

Alcohol health equity audit series

Commissioned Alcohol Services

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Introduction

Alcohol misuse remains a leading risk factor for premature mortality, morbidity, and disability in England¹. 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 issues². 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 to understand the local impact of harm from alcohol and its contribution to inequality.

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). 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 describes findings from an analysis comparing data from alcohol support services in West Sussex with an estimated population model of alcohol consumption. It is a chapter in the West Sussex Alcohol HEA Series. Other chapters in the series include:

- Alcohol Consumption & Estimated Need
- Health Care & Mortality
- 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 website (<https://jsna.westsussex.gov.uk/alcohol-health-equity-audit-series/>).

This report describes service data from the main alcohol early intervention and specialist services in West Sussex;

Main West Sussex commissioned services

The Community Pharmacy Identification & Brief Advice Service	The Alcohol Wellbeing Advisor Service within West Sussex Wellbeing Service	DrinkCoach, digital intervention (HumanKind)
The Specialist Drugs and Alcohol Service, (Change Grow Live)		

From this analysis, we identify inequity in access and outcomes to services for certain groups and make recommendations for developments to address these.

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.

Key findings

Here are the key findings for each of the Alcohol Support Services.

COMMUNITY PHARMACY IDENTIFICATION & BRIEF ADVICE SERVICE

- More people were assessed as drinking at hazardous and harmful levels than expected, based on the West Sussex population estimate of need (27% vs 16.6% hazardous, 8.3% vs 1.9% harmful).
- There was a higher proportion of females drinking at hazardous risk levels within the service than expected, based on the population estimate of need (43.8% vs 35%).
- Females were more likely to decline a leaflet/advice than males and less likely to be signposted to the Specialist Alcohol Service.
- There were more people aged over 65 years old within the service compared to the population estimate of need, with significant differences in outcomes found by age group.

DRINKCOACH

- More females completed the online Alcohol AUDIT, with the highest proportion of completions among those aged 45-54 years.
- More AUDIT questionnaires were completed by people residing in Horsham, followed by Chichester and then Arun.
- More than half of people accessing the Skype-based coaching service had an initial baseline assessment of probable dependence.
- Whilst numbers are small, there appeared to be a relatively high proportion of Skype-based DrinkCoach support being delivered to residents in Chichester and Horsham.

ALCOHOL WELLBEING ADVISOR SERVICE

- There was greater proportion of females in each AUDIT category within the service than we might expect to see compared to the estimate of need for the West Sussex population.
- The majority of cases assessed with a baseline of probable dependence were amongst the 35-54 year olds, with slightly more cases in males in these groups. This aligns to what we would expect based on the population estimate of need.

- Younger age groups were more likely to be 'lost to follow up' following interventions.
- The proportion of clients from a minority ethnic background accessing the service appeared to be somewhat higher than we might expect based on the population estimate of need.
- Using employment status as a proxy for deprivation, data suggests that the least deprived groups are accessing the service the most, followed by the most deprived groups.

SPECIALIST DRUG & ALCOHOL SERVICE (ADULTS AGED 25+)

- Four in five clients accessing the Specialist Alcohol Service had a baseline AUDIT assessment of probable dependence.
- Compared to the estimated population of need, males (particularly between the ages of 25-44 and over 75) were under-represented.
- Moreover, males had a significantly higher incompleteness rate at discharge compared to females (with as few as one in three males aged 35-44 years completing their intervention sessions).
- There was a clear deprivation gradient where more specialist service clients resided in the 10% most deprived areas in West Sussex compared to people in the 10% least deprived areas.

SPECIALIST DRUG & ALCOHOL SERVICE (THOSE AGED UNDER 25)

- Worthing residents accounted for one in five interventions (19%), followed by Horsham (18%), Arun (16.5%), Mid-Sussex (14%), Crawley (12.5%), Chichester (11.5%) and Adur (6%).
- Those at risk of homelessness had a higher rate of incompleteness of the intervention compared to those in stable housing.
- More than a third (37%) of cases related to people who were Not in Employment, Education or Training (NEET).

Commissioned Early Intervention Alcohol Services in West Sussex

Across West Sussex, there are a range of evidence-based alcohol early intervention services to meet the needs of adults drinking at levels which may be putting them at increasing-risk or higher-risk of harm. These services intervene early to support people to make changes to their drinking behaviours which are necessary to promote health and wellbeing.

Intervening earlier aims to prevent or reduce alcohol-related harm. It seeks to divert some people away from needing specialist support in the future and ensures that those who do need treatment are less advanced when they present to specialist services.

There are three main early intervention services for alcohol support in West Sussex. Except for the Community Pharmacy Identification & Brief Advice Service, which offers screening to all, access to early intervention services is based upon the level of alcohol consumption and harm to the individual.

These services typically use the Alcohol Use Disorders Identification Test (AUDIT) screening tool, which was developed by the World Health Organisation (WHO).

West Sussex commissioned early intervention services

The Community Pharmacy Identification & Brief Advice Service	The Alcohol Wellbeing Advisor Service within West Sussex Wellbeing Service	DrinkCoach, digital intervention (HumanKind)
Open to all	Typically working with those with an AUDIT score of 8-19	

West Sussex early intervention services support people assessed as drinking at 'hazardous or harmful levels' and where risk from alcohol is considered as mild to moderate.

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.

The Alcohol Wellbeing Adviser Service and DrinkCoach service are expected to be working with people assessed with a baseline AUDIT score of between 8 and 19. However, some service users present to early interventions with AUDIT scores indicative of probable dependence (20+). All services have rigorous triage processes and ensure service users are in appropriate placements.

We focus mainly on the characteristics of people taking part or receiving each intervention and discuss potential inequities of access to the various services, though where possible and appropriate, we explore outcomes such as programme completion. Small numbers preclude a heavy focus on outcomes, though it is hoped that future iterations of the equity profile can develop our understanding of these aspects.

Community Pharmacy Identification and Brief Advice Service

The Community Pharmacy Identification & Brief Advice Service opportunistically screen adults in participating community pharmacies across West Sussex. This is usually the earliest opportunity to ascertain an indicative level of risk from a person's alcohol consumption.

Rather than completing the full AUDIT questionnaire, alcohol risk level is identified with the use of the AUDIT C scratch card, which contains the first three questions of the full AUDIT screening test. As such, the scores range from 0 to 12 and provide an indication of risk that can be roughly translated to the full AUDIT tool as below:

Table 1.1: AUDIT risk categories by AUDIT-C and AUDIT score range

Risk category	AUDIT-C score range	AUDIT score range
Lower risk	0-4	0-7
Hazardous risk	5-7	8-15
Harmful risk	8-10	16-19
Probable dependence	11-12	20+

Individuals scoring above 5 on the AUDIT C scratch card (representing a full AUDIT score of 8+ and indicative of increasing harms) will receive brief advice on alcohol and signposting to the Alcohol Wellbeing Adviser Service or DrinkCoach, where appropriate.

Since the AUDIT C provides only an indication of alcohol risk, the full AUDIT tool would typically be carried out if individuals are to be referred on to the Specialist Alcohol Service.

This rapid, self-completed screening tool in this setting is useful because it captures the wider population who are using the pharmacy. It is currently our best guess at a population level picture of alcohol consumption across the county, with which to compare against the estimated model of alcohol consumption based on national prevalence figures.

It is important to note a key difference between the two data sources. Unlike the national prevalence study which asks a random sample of people to complete a range of health-related questionnaires, in most circumstances, non-drinkers are unlikely to complete the scratch card self-assessment of AUDIT-C in pharmacies.

Moreover, not all West Sussex residents will use community pharmacy services; with people usually likely to visit pharmacies only if they are unwell or seeking health advice/help. As such, it should be noted that certain groups, may be overrepresented in these figures, for example older age groups.

Data from the West Sussex Community Pharmacy Identification and Brief Advice Service was obtained and analysed for the period April 2019-March 2022.

Table 1.2: Community pharmacy activity overview and indicative risk (April 2019 – March 2022)

Risk category	People	Proportion	National prevalence
Lower risk (and non-drinkers)	1,076	63%	80.3%
Hazardous	461	27%	16.6%
Harmful	141	8.3%	1.9%
Probable dependence	31	1.8%	1.2%

The majority of people taking the self-assessment (63%) were categorised as lower risk (table 1.2), with no further action required.

Just over one in four (27%) were assessed as drinking at potentially hazardous levels. This is greater than the 16.6% expected based on the national prevalence assumption. A further 8.3% were assessed as potentially drinking at harmful levels. This compares to a modelled 1.9% from our national estimate.

Finally, 1.8% of individuals in community pharmacies were assessed as potentially drinking at dependent levels, which is similar to what we would expect based on the population estimate of need (1.2%).

Overall, this indicates that there are more people in West Sussex drinking at riskier levels compared to the national estimates, for all risk categories (hazardous, harmful, and probable dependence levels). However, as noted above, non-drinkers are unlikely to complete the scratch card self-assessment of AUDIT-C in pharmacies.

Indeed non-drinkers (identified as having an AUDIT score of 0) represented 14% of overall responders in the West Sussex Community Pharmacy service, compared to 22.8% of those participating in the national APMS study.

Those with AUDIT-C scores above 4 are offered information and advice and in some cases are signposted to specialist drug and alcohol services. Over the study period, 633 people were given some sort of further information or signposting, although one in four (176, 27.8%) declined. It is not possible to say whether those who were signposted to specialist services took up the offer,

Applying the national prevalence figures to the local population, we might expect more males than females in the higher risk AUDIT categories.

Table 1.3a and 1.3b shows the differences in proportions of people completing the AUDIT-C scratch card in the pharmacy setting by sex and what we might expect given the national prevalence.

The proportions in each category are comparable, although there were more females in the hazardous risk group in the West Sussex Community Pharmacy Identification and Brief Advice Service than we might expect given the estimated population.

Table 1.3a: Community pharmacy activity overview and indicative risk by sex; Local activity

West Sussex Community Pharmacy Identification and Brief Advice Service; April 2019-March 2022			
Risk category	Males	Females	Total
Lower risk (and non-drinkers)	43% (464)	57% (612)	1,076
Hazardous	56.2% (259)	43.8% (202)	461
Harmful	63.8% (90)	36.2% (51)	141
Probable dependence	71% (22)	29% (9)	31

Table 1.3b: Community pharmacy activity overview and indicative risk by sex; Estimated need

National prevalence Adult Psychiatric Morbidity Study; Aged 16+; 2014			
Risk category	Males	Females	Total
Lower risk (and non-drinkers)	44%	56%	-
Hazardous	65%	35%	-
Harmful	66%	34%	-
Probable dependence	75%	25%	-

Some significant differences were found between females and males in terms of outcomes of the AUDIT-C assessments.

Across the service, 64% of females compared to 73% of males were provided with a leaflet and given brief advice. Data showed that 34% of females compared to 24% of males were offered a leaflet but declined.

Finally, of those who were offered information, advice, or signposting, one in three females (33.6%, 88 people) compared to one in four males (23.7%, 88 people) declined. This difference was significantly different as measured by a simple Chi Square test ($X^2 = 7.5308$, $df = 2$, $p\text{-value} < 0.05$). However, with small numbers of people over this three year period, the results should be considered with caution.

Analysis by age for this dataset is at a broader age band level compared to other services, as more detailed data was not available. The age bands provided include 18-35 year olds, 36-50 year olds, 51-64 year olds and people over 65 years old. As such, it was not possible to directly compare these age bands to the population estimate of need.

Table 1.4: Community pharmacy activity; Number of completed AUDIT-C assessments by sex;

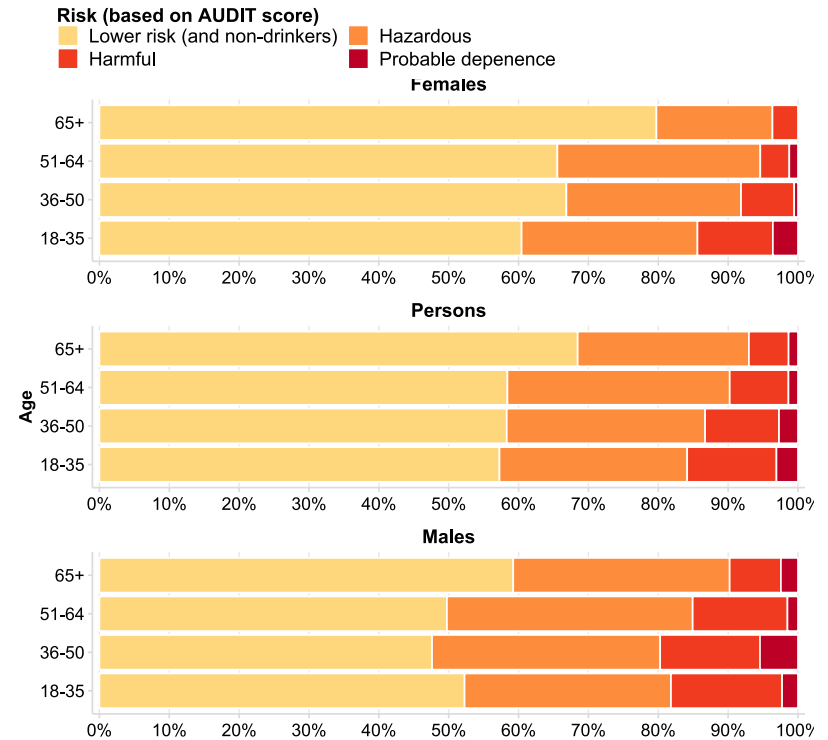
Age group	Males	Females	Total
Under 18	-	-	7
18-35	88 (38.8%)	139 (61.2%)	227
36-50	147 (44.4%)	184 (55.6%)	331
51-64	199 (45.2%)	241 (54.8%)	440
65+	368 (55%)	301 (45%)	669
Unknown	27 (77.1%)	8 (22.9%)	35

Two thirds of people taking part in the AUDIT-C assessment were aged 50 and over, with one in ten (13%) aged 18-35 and one in 20 (19.4%) aged 36-50. The increased participation in the AUDIT-C assessment among those aged 50 and over, may be indicative of the age groups likely to use community pharmacy services more frequently.

Figure 1.1 shows that younger males tended to have higher risk scores (particularly 36-50 year olds, where at least half of those completing the assessment get a score indicative of increasing risk 5 or more).

Figure 1.1: Community pharmacy identification and brief advice service AUDIT-C assessment risk

April 2019-March 2022; by age and sex;



Significant differences were found by age group and complete outcomes (receiving information) vs incomplete outcomes (declining a leaflet/advice). This ranged from 22% in people aged 51-64 declining information to 39% in people aged 18-35 ($X^2 = 12.056$, $df = 3$, $p\text{-value} < 0.01$), suggesting younger age groups in this setting were less receptive to the support offered.

DrinkCoach

DrinkCoach is an early intervention service comprised of an online AUDIT screening tool, a free app to support people to track and change their drinking, and a Skype-based coaching service with access to Specialist Alcohol Coaches. This service is for anyone aged 18 and over.

This uses the full 10 item AUDIT scale but is quick and easy to complete online, enabling people to anonymously check their alcohol consumption to find out whether they may benefit from changes to their drinking, as well as providing tips and advice.

An offer of free DrinkCoach Skype sessions is made to those completing the online AUDIT who are assessed as drinking at levels hazardous or harmful to health (AUDIT 8-19). Service users will be offered from two to twelve coaching sessions, depending on need. Sessions are available during evenings and at weekends, as well as during the week, ensuring accessibility for those who are working or otherwise unwilling or unable to attend face to face appointments. The aim of coaching sessions is to achieve an overall reduction in alcohol consumption and an improvement in the health and wellbeing of service users. Individuals assessed as probable dependent (AUDIT 19+) on the online AUDIT tool will be signposted to West Sussex Specialist Alcohol Service.

West Sussex residents are able to book DrinkCoach Skype sessions on completion of the online AUDIT Tool, or can book sessions directly, for example on the recommendation of a health professional or social worker.

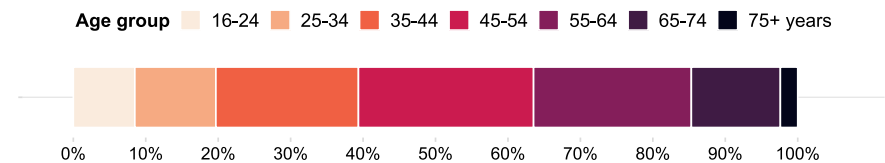
Data from the DrinkCoach Service was obtained and analysed for the period April 2019 to March 2022. We briefly describe the characteristics of those who complete the screening tool and separately we explore the access and outcomes of those who go on to engage with specialist alcohol coaches online.

Between April 2019 and March 2022 there were 17,002 visits to the DrinkCoach AUDIT website. Of these visits, there were 10,074 AUDITs completed.

Data showed that slightly more females compared to males completed the AUDIT on the website (51.3% compared to 48.7%). The majority of people completing the AUDIT screening online were aged 35 and over. Those aged 65+ comprised one in seven people completing it.

Figure 2.1: number of people completing DrinkCoach online AUDIT screening

April 2019-March 2022; by age;



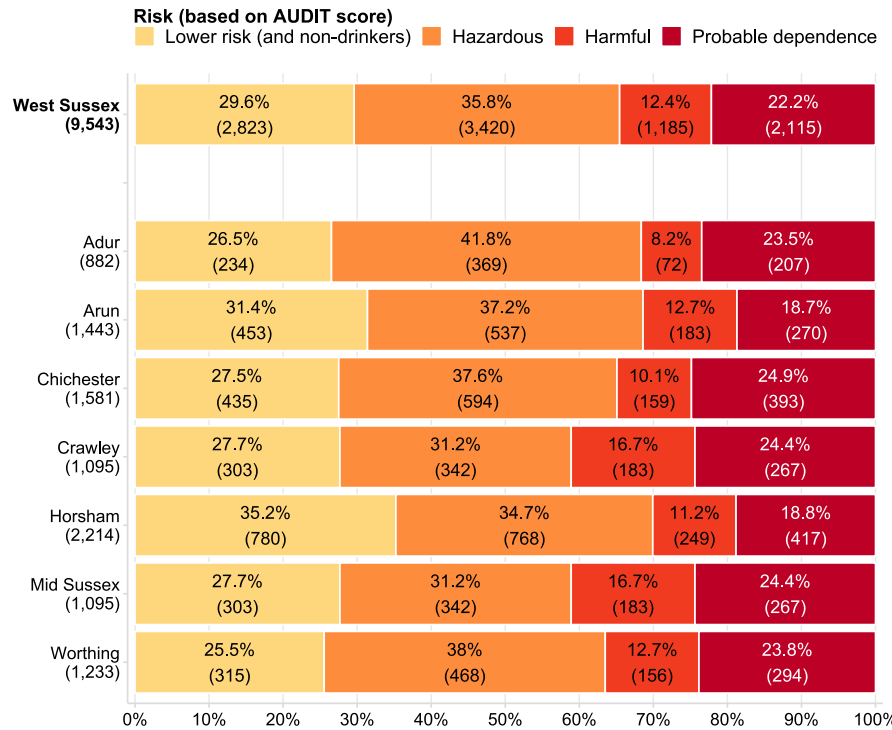
The AUDIT risk group by age was unavailable.

