Alcohol

Needs Assessment

August 2022

Prepared by:

Dr Jack Haywood, *Public Health Registrar*
Alexander Wicking, *Public Health Intelligence Analyst*
Susanna Keiderling, *Senior Health Protection Practitioner*

Contents

1. Acknowledgements

We wish to express our gratitude to the following for contributing to the Alcohol Needs Assessment:

Mimi Morris-Cotterill (Assistant Director, Lead Commissioner for Substance Misuse and Alcohol, LBB) and Finola O'Driscoll (Senior StrategistLBB), for helping to formulate the structure and requirements of the needs assessment

Joanna Ryan (Senior IT Clinical Trainer, One Bromley), for assisting with alcohol data from primary care settings

Jonathan Walker (Senior Public Health Intelligence Analyst, LBB), for assisting with the extraction and analysis of hospital episode statistics (HES) data

Eleanor Sweeting (Trainee Public Health Intelligence Analyst, LBB), for assisting with the extraction and analysis of alcohol-specific mortality data

Emily Duignan (Bromley Service Manager, CGL), Esme Jalla (Bromley Changes Service Manager) and India Garrett-Coker (Data Analyst, CGL), for providing data regarding service users in BDAS and providing invaluable insight and background

To service users, colleagues, volunteers, and employees of the following organisations for assisting in identifying the needs of people who use substances in Bromley and providing key information to identify unmet need;

- Alcoholics Anonymous
- LBB Adult Social Care
- LBB Children's Social Care
- LBB Housing
- King's College Hospital NHS Foundation Trust Maternity Services
- Oxleas NHS Foundation Trust Mental Health Services
- Social Prescribing Team
- Police Service
- Youth Justice Service
- LBB Health Visitors
- LBB School Nurses including Named Nurse for Children Looked After and Lead for Youth Justice

- Clarion Housing
- Bromley Changes
- Primary Care colleagues
- Emergency Care colleagues
- Alcohol Liaison Team at the Princess Royal University Hospital

2. Executive Summary

Alcohol is consumed widely, often in non-harmful quantities. However, many consume quantities which increase health risks, including mental health, and cause social issues, both in their own families and in society. Alcohol consumption patterns vary by age, gender, deprivation, and many other demographic variables. The Covid-19 pandemic has also changed alcohol consumption and alcohol-related morbidity trends nationally. Local authorities are responsible for the commissioning of alcohol treatment and recovery services, and this needs assessment aims to make recommendations to meet unmet alcohol need in Bromley. It should be consulted alongside the Substance Misuse Needs Assessment (SMNA) for commissioning purposes, as drug and alcohol services are commissioned together – the Bromley Drug and Alcohol Service (BDAS).

There is very little data about alcohol consumption at a local level, except AUDIT-C and AUDIT screening data from primary care for adults. However, there are limitations to this including selection bias and reliability of responses. In addition, AUDIT-C has shown an increase in non-drinkers and a decrease in the highest alcohol risk groups from 2019/20 to 2021/22, with AUDIT indicating an opposite trend. Therefore, this data should be taken with caution. It should also be noted that there are significant gaps in AUDIT screening. It has been estimated that there is an 86% unmet alcohol-treatment need in Bromley (82% nationