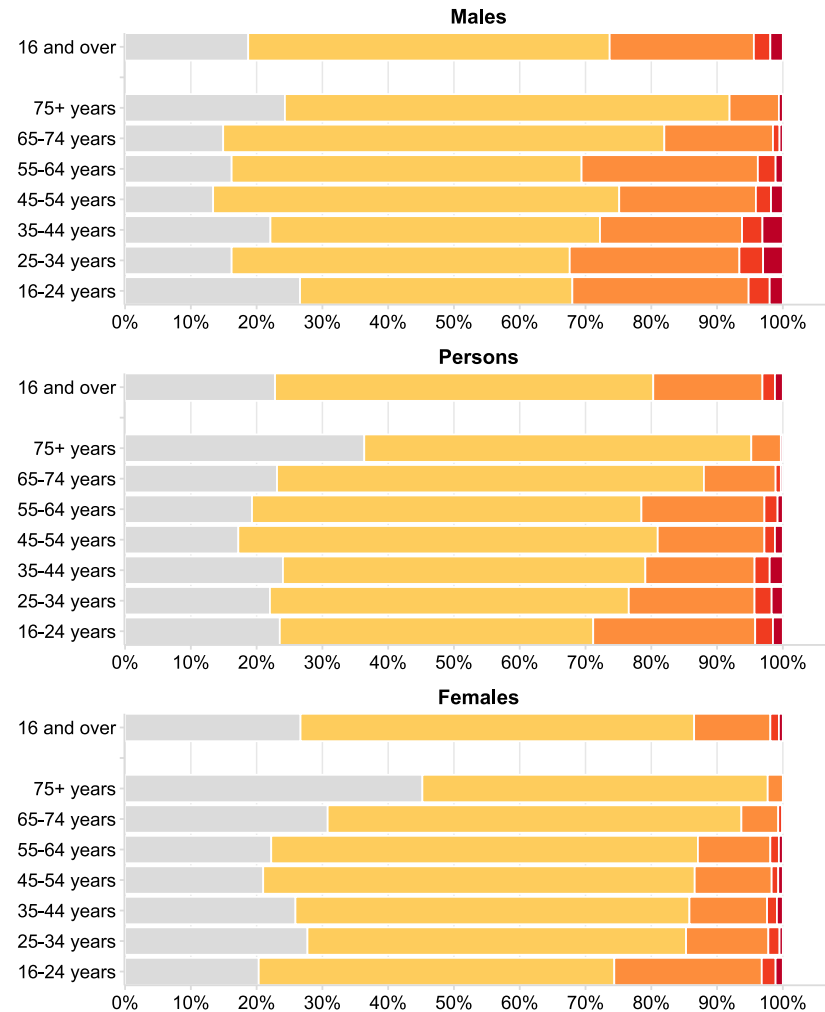
Probable dependent drinking is much more prevalent among males. Males aged 25-54 are estimated to have the highest prevalence of probable dependent drinking.

**Estimated alcohol consumption by risk (AUDIT) and by age and sex;**

England: adults aged 16+; 2014

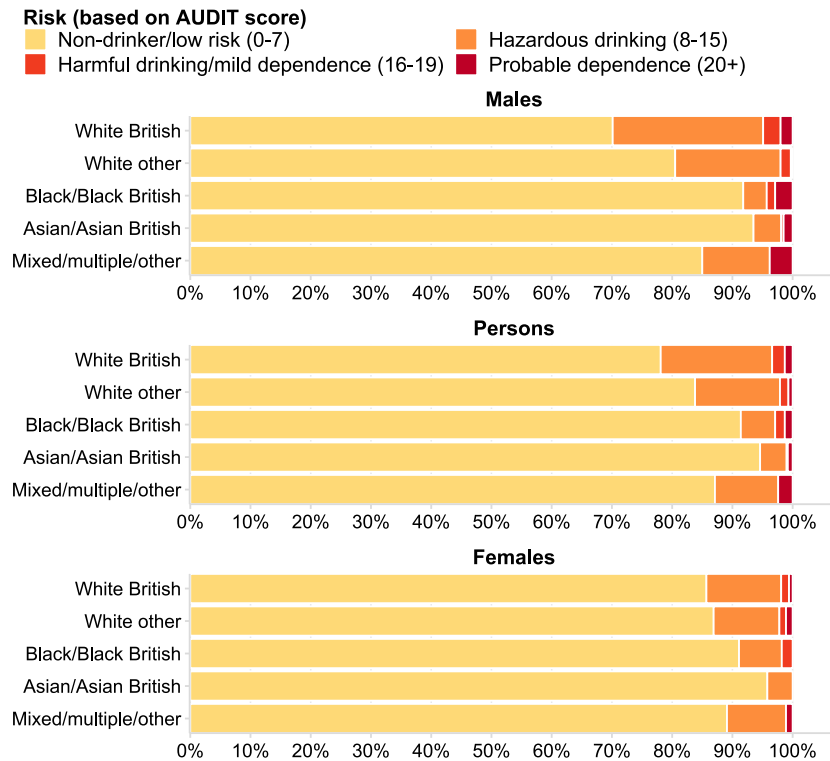
**Risk (based on AUDIT score)**

- Non-drinkers
- Low risk (AUDIT score 1-7)
- Hazardous drinking (AUDIT score 8-15)
- Harmful drinking/mild dependence (AUDIT score 16-19)
- Probable dependence (AUDIT score 20+)



Source: Adult Psychiatric Morbidity Study, NHS England, 2014.

**Estimated alcohol consumption by risk (AUDIT) and by ethnicity and sex;**  
England; adults aged 16+; 2014



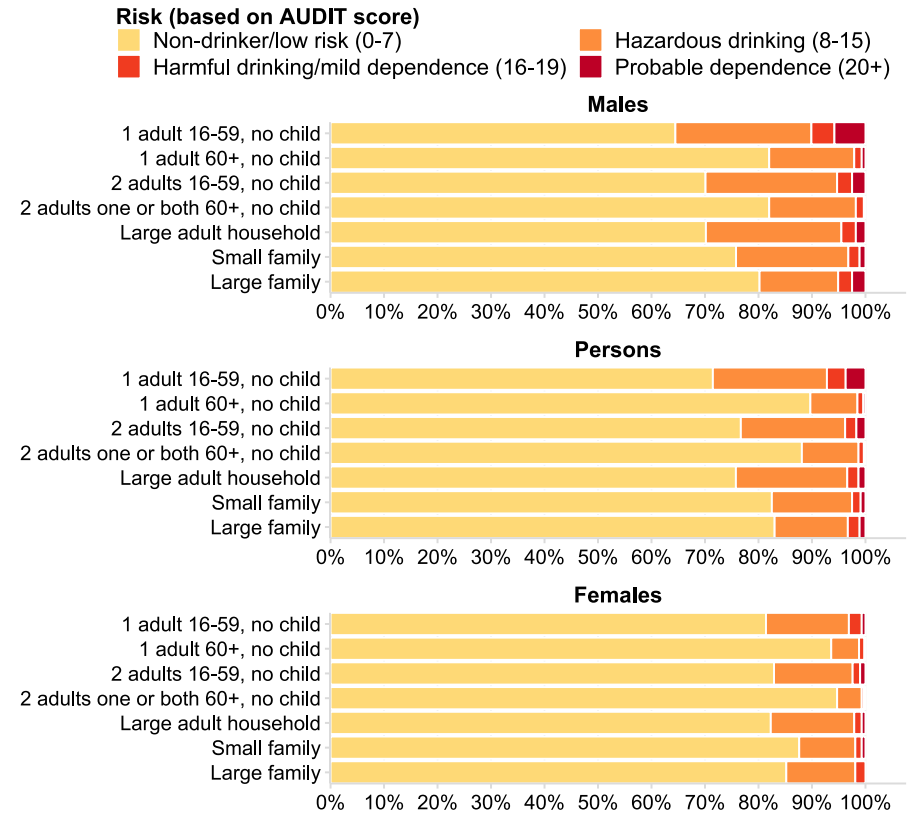
Note: Non drinkers and low risk (score 1-7) are combined.  
Source: Adult Psychiatric Morbidity Study, NHS England, 2014.

White British Groups are estimated to have the highest prevalence of drinking at hazardous and harmful levels; driven mostly by males. Asian groups are estimated to have the lowest prevalence of drinking at these levels.

Estimates suggest that people of other (including mixed) ethnic groups have the highest prevalence of probable dependent drinking and Asian groups have the lowest prevalence.

Those living in adults only households, particularly single adults, had the higher proportion of increasing risk drinking, but this prevalence drops from around one in four to one in ten after the age of 60 plus.

**Estimated alcohol consumption by risk (AUDIT) and by household type and sex;**  
England; adults aged 16+; 2014

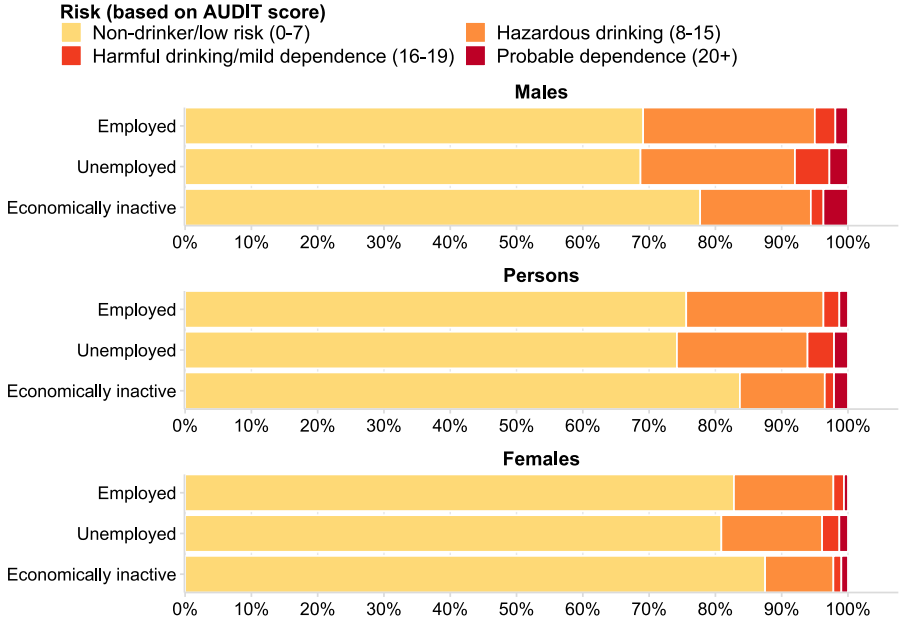


Note: Non drinkers and low risk (score 1-7) are combined.  
Source: Adult Psychiatric Morbidity Study, NHS England, 2014.

The proportion of increasing risk drinking (AUDIT score 8 and over) was similar among employed and unemployed males, but the prevalence of harmful and probable dependence risk drinking was almost double in unemployed compared to employed adults aged 16-64 years.

**Estimated alcohol consumption by risk (AUDIT) and by employment status and sex;**

England; adults aged 16-64 years; 2014



Note: Non drinkers and low risk (score 1-7) are combined.  
 Source: Adult Psychiatric Morbidity Study, NHS England, 2014.

## AUDIT as a measure of service need

An AUDIT score of 8-15 suggests a probable need of brief alcohol intervention and those scoring 16-19 may warrant an 'extended brief intervention' with referral to specialist treatment for those who don't respond to the initial intervention (stepped care). An AUDIT score of 20 or more is indicative of a need for referral to specialist services for further assessment and treatment.

However, the AUDIT tool is only one brief screening tool and is not wholly indicative of dependence. The Severity of Alcohol Dependence Questionnaire (SADQ) is an alternative screening tool with a focus on symptoms of dependence following periods of heavy drinking.

The SADQ is a self-report questionnaire consisting of 20 items, covering a range of dependence symptoms, from physical and affective withdrawal symptoms, cravings and relief drinking as well as typical daily consumption. Answers to all questions are scored from zero to three and summed to give a total score ranging from zero to 60. There are currently no prevalence estimates of dependent drinking based on the SADQ.

Whilst the APMS 2014 shows that SAQD and AUDIT have strong concordance among those scoring 10 or more on the AUDIT tool, it also shows that up to two thirds of people scoring 20 or more in the AUDIT tool then go on to score as having no to mild dependence symptoms on the SADQ. This means that not all of those with an AUDIT score above 20 may have a level of need appropriate for specialist services.

It is therefore important to consider that whilst the AUDIT score can be used as a description of risk, and to indicate broad prevalence of alcohol consumption in the UK, we must be careful not to suggest that all those with probable dependence as defined by AUDIT are appropriate for specialist alcohol services as it may overstate the dependent population.

## Estimating need – the population model

Researchers commissioned by Public Health England have used the APMS 2014 and a combination of AUDIT and SADQ scores to develop estimates of dependent drinking population at county level<sup>17</sup> although this does not describe areas within local authorities) or the breadth of drinking levels covered by all alcohol services.

However, in the absence of local estimates of broad levels of alcohol consumption, the first iteration of the equity profile uses the national prevalence estimates from AUDIT score and the APMS 2014 as a basis. The model (described in the next section) indicates the proportion of people across different groups we might expect within services, if national prevalence estimates applied to West Sussex.

In the future, if data availability and quality improve, we will attempt to improve our estimates of the local picture of alcohol consumption using more sophisticated methods of modelling of health behaviours such as those outlined by academics<sup>18,19</sup>. which pull together demographic and other local data sources such as hospital admissions, to create more locally representative versions of national estimates from established methodologies.

## Creating the population model – methodology

We applied the percentages from the reference tables outlined on the previous pages to population estimates collated from the 2021 Census. This information was used to understand how many at risk drinkers may need services delivered across the county if West Sussex had the same pattern of alcohol consumption as England.

The first equity profile, published in draft form in late 2022, used a combination of mid 2020 population estimates and experimental data on ethnicity and sex at local authority district and borough level. Updating analyses to the 2021 Census allows us to utilise the very latest understanding of characteristics of our population.

The most granular geography used for estimates of need and service utilisation in the HEA series is ward level (electoral divisions as at 2022 boundaries) although population estimates are available at output area (a statistical geography based on population estimates). This is because ward geographies, compared to output areas, are generally larger and have more colloquial names and boundaries (such as edges of villages/towns) rather than being known by codes and having boundaries which dissect at unusual places such as the middle of streets. As such, wards are often more meaningful for stakeholders.

We have applied prevalence estimates by age and sex at the most granular area level and aggregated results to larger geographies (such as local authority districts and boroughs or West Sussex overall) rather than applying overall prevalence estimates at the West Sussex level population estimates.

Analysis was conducted using a reproducible analytical pipeline, coding analyses in R which can be repeated as new data becomes available.

### Good to know

AUDIT based risky drinking prevalence data was based on national surveys, and therefore **may not be generalisable** to West Sussex. This **data was also almost 10 years old** and based on other recent surveys, we know that risky drinking prevalence has increased. The population model is likely, therefore, to be an under-estimate.

Prevalence data was **not available for every characteristic** of interest, such as sexual orientation, disability. Moreover, the definitions of APMS questions around employment status and household type do not match the definitions of these topics in Census 2021 and as such are not directly comparable.

In the first iteration of the equity profile, we were only able to look at age and sex together and ethnicity and sex at local authority level. It is acknowledged that these characteristics (and others) are likely to interact and there may be significant variation in alcohol use and outcomes of service use within sub-groups (e.g. males aged 16-24 from black and ethnic minority groups).

Again, future Census 2021 releases exploring the combination of these characteristics may enable multivariate exploration of service user information.

The Census 2021 data is now available for users with additional data becoming available over time on both characteristics and combinations, such as age by sex by ethnicity. As such, we will continue to monitor new prevalence estimates and will update the population model whenever new data becomes available.



## The local estimated picture

Based on an estimated population of 726,900 residents (aged 16 and over) and a prevalence of increasing or higher risk drinking (AUDIT score 8 and over) we estimated that approximately **133,600 people in West Sussex are consuming alcohol at levels risky to their health** and may benefit from support.

This includes more than **8,000** residents drinking at probable dependence levels (see table below).

### Estimates of drinking levels by AUDIT risk group among adults aged 16+; West Sussex (aggregating national age/sex specific prevalence at ward level)

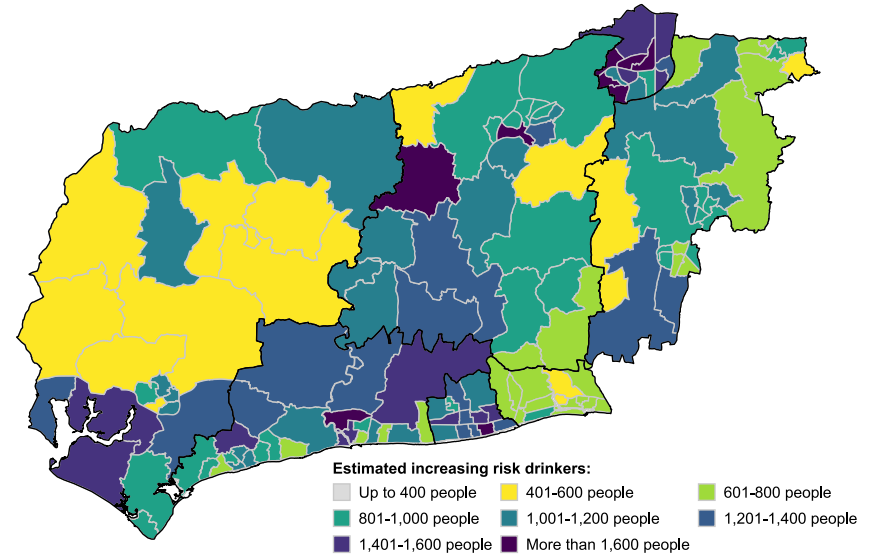
Area	Non-drinkers/low risk	Hazardous drinking	Harmful drinking/mild dependence	Probable dependence
West Sussex	593,300	113,200	12,300	8,100
Adur	43,400	8,100	900	600
Arun	115,100	20,800	2,200	1,400
Chichester	86,000	15,900	1,700	1,100
Crawley	74,700	15,800	1,800	1,200
Horsham	98,500	18,800	2,000	1,300
Mid Sussex	100,400	19,400	2,100	1,400
Worthing	75,300	14,400	1,600	1,000

\* Figures have been rounded to nearest 100

Based on the population model, and the overall age and sex structure of the population across West Sussex, we might expect Lower Tier Local Authorities of Arun, Mid Sussex and Horsham to have the highest number of hazardous, harmful, and probable dependent drinkers.

Adur is estimated to have lowest number.

Estimated number of increasing risk drinkers (aged 16+); West Sussex Wards (2022 boundaries)  
Based on the age/sex population structure of wards as at Census 2021



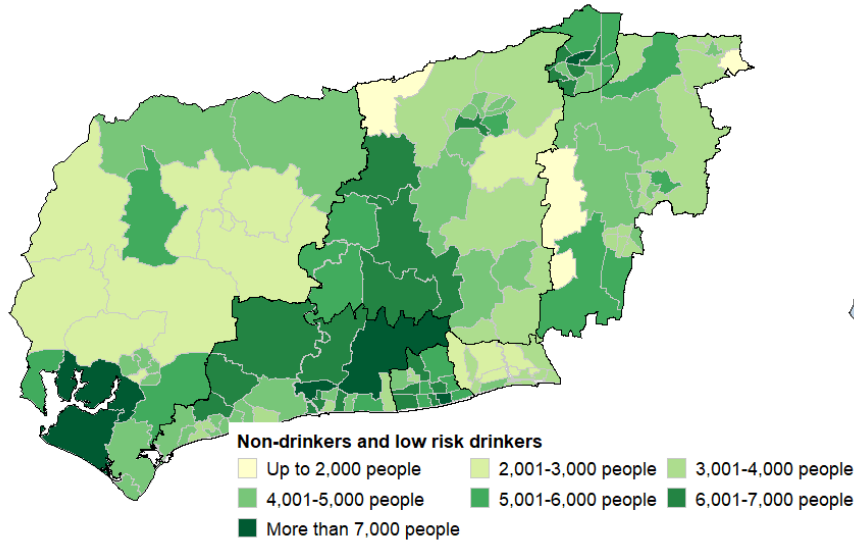
The maps overleaf show each of the four AUDIT risk groups by ward, using our age/sex specific prevalence population model.

The maps show estimated counts of people in each audit category by ward and therefore, largely correlate to areas that have larger populations. This information provides a visual representation of the areas where we might reasonably expect to see the most need.

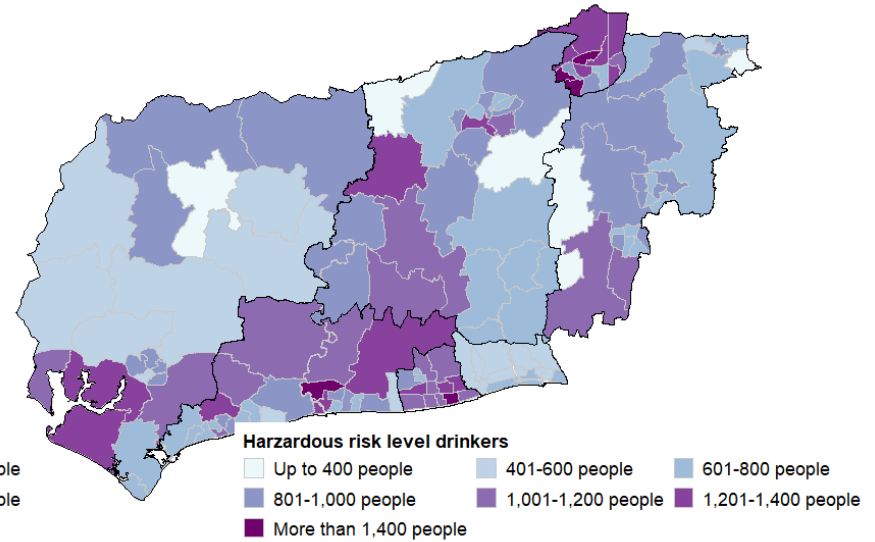
Note that there are difference scales for each risk group (e.g. the probable dependence map shows the range from around 30 to around 100 whilst the non-drinkers and low risk shows a range from around 2,000 to more than 7,000 people).

Estimated number of increasing risk drinkers (aged 16+); West Sussex Wards (2022 boundaries)  
 Based on the age/sex population structure of wards as at Census 2021

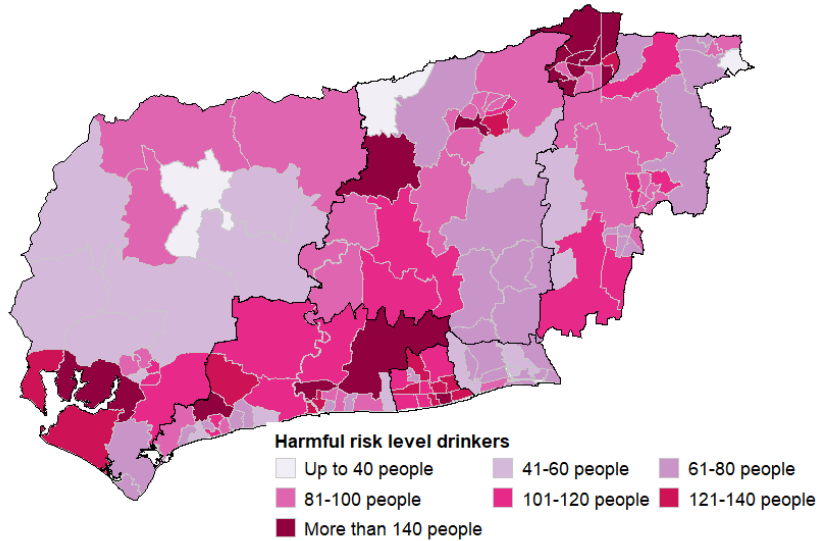
**Non-drinker and low risk drinkers (AUDIT score 0-7);**



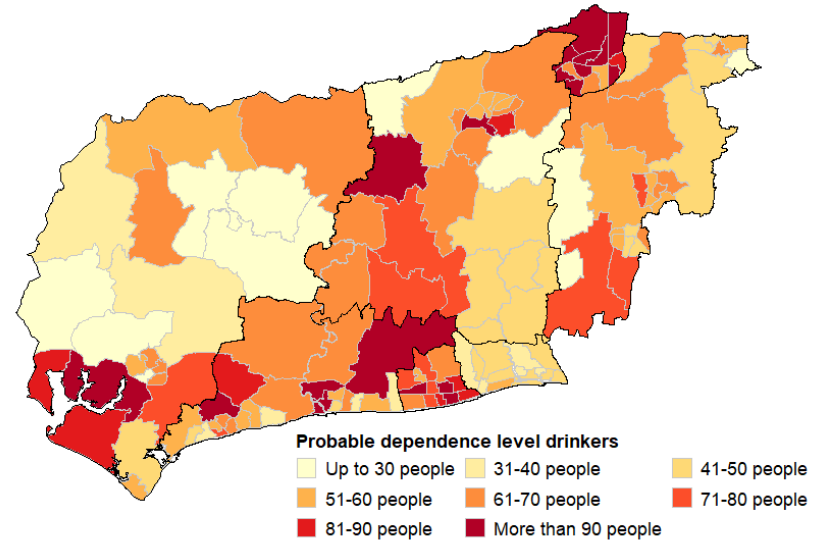
**Hazardous drinking (AUDIT score 8-15)**



**Harmful drinking/mild dependence (AUDIT score 16-19)**



**Probable dependence (AUDIT score 20+)**



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