The majority (91.6%) of those completing the AUDIT were White British, with 2.2% completed by White Irish groups and 3.7% completed by other White groups. The remaining 2.5% from other ethnic groups.

Figure 2.2 shows the proportion of responders who gave their residence in each of the West Sussex districts (numbers in brackets are the total number of people completing the AUDIT screening tool).

Figure 2.2: Proportion of people completing the DrinkCoach online AUDIT assessment by risk category and West Sussex local authority district;

April 2019-March 2022;



There was greatest uptake among those living in Horsham, Chichester, and Arun. Horsham and Arun had the highest proportion of low risk drinkers completing the questionnaire as well as the lowest proportion of completers with score indicative of probable dependence.

As with the community pharmacy intervention, whilst some non-drinkers completed the AUDIT questionnaire, those who do not drink alcohol may be unlikely to visit the DrinkCoach site or complete the test which means it is likely to be biased towards those who do drink and underrepresent non-drinkers in the county.

All of those that completed the online AUDIT received on screen advice about their drinking. Additionally, 12.7% read more about their drinking, 6.8% selected a link to find support near to them. A total of 136 people booked an online appointment with a Specialist Alcohol Coach.

A total of 136 people were seen by a Specialist Alcohol Coach from April 2019 to March 2022. Data showed that 18% (25 service users) were drinking at hazardous levels (AUDIT 16-19) at the start of their coaching. A further 21% (29 service users) were assessed as drinking at harmful levels (AUDIT 8-15) and. More than half (58%, 79 service users) of people entering the coaching service had a baseline assessment of probable dependence (AUDIT 20+).

One in five (21%, 29 service users) were those living in Horsham, and the second highest local authority for services users was Mid Sussex (23 service uses, 17% of all DrinkCoach online advisor service users). The number of service users from Arun was lowest with just nine clients.

However, the number of people in the intervention overall is too low to draw strong conclusions of variation across the districts and may simply reflect that more people accessed the website from certain districts.

Whilst there are no substantial differences in activity by sex, there were more females using the service (table 2.1) than we would expect based on the population estimate of need (see table 1.3b for the national prevalence reference table).

Table 2.1: DrinkCoach online advisors activity baseline indicative risk by sex; Local activity

Risk category	Males	Females	Total
Hazardous	44% (11)	56% (14)	25
Harmful	44.8% (13)	55.2% (16)	29
Probable dependence	44.3% (35)	55.7% (44)	79

The number of people in the lower risk group by sex has been suppressed due to low numbers

The high representation of females was not found in the Community Pharmacy Service. However, the samples are small in some categories and so the results should be interpreted with caution.

In people aged over 35 years old, the treatment completion rate was approximately 85%. In those aged 25-34 this dropped to 71% (however the number of people in this age group was small). No statistical tests were conducted due to a high number of small values when breaking down the data by age and sex.

The small number of people taking part in DrinkCoach online advisors' intervention, even when pooled across three years, meant that analyses by AUDIT group, age and sex, and by other characteristics such as local authority district were limited and mostly inconclusive.

It was also not possible to directly compare to the population estimate of need, which is available at each risk score.

Finally, whilst the provider aims to collect sexual orientation, disability, ethnicity, religious beliefs, housing and employment data, these fields had

either not been routinely completed or there were extremely low numbers in some minority groups. Therefore, analysis across these characteristics was not possible.

Whilst numbers are small, there does appear to be a relatively high proportion of DrinkCoach activity in some of the more rural LTLAs. Chichester and Horsham have higher levels of activity compared to the less rural areas of Crawley and Worthing, for example.

This may be because access to this online service was more convenient than attending a face-to-face service for some people living in rural areas. There may also be a lack of a very local alternative provision or limited transport options in rural areas and results might indicate that the DrinkCoach service is meeting a need specific to these locations.

Alcohol Wellbeing Advisor Service

Alcohol Wellbeing Advisors (AWA) are located in each of the District & Boroughs, as part of the West Sussex Wellbeing Programme. The service offers face-to-face, extended brief interventions to adults who are drinking at hazardous or harmful levels.

Horsham Wellbeing launched the first AWA Service in February 2020, with other areas following suit during the remainder of 2020 and 2021. National Covid-19 lockdowns interrupted the launch of some services, with the full service operational by Autumn 2021. Data from activity completed by the AWA service from October 2020-March 2022 covers the time of limited service provision.

People may use the service once or return for additional interventions. When comparing activity within population groups compared to the population estimate of need, we have used data relating to the most recent episode of care or engagement. There were 13 service users who access the AWA more than once.

Table 3.1: AWA activity; Number of people by age and sex

Age group	Males	Females	Total
16-24	-	-	-
25-34	43.6% (17)	56.4% (22)	39
35-44	53.4% (39)	46.6% (34)	73
45-54	56.2% (41)	43.8% (32)	73
55-64	44.9% (35)	55.1% (43)	78
65-74	29.6% (8)	70.4% (19)	27
75+	-	-	-
All ages*	146	156	302

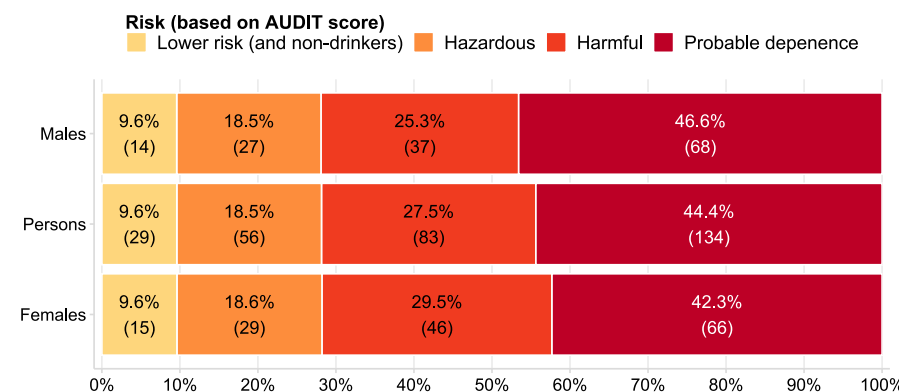
We have suppressed low numbers to avoid possible identification of individuals.
The all ages row includes 16-24 and 75+ year olds

Table 3.1 shows that there were relatively equal numbers of males and females accessing the AWA service for most age groups with slightly more males in the 35-44 and 45-54 age group. However, for those aged 65-74, females made up almost three quarters of service users; although the numbers in these groups are quite small.

Showing the numbers of people in each age group by sex for their starting AUDIT score is not possible due to very small numbers. As such we have just looked at AUDIT score by sex for all ages. Two in five of those taking up the AWA service had a baseline AUDIT risk score indicative of probable dependence. There was little difference in the proportion of males and females in each AUDIT group (figure 3.1).

Figure 3.1: Proportion of AWA service users by sex and their starting AUDIT assessment risk category

October 2022-March 2022; by sex;



The estimated population of need model indicated more males in each risk group, roughly representing two out of three people in each category: albeit in the whole population, not just those seeking support from an alcohol service. Whilst tentative, it might imply that if the AWA service were equitable, we would expect to see more males, particularly in harmful and probable dependence groups using the service.

The majority of cases assessed with a baseline of probable dependence were amongst the 35-54 years age groups. There were slightly more cases among males in these groups although not to the degree we might expect from national prevalence assumptions and our model of need.

In females, most probable dependence cases were in the 35-44 year group and 45-54 years group and for males most cases were in the 35-44 years group and 45-54 years group. This aligns to what we would expect based on the population estimate of need.

Since the AUDIT screening tool provides early intervention services with only a broad measure of risk from alcohol, individuals entering the service with an initial AUDIT assessment indicative of probable dependence (20+), also receive a further SADQ (Severity of Alcohol Dependence Questionnaire) test.

This is used to measure the severity of this dependence and to help determine their suitability for treatment within the Wellbeing Service or the need for onward referrals to specialist alcohol services.

Following the SADQ assessment, one quarter (25%) of people assessed as experiencing probable alcohol dependence at baseline were referred on to the Specialist Alcohol Service. Others were assessed as having support needs appropriate for the AWA service.

There were a small number of AWA service users recorded as under 16 years old. As the contract is for adults only, it is likely that this is a data error.

Of those who did progress through the AWA intervention roughly half (149 cases, 49.3%) had a mutually planned exit of the programme recorded. A further one in seven cases (14.9%, 45 clients) were referred onto Specialist

Alcohol Services and one in five cases were lost to follow up (19%, 57 cases). The remaining 51 service users (16.9%) had no outcome recorded.

Although the numbers in each age group are too small to draw any strong conclusions, there was variation in outcome by age group with significant differences found (X-squared = 25.2, df = 14, p-value < 0.05). For instance, 40% of those 25-34 years were lost to follow up, compared to 0% of the 65-74 year olds.

There were no significant differences in outcomes by sex. One fifth of cases were lost to follow up (19% females and 20% males) and approximately half of cases had a mutually planned exit (48% males, 51% females). Further to this, 14% of males and 16% of females were referred on to the Specialist Alcohol Service. The remaining cases did not have an outcome recorded. In some instances, this may have been because they were still receiving treatment, but this was not specified.

One in ten (9.5%) clients using the AWA service were from a minority ethnic group, with 86.1% of clients from White British backgrounds and the remaining 4.4% with no ethnicity data recorded. The number of cases in the minority ethnic group were too small to consider by AUDIT category and we cannot directly compare this proportion to the estimated population. However, the proportion of clients from a minority ethnic background appears to be somewhat higher than we might expect based on expecting between 2.8% and 7% of the estimated population to be from a minority ethnic group.

The only geography of residence detail available in this dataset was the first four digits of the client's postcode. This was not sufficiently detailed to ascertain LTLA. Therefore, a summary has been provided below based on the activity within each service. It is however recognised that the service attended may not always be within the LTLA where the client lives, as they may work in that area or found that particular service was the most convenient for another reason.

The Horsham Wellbeing Hub was responsible for two in five AWA service interventions (132 interventions, 41.6%), but this may be due to Horsham Wellbeing Hub being the first provider to begin delivering this activity and other providers not gaining substantial clients for some time as many public health services were suspended as the country responded to the global COVID-19 pandemic.

The proportion of people who used the service that considered themselves to have a disability was relatively low at 8.8%. The remaining cases had been coded as not having a disability. This may reflect a data capture issue. For instance, advisors might only ask about physical disabilities that they may need to be aware of to ensure adequate access to face to face appointments. The number of cases who reported a disability were too small to consider by AUDIT category. Similarly, the numbers in some groups became too small when considering outcomes by disability status.

Just over one quarter (27%) of cases were people working in managerial or professional roles, followed by 21% of cases who were unemployed.

Deprivation data was not available. However, if we were to view employment status as a proxy for this, data suggests that the least deprived groups are accessing the service the most followed by the most deprived groups. Although, the numbers are relatively small, and we have not been able to account for variation between providers and so this should be interpreted with caution.

When considering outcomes, statistical tests were not run due to very small numbers in some groups. However, it is noteworthy that 27% of people who were unemployed were lost to follow up compared to 17% of those in managerial/professional roles.

Specialist Drugs & Alcohol Service (Adults 25 years & over)

The Specialist Drug & Alcohol Service is provided by Change Grow Live. The overall aim of the service is to provide a full range of harm reduction and treatment services (alcohol and drug provision) to meet the needs of the West Sussex local population, incorporating both community and residential based provision. The service offers tailored specialist support for people who are drinking at dependent levels (AUDIT 20+) and aged over 25 years old.

The service provided data for all cases receiving support for alcohol (and alcohol and non-opiate drugs) who had been on the caseload in the study period (April 2019-March 2022). The dataset therefore represents a subset of service users that had accessed support for alcohol treatment within the wider substance misuse service. There were 515 records which were triaged before the study period. However, as they were still on the caseload during the study period, these cases have been included in the analysis.

This dataset therefore comprised 3,470 records. As service users may return for multiple interventions (hereafter called spells), the dataset represents 3,005 unique individuals.

A total of 399 services users had multiple spells. This comprises 341 clients with two spells, 50 clients had three spells of care and eight clients had four spells of care by the end of the study period.

The median number of days from triage to discharge from service was 185 days. However, 425 records had no discharge date listed during the study period. These records have been included for analysis for activity and access but excluded from outcomes analysis.

In some cases where an individual had more than one spell of care, we have used data relating to the most recent spell of care only. This is to avoid double counting. This applies particularly to analysis of access to the service by age, sex, LTLA and ethnicity.

For the analysis of outcomes, all records with a recorded discharge date are included in the analysis. This includes those with an AUDIT score of less than 8. The provider advised that people with a baseline AUDIT score of less than 8 that are referred into the service, typically have additional complexities, and so are still considered to require the support of the specialist service.

Table 4.1 shows there were more males accessing the service than females, in every age group. This is broadly concurring with what we might expect given the estimate of need model.

Table 4.1: Specialist Alcohol Service activity; Number of people by age and sex;

Age group	Males	Females	Total
16-24	-	-	-
25-34	64.6% (381)	35.1% (207)	588
35-44	63.1% (522)	36.6% (303)	825
45-54	59.3% (471)	40.7% (323)	794
55-64	56.5% (316)	43.3% (242)	558
65-74	63.7% (128)	36.3% (73)	200
75+	73.3% (22)	26.7% (8)	30
All ages*	1,840	1,156	3,005

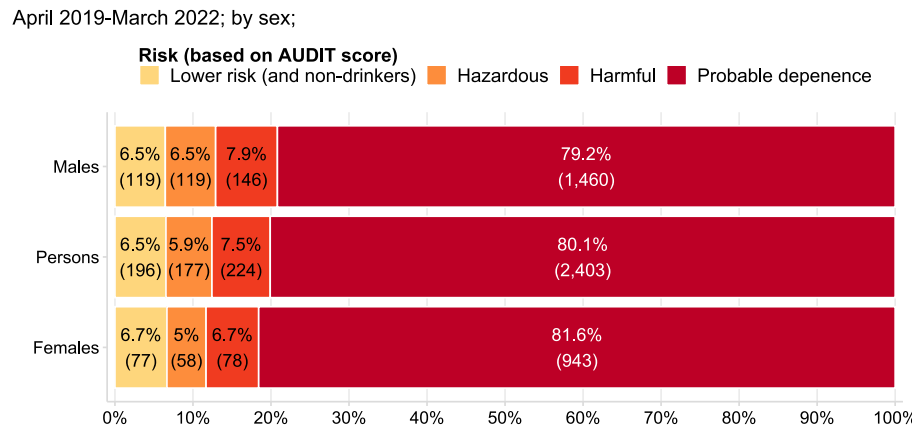
We have suppressed low numbers to avoid possible identification of individuals.

The all ages row excludes the 16-24 year olds from the totals to prevent disclosure by deduction and the total column includes only those where sex at birth was known.

A handful of service users were aged 16-24 years. It is thought that these service users may have required further assessment within the adult service, such as psychiatric assessment or neurodevelopmental evaluation.

Four out of five service users triaged within the Specialist Alcohol Service were assessed as experiencing probable alcohol dependence (figure 4.1, overleaf). This is much greater than the proportion of service users in our early intervention services, as expected. The smaller number of service users assessed as drinking at hazardous or harmful levels are likely to have had additional complexities that require treatment from the specialist service. There did not appear to be any substantial difference in the proportion of service users in each AUDIT risk group; though there was a slightly higher proportion of females (81.6%, 943 service users) compared to males (79.2%, 1,460 service users).

Figure 4.1: Proportion of Specialist (25+ years) Alcohol Service users by sex and their starting AUDIT assessment risk category



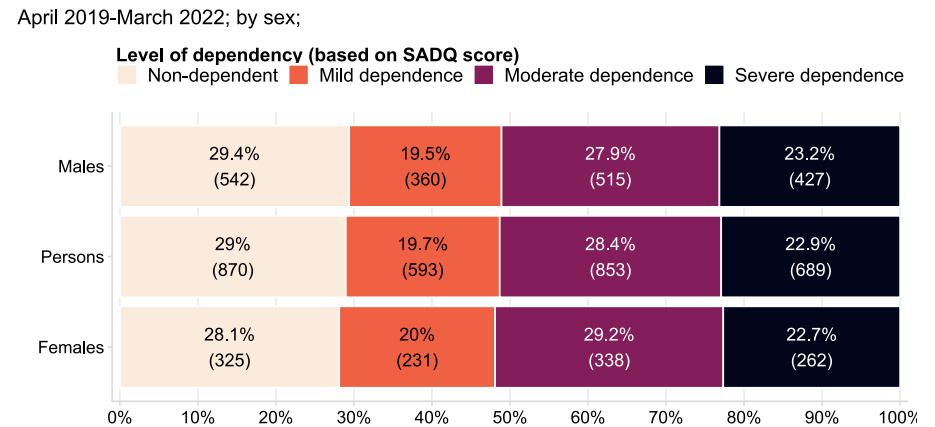
The AUDIT tool provides a broad measure of risk from alcohol. The Specialist Alcohol Service, like our early intervention services, therefore

also undertake a SADQ assessment with clients to determine the severity of alcohol dependency.

The breakdown of service users (across the whole study period) by SADQ dependence category is given in figure 4.2 which shows similar proportions of dependency for males and females.

Around half of those in the Specialist Alcohol Service have SADQ dependency scores indicative of mild or non-dependence.

Figure 4.2 Specialist Alcohol Service users by sex and their starting SADQ level of dependency score



At this stage, we have not produced an estimated population model using prevalence assumptions on the level of dependency (measured with SADQ). As such, this is for context only as we cannot compare these findings to what we might expect an equitable service to comprise

When looking at specific population groups, the numbers within some minority groups were small. As a result, we look at activity for some groups across West Sussex as a whole, rather than at small area level. At times, we have grouped together minority groups to analyse broad differences.

For instance, instead of looking at individual sexual orientations, we have looked broadly at heterosexuals compared to LGB+ groups (all minority sexual identities). It is noted that these subgroups are in no way homogenous. However, with the sample sizes available, this was a pragmatic approach to understanding any broad differences.

Those in LGB+ groups represented 5% (147) of service users, although those with unknown or unrecorded sexual orientation represented a further 9% of service users. It is possible that some LGB+ groups are represented in some of the unknown records. Where sexual orientation was recorded as heterosexual, 80% of service users had AUDIT scores indicative of probable dependence. This increases to 85% of service users who reported their sexual orientation as LGB+.

One third (31.5%, 947 service users) of records related to people with one or more disability with 25% of records related to people with one disability, 5% of records related to people with two disabilities, and 1.8% of records related to people with three disabilities.

The most commonly reported disability was behaviour and emotional (15.5%, 467 service users), followed by mobility and gross motor related disabilities (6.1%, 184 service users), and learning related disabilities (4.5%, 134 service users). The remaining disabilities recorded were spread across 13 other categories of disability.

There were negligible differences in starting AUDIT risk groups among those who reported at least one disability compared with those reporting no disability.

Almost two thirds (65%) of referrals to the Specialist Alcohol Service were self-referrals, with 9.5% of referrals from GPs. The remaining records were referred via 35 different sources.

The majority of records related to service users not known to the criminal justice team (86.8%), with 11.6% known previously to a criminal justice team and 1.6% currently known to the criminal justice team. Less than 0.5% of records for the period related to service users who were pregnant at the time of accessing support.

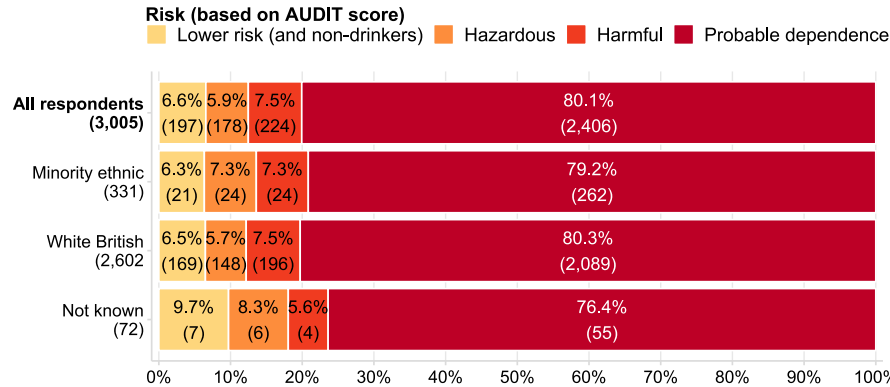
As discussed in the Alcohol Consumption & Estimated Need chapter of the HEA Series, the national prevalence estimates suggest some differences in alcohol consumption by different ethnic groups (which also appear to be moderated by sex).

As the data was limited, for the purpose of our population estimate of need we considered the proportion of service we would expect to be used by White British groups and the proportion we would expect to be from minority ethnic groups.

Figure 4.3 shows the proportion of people in each ethnic group by their starting AUDIT score. Minority ethnic groups represented 11% of service users in the Specialist Alcohol Service between April 2019 and March 2022.

Figure 4.3: Proportion of Specialist (25+ years) Alcohol Service users by broad ethnic group and their starting AUDIT assessment risk category

April 2019-March 2022;



The number of cases from minority ethnic groups with baseline AUDIT assessment of 8-15 or 16-19 were quite low, so should be interpreted alongside the population estimate of need with care. However, there appears to be a slightly greater proportion of cases from minority ethnic groups with an AUDIT score of 20+ than the population estimate suggests.

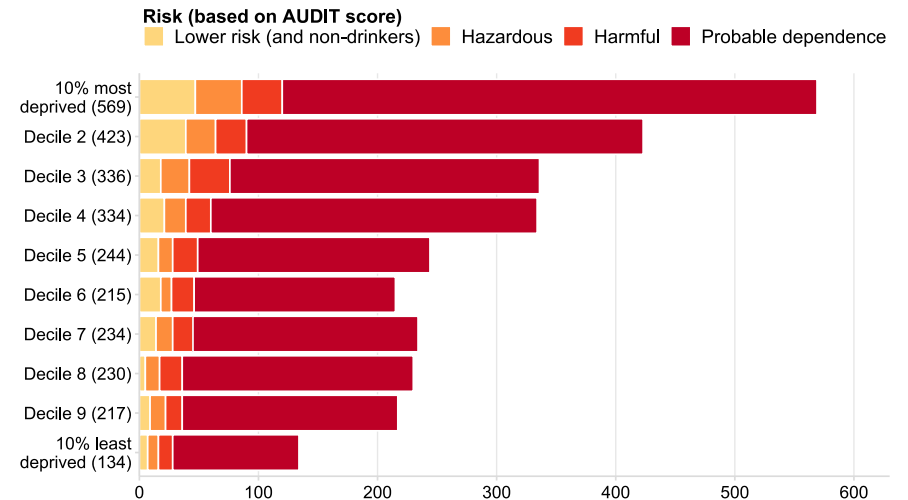
Regarding the outcomes of treatment, the incompleteness rate was 53.7% in cases who were White British, compared to 58.5% of cases who were from a minority ethnic group.

Environmental disadvantage is measured using the 2019 Index of multiple deprivation (IMD, Department for Communities and Local Government). This is 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). Areas are then divided into ten equal groups called deciles.

Figure 4.4 shows the gradient of service users by deprivation decile from most to least deprived areas of West Sussex. There were more than four times the number of service users from the most deprived neighbourhoods (569) compared to the least deprived (134).

Figure 4.4: Number of Specialist (25+ years) Alcohol Service users by deprivation decile and their starting AUDIT assessment risk category

April 2019-March 2022; Deprivation rankings within West Sussex



Similar to the national prevalence assumptions however, there is no pattern of the proportion of people in each decile who had starting AUDIT risk scores indicative of higher risk drinking. In both the least and most deprived deciles of West Sussex, 79% of service users were in the probable dependence risk category.

A slightly higher proportion of those living in the most deprived deciles had not completed their treatment on discharge compared to those living in the least deprived deciles (55.9% compared to 52.4%) but this difference was not statistically significant.

For many other characteristics available to us from the Specialist Alcohol Service provider we can only analyse at West Sussex level and for all service users (not broken down by individual AUDIT risk group) due to small numbers and missing data. Moreover, the estimated need model using national prevalence assumptions did not account for these characteristics.

Nonetheless, it is useful to describe what we can about the groups (country of birth, religion, housing, employment and relationship status) differential access to the service to highlight potential inequalities of access that could be addressed in the future.

Almost all service users were born in the UK (92.5%). The second most common country of birth was Poland, but this only represented 1.15% of records. The numbers in minority groups were too small to explore for further analysis.

The majority of records relate to people who have no religion (61.4%). One fifth (20.2%) of records related to people who reported their religion as Christian. The remaining records related to other religions, but there were insufficient numbers in any of these for further analysis. There were no clear differences in broad outcomes between people who were Christian and those who stated their religion as 'none.'

One in ten records (10.5%) relate to people who were assessed as having a housing problem and a further 4.5% of records indicate the presence of an urgent housing problem. Those with a housing issue had a higher incompleteness rate (63.3% or 67.8% for housing problem and urgent housing problem respectively) compared to those without a housing problem (52.1%). These were statistically significant differences (X-squared = 26.444, df = 2, p-value < 0.001).

Two in four records (42%) related to those who were in regular employment, 31% were unemployed and 15.3% were not working due to long term sickness/disability. There were significant differences in broad outcome by employment status. Half (51.4%) of those in regular employment didn't complete treatment, increasing to 56.3% in those unemployed and seeking work, 58.9% in those unemployed but not seeking work and 60% in people who were not able to work due to long term sickness/disability (X-squared = 14.76, df = 3, p-value < 0.01)

Finally, almost one in ten (9.3%) records related to people who were divorced or separated, with 14.4% who were married or in a civil partnership. One in three (29.9%) records related to people who were single. The remaining records related to people who had reported another marital status or had not disclosed their marital status.

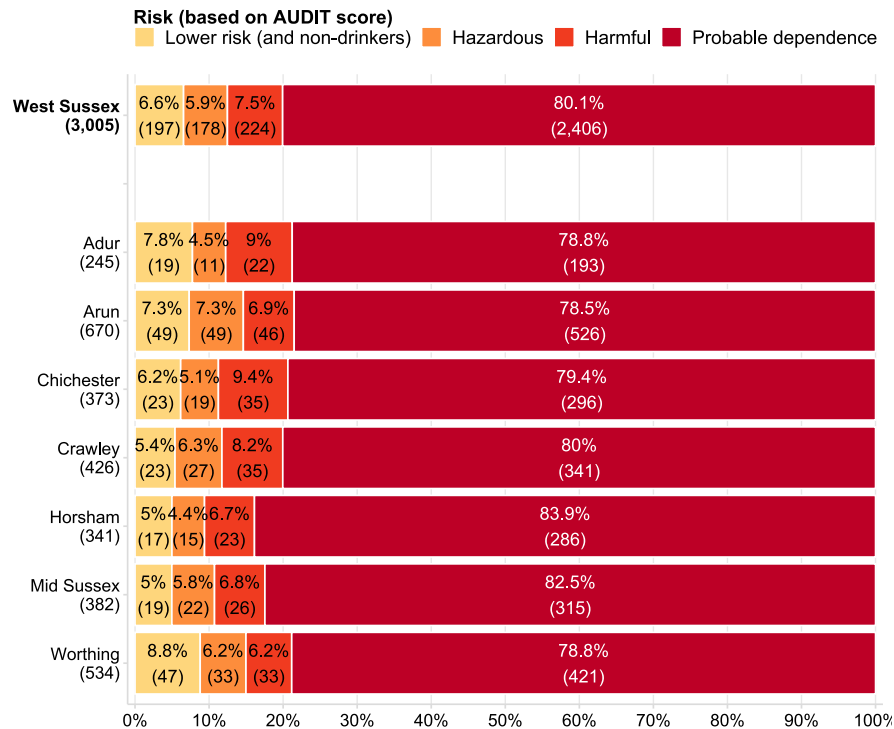
There were significant differences in broad outcomes by relationship status, with incompleteness rates highest among single people (59%), 52% in people separated or divorced and 44% in people in civil partnerships/married (X-squared = 27.883, df = 3, p-value < 0.001).

The numbers of people in these population groups preclude a detailed analyses of the outcomes of the Specialist Alcohol Service at this stage. For most characteristics, there were little or no differences in terms of outcomes. It is hoped that in the future, data quality (particularly around missing data) can be improved and that with more data we should be able to repeat this equity profile with a focus on treatment outcomes.

Two out of five service users resided in Arun (670, 22%), the local authority with the most service users, followed by Worthing (17%, 534 service users), and Crawley (373, 12.4%). As shown in figure 4.4, there were a greater proportion of those in the probable dependence risk groups in Horsham (representing 83.9% of service users) and Mid Sussex (82.5%) compared with the rest of West Sussex. The West Sussex figures include a small number of records in which the service user resided outside of West Sussex or had no fixed abode.

Figure 4.4: Proportion of people in the 25+ Specialist Alcohol Service completing the AUDIT assessment by risk category and West Sussex local authority

April 2019-March 2022;



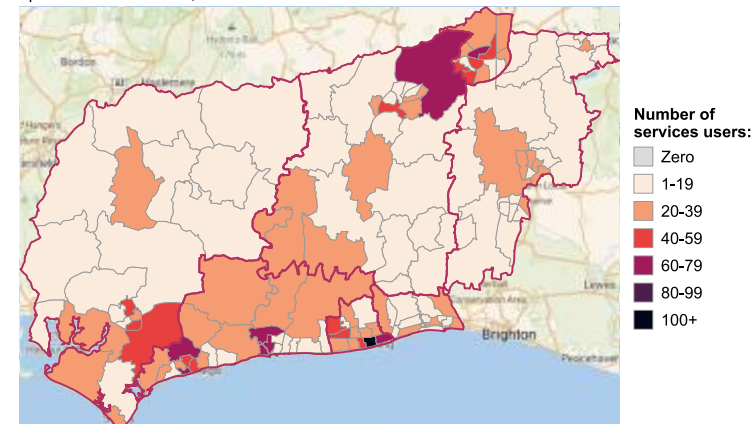
With 3,005 records in the dataset, it was possible to consider small area (ward level) activity for the Specialist Alcohol Service. As of 2022, there were 132 wards across the county; these vary in size and population covered. The average number of over 25s in a West Sussex ward was 9,860, (ranging from 4,060 to 16,350) as reported from the 2021 Census.

When considering variation by ward area, a best fit methodology was used to map Lower Layer Super Output Area level (as identifiable data such as postcode was removed prior to access) activity to ward, as we did not have ward data available. As a result, we cannot be 100% certain that all records have been assigned to the correct ward, although we expect this impact to be minimal.

The map in figure 4.5a shows there are clusters of high activity along areas of the Coast, particularly Bogor and Worthing, and to the southwest of Crawley. This largely correlates to where the Specialist Alcohol Service hubs are located.

Figure 4.5a: Number of people in the 25+ Specialist Alcohol Service; West Sussex Wards (2022 boundaries)

April 2019 - March 2022;



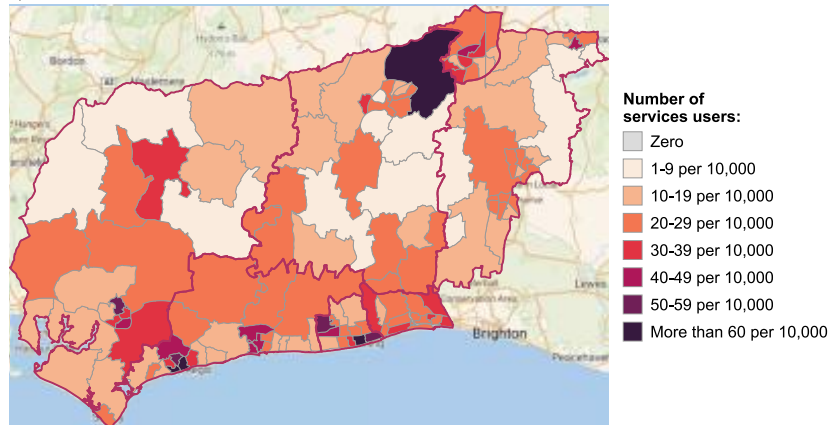
It should be noted that this is based on small numbers, even when three years of data are pooled across the three year study period and so conclusions should be treated with caution. It also includes service users no matter what the starting AUDIT score was. Whilst this includes some who scored as low risk, all of these people sought support for drinking in the specialist service and so were included.

As noted, the population numbers in each ward vary and so some wards with larger numbers of people will likely have greater numbers of service users; this does not mean one area is better or worse than another.

However, in figure 4.5b we have accounted for the variation in population size by calculating a rate of service users per 10,000 population aged 25 and over. When presented as a rate, there is more activity in rural Chichester areas and in Mid Sussex than we see from the numbers alone.

Figure 4.5b: Rate of people in the 25+ Specialist Alcohol Service per 10,000 population aged 25+; West Sussex Wards (2022 boundaries)

April 2019 - March 2022;



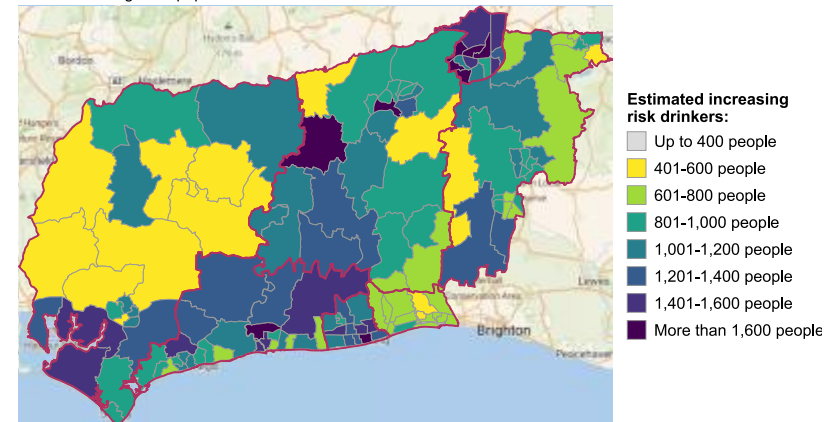
Finally, map 4.5c shows the estimated number of increasing risk drinkers (aged 16+) as a reference from our estimated population model.

This map is also available as an interactive map on the West Sussex JSNA Website - <https://jsna.westsussex.gov.uk/alcohol-health-equity-audit-series/>

From the estimated need map, we might have expected greater activity near Billingshurst in Horsham and Hassocks in Mid Sussex, as well as near the Witterings and Harbour Villages of Chichester.

Figure 4.5c: 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 highlight some important geographical variation in those accessing the Specialist Alcohol Service which can be hidden when looking at local authority level access only and it highlights some areas of the county which may benefit from additional targeted work.

The numbers at small area level are too small in some of the AUDIT risk groups to show analyses at this level. Moreover, as the probable dependence risk group counts for four out of five users, there is no substantial difference in exploring the geographical variation in this group compared with all service users.

There are sufficient numbers of service users in the Specialist Alcohol Service to explore each of the AUDIT increasing risk groups (AUDIT score 8+) by age and sex in more detail at West Sussex level.

Hazardous risk drinking

A total of 178 service users had a starting AUDIT score indicative of hazardous alcohol use (AUDIT score 8-15). Two out of three of these service users were male (119, 67%). In the national prevalence figures, males also represent two thirds of people in this risk group. More than half of service users in this group were age 25-44 years. Table 4.5 shows the number of service users in each age group and sex for hazardous risk drinkers. The number of people in each group are given in brackets, though we have suppressed this number for 16-24 and 65-74 year olds as the numbers in some cells were below five.

Table 4.2: Specialist Alcohol Service activity; Number of people by age and sex in the hazardous risk drinking group (AUDIT 8-15)

Age group	Males	Females	Total
16-24	-	-	*
25-34	68.1% (32)	31.9% (15)	47
35-44	74.2% (49)	25.8% (17)	66
45-54	63.6% (21)	36.4% (12)	33
55-64	65% (13)	35% (7)	20
65-74	30% (*)	70% (*)	*
75+	0	0	0
All ages*	119	58	178

We have suppressed low numbers to avoid possible identification of individuals.

The all ages row includes 16-24 year olds

In every age group, except the 65-74 year olds, males outnumbered females by roughly two to one. In the 65-74 year old group, there were twice as many females. However, the numbers in this group are small.

In the eligible population model, whilst representing the general population rather than those in treatment, we would expect two in three people at each age between 25-34 and 55-64 years to be male, with an even higher proportion of males in the hazardous risk group who were 65-74 years (72%).

Higher proportions of males aged 25-34 and 35-44 were seen within the Specialist Alcohol Service compared to what we might expect based on the population estimate. However, limited conclusions can be drawn about equity of access regarding this cohort, as we would expect the majority of people drinking at hazardous levels to be seen within early intervention services.

Harmful risk drinking

There were 224 (table 4.3) individuals with a starting AUDIT risk score indicative of harmful risk drinking (AUDIT 16-19); 34% were female and 66% were male as expected based on our population estimate of need described earlier.

Table 4.3: Specialist Alcohol Service activity; Number of people by age and sex in the harmful risk drinking group (AUDIT 16-19)

Age group	Males	Females	Total
16-24	0	0	0
25-34	74% (37)	26% (13)	50
35-44	52.5% (32)	47.5% (29)	61
45-54	56.1% (23)	43.9% (18)	41
55-64	70.5% (31)	29.5% (13)	44
65-74	86.4% (*)	13.6% (*)	*
75+	66.7% (*)	33.3% (*)	*
All ages*	146	78	224

We have suppressed low numbers to avoid possible identification of individuals.

The all ages row includes 16-24, 65-74 and 75+ year olds

Probable dependence risk drinking

By far the biggest group of people using the Specialist Alcohol Service, as expected, were those with AUDIT scores indicative of probable dependence (2,406 service users). Three in every five of these were male (60.8%, 1,460 service users).

Service users in this group tended to be slightly older than in the two other AUDIT risk groups, with more than half of service users between the ages of 35 and 54. Table 4.4 shows the breakdown of these service users by age and sex.

Table 4.4: Specialist Alcohol Service activity; Number of people by age and sex in the probable dependence risk drinking group (AUDIT 20+)

Age group	Males	Females	Total
16-24	*	*	*
25-34	63.7% (274)	36.3% (156)	430
35-44	63.4% (405)	36.6% (234)	639
45-54	59% (397)	41% (276)	673
55-64	55.1% (259)	44.9% (211)	470
65-74	63% (104)	37% (61)	165
75+	78.3% (*)	21.7% (*)	*
All ages*	1,460	943	2,406

We have suppressed low numbers to avoid possible identification of individuals.
The all ages row includes 16-24, 65-74 and 75+ year olds

In the eligible population model, we might expect three in every four people (75%) in the probable dependence risk group to be male. As such, this data indicates that we are perhaps seeing more females than we might expect in this service. This is contrary to the other two increasing risk groups in which higher proportions of males, for most age groups, were being seen within the Specialist Alcohol Service compared to what we might expect based on the population estimate.

However, limited conclusions can be drawn about equity of access regarding this cohort, as we would expect the majority of people drinking at harmful and hazardous levels to be seen within early intervention services. The fact that these groups are being seen in the Specialist Alcohol Service may reflect that there are additional complexities in relation to these clients.

We saw in the early intervention services that more females than we might expect (relative to males) were presenting at services such as Community Pharmacy, DrinkCoach and AWA. Conversely, we might describe this as our early intervention services not being equitable with regards to males accessing the services (that we have more to do to ensure males are accessing those early intervention services, particularly males in higher AUDIT risk groups of harmful/mild dependence and probable dependence).

From the Specialist Alcohol Services, over the three year study period, we see that there are more males than females in these increasing risk groups (6.5% of males were in the hazardous risk group compared to 5% of females and 7.9% of males were in the harmful risk group compared to 6.7% of females).

It might be suggested that what we see when considering all the services across the alcohol pathway is perhaps a displacement from the expected pathways of commissioned services. Perhaps those males who we think should be appropriate for early intervention services are instead presenting to the Specialist Alcohol Services. Conversely, as seen from the Alcohol Wellbeing Adviser Service, adults with dependency are also presenting to early intervention services.

Future work may benefit our understanding of why males attend certain services along the alcohol pathway instead of others and perhaps focusing on their perceptions of early intervention services being the place to seek help.

This is not to say that anyone's access to the Specialist Alcohol Service is inappropriate; there are several reasons why people may benefit from this service either in addition to or instead of the other commissioned alcohol services and every referral to the service is triaged appropriately for service users. This simply highlights that the AUDIT risk score can mask additional needs that can be met by the Specialist Alcohol Service.

Moreover, in light of early intervention services such as DrinkCoach and AWA also working with service users who have AUDIT scores indicative of probable dependence, this work highlights that the AUDIT screening tool should not be the only method of defining a person's need for support.

Children and Young Person's Drug and Alcohol Service

The Children and Young Person's Drug & Alcohol Service is also provided by Change Grow Live and delivers structured and non-structured interventions to children and young people under the age of 25.

Structured alcohol treatment involves a formal programme of support with a package of concurrent or sequential alcohol-focused interventions. It includes a comprehensive assessment of need, and a recovery care plan, which is regularly reviewed with the client. Unstructured treatment is any support provided outside of this structure and can include amongst other activities harm reduction and wider support.

Data from activity in the Children and Young Persons Drug and Alcohol Service for the period April 2019 and March 2022 was obtained and analysed. There were 1,253 records in the dataset representing 887 individuals. In the analysis, we have kept the most recent record (by referral date) for each unique individual.

As the eligible population was built on adults aged 16 year and over in discrete age bands, comparisons to the population estimate have not been made; though it is still useful to describe differences in uptake.

In this dataset we have considered three age bands- those under 16, those aged 16-24 and those aged 25 plus. Four out of five service users were aged 16-24 years (82%, 730 people). A small handful of users (five) were aged over 25 years.

The reason for the over 25s accessing the Children and Young Persons (CYP) service is unclear but it is possible that these service users had previous interventions in the CYP service and benefited from the consistency of what is offered here rather than in the over 25s service.

Two out of three service users (68%, 610 people) did not have an AUDIT score in their most recent intervention. Of those who did have an AUDIT risk score at the start of the intervention (277 service users), two thirds had scores indicative of probable dependence (65.7%, 182 service users), 10% had scores indicative of harmful risk drinking (29 service users), and 17.3% had scores indicative of hazardous risk drinking (48 service users).

The majority of interventions were unstructured (71.9%, 638). As noted, some service users returned for subsequent interventions. A total of 270 service users (30.4% of all service users) had more than one intervention recorded over the study period.

In their most recent interventions, at least half of service users (488, 55%) attended the CYP service for non-opiate drug use in addition to alcohol use. One third of service users were there for alcohol alone, and the remaining 10% had no information recorded on the substance treated.

Just over half (56.7%, 503 people) of service users were male, and 41% were female (366 service users). The provider has started to collect data on gender identity which will enable an understanding of any inequalities amongst trans, non-binary and gender non-conforming people in the future. However, currently the numbers within the dataset are too small to analyse.

One in three records did not have ethnicity recorded. Of those who did report their ethnicity, 10% reported their ethnicity as minority ethnic. When considering outcomes for treatment, the numbers were too small in the minority ethnic group for analysis.

Table 5.1 shows the number of service users by their local authority of residence. The West Sussex figure includes those who were out of area, no fixed abode, or unknown residence.

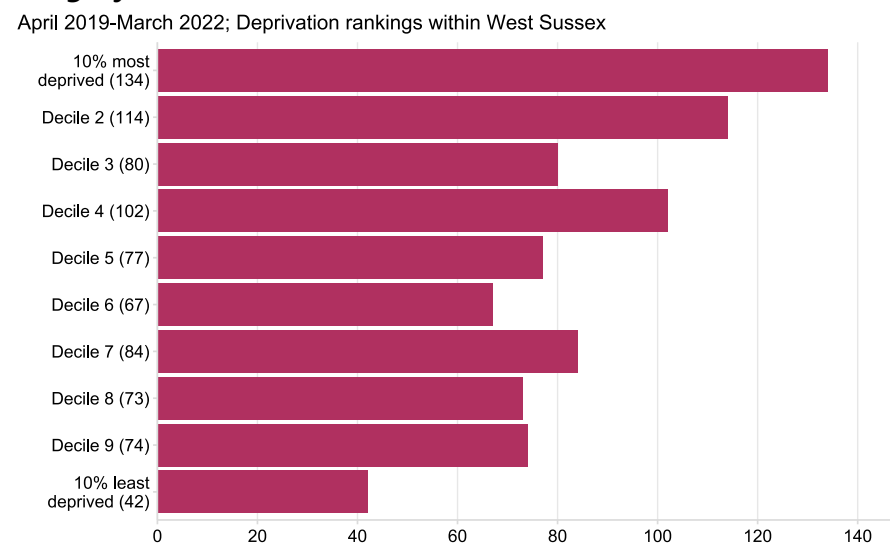
Table 5.1: CYP Specialist Alcohol Service activity; Number of people by local authority and sex;

Local authority	Males	Females	Total
Adur	49.2% (31)	47.6% (30)	63
Arun	60.3% (82)	38.2% (52)	136
Chichester	54.5% (48)	42% (37)	88
Crawley	50.9% (54)	48.1% (51)	106
Horsham	57.1% (84)	40.8% (60)	147
Mid Sussex	58.7% (84)	41.3% (59)	143
Worthing	53% (87)	42.7% (70)	164
West Sussex	503	366	887

The local authorities with the most CYP service users over the study period were Worthing (164, 18%), followed by Horsham (147, 16%), Mid Sussex (16%), and Arun (15%).

As with the adults Specialist Alcohol Service, there were three times the number of service users from the most deprived neighbourhoods of West Sussex compared to the least deprived neighbourhoods (figure 5.1).

Figure 5.1: Number of CYP Specialist Alcohol Service users by deprivation decile and their starting AUDIT assessment risk category



Whilst the CYP service intends to collect sexual orientation data, just one in four records had his information recorded. Of those records with a sexual orientation recorded (211 service user records), 80% (170 people) reported their sexual orientation as heterosexual and 15% reported their sexual orientation as bisexual (11%), or gay/lesbian (4%). Given the large number of records where this information was not known, no further analysis was possible.

As with other characteristics, the majority of records had no information for disability status (66%). Of those where disability status was known (301 records), one in three (116 service users, 38%) reported a disability.

The data on country of birth was more complete with just one in five records missing this information. Of those who gave a country of birth, 97% reported their country of birth to be the UK (680 people). Just 19 service users reported their country of birth to be anything other than UK though it is possible that those born in other countries are represented by the not stated group.

The majority of records did not have religion recorded (85%) and so analysis was not possible for this factor.

The absence or presence of a housing issue was only recorded for those participating in a structured intervention (249 service users). One in ten of those were at risk of homelessness (25 service users). Regarding outcomes, those at risk of homelessness had a higher rate of incompleteness of the intervention compared to those in stable housing (46% compared to 18%) and this was found to be a significant difference ($\chi^2 = 10.393$, $df = 1$, $p\text{-value} < 0.01$).

Employment and education status was also only recorded for those participating in a structured intervention. Around one in three (33%) of those in structured treatment were Not in Employment, Education or Training (NEET), another third (36%) were in employment or training, and 25% were in education. The rate of records incomplete at discharge was slightly higher in those who were NEET (24%) compared to those in education or employment or training (both 19%). However, this was not a statistically significant difference.

Recommendations

All individuals have unique experiences of access to West Sussex commissioned alcohol services. However, this chapter of the HEA series has outlined that there are inequalities in access and outcomes from some groups across certain services.

Under the Public Sector Duty of the Equalities Act 2010, Local Authorities are required to take action to advance equality of opportunity in people from protected characteristic and take steps to meet the specific needs of those from protected characteristics groups, where these differ to the needs of others.

Recommendations have therefore been developed to improve equity of access and outcomes locally:

- Services should seek to improve data for inequalities, including protected characteristics and where possible, full postcodes, to enable greater geographical and deprivation analysis.
- The HEA should be refreshed as part of a rolling programme to address inequalities in this area.
- Commissioners and providers should work together to improve access for groups that are accessing services less than might be expected, for example males, in younger age groups.
- Steps should be taken to engage more people drinking at hazardous and harmful levels and support them into early intervention services, such as promotion of Making Every Contact Count Training (MECC).
- Any potential issues regarding access to the specialist service in rural areas should be investigated in view of the higher activity rates in urban areas.

Where groups appear under-represented and with higher incompleteness rates, qualitative research to identify barriers and service experience should be considered (e.g., men aged 35-44).

Support available for people with housing issues or at risk of homelessness, should be reviewed to improve completion of treatment.

Further engagement should take place with groups where sample sizes were small or data was limited, to understand the user experience of services (e.g., LGBTQ+, minority ethnic groups).

Conclusion

These analyses of West Sussex commissioned alcohol services showcases the breadth of great work and support provided across the county to reach those in need. We have described the characteristics of service users from our earliest intervention points (community pharmacy self-completed identification of risks) to our specialist alcohol services offering structured, bespoke, and in-depth treatment over several weeks and months.

This has highlighted differences in access and outcomes amongst different groups of people including some of our minority groups such as those in ethnic minority groups and LGB+ groups.

Where possible, we have compared the data from providers to what we think we know about the estimated population of need in West Sussex, by applying age and sex specific prevalence assumptions from the AUDIT scale of risk to population estimates. This is simplistic, and there are many caveats, but this offers a starting place for us to plan ways to address inequities of access for certain groups. In many cases, we simply highlight the need to collect more robust data to monitor changes.

Notwithstanding the completeness of the data and small numbers in some groups of interest, there are several findings of importance to note.

Firstly, there appears to be high proportion of service users presenting to early intervention services with an AUDIT assessment indicating probable dependence. On the face of it, this suggests that many people may be leaving it late to seek support and highlights the importance of streamlined pathways between early intervention services and the Specialist Alcohol Service.

Conversely, one in five service users in the Specialist Alcohol Services for adults, had AUDIT scores indicative of lower as well as increasing risk and mild dependence. This might suggest that some people decide to go to specialist services instead of some of our earlier intervention self-supported or online interventions. This may be due to additional complexities and/or co-occurring drug misuse.

There are many reasons that people will choose to access particular services. The AUDIT score alone may be an insufficient indicator of which service people should be signposted or referred to. Sometimes those who score high on AUDIT subsequently score as having no or mild dependence on additional scales (such as the SADQ). To address this services have comprehensive triage processes that ensure their service users are appropriately placed.

The proportion of men accessing early intervention services did not align with the population estimate of need, suggesting that men may find it more difficult to access support for problematic drinking than women, with this trend particularly evident within the DrinkCoach and AWA service. Outcomes for men were poorer, particularly in the Specialist Alcohol Service, where there were higher incompleteness rates compared to women, with treatment for those in younger age groups more likely to be incomplete.

Geographical location also appears to have some impact on access to services. There were higher levels of activity within DrinkCoach, a mostly online intervention, in more rural districts such as Chichester and Horsham and this may reflect a lack of alternative provision in these areas or limited transport to access face to face services. Similarly, within the Specialist Alcohol Service, the rural areas of Horsham and Mid Sussex have a lower than expected service use.

The equity profile showed that services are reaching those people living in more deprived areas; with almost three times the number of service users in our specialist services in the most deprived areas of West Sussex compared to the least deprived areas. This may reflect the physical locations of some of these services along the coastal and inner city areas of the county.

We know from published evidence (discussed in the other chapters of this HEA series) that those in more deprived areas tend to experience greater harm from alcohol. However, the gradient is less clear in terms of 'at risk' drinking across the deprivation deciles. In some cases, more higher risk drinking is found in less deprived s. Early intervention services are designed to support any high risk drinking and we should therefore, seek to increase the uptake of these services across the deprivation spectrum, including those in less deprived, and rural areas.

The national data on which we have based our estimated need model is a decade out of date and is not necessarily representative of the needs of people in West Sussex. It is hoped that a better understanding of the estimated need across the county can be achieved with future local community health surveys.

There were other demographics and characteristics that had an impact on access and outcomes from services. Within the Specialist Alcohol Service, cases for people recorded as 'single' were more likely to be incomplete. Similarly, people who were recorded as unemployed or at risk of homelessness were more likely to have incomplete treatment. At this stage we were limited in our ability to assess whether these groups were under or overrepresented in services due to a lack of a base line understanding of need in the local community for groups such as those experiencing homelessness and those in other minority groups.

Finally, qualitative work with a subset of service users would enhance our understanding of the reasons our service users choose particular services over others, and this would help us to address potential barriers across the pathway to ensure everyone has access to some provision of the alcohol support services they need.

References

¹ GBD 2019 Risk Factors Collaborators. Global burden of 87 risk factors in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet*, Volume 396, Issue 10258, 17–23 October 2020, Pages 1223-1249, [https://doi.org/10.1016/S0140-6736\(20\)30752-2](https://doi.org/10.1016/S0140-6736(20)30752-2)

² World Health Organization (2023). Alcohol Fact Sheet <https://www.who.int/news-room/fact-sheets/detail/alcohol> accessed July 2023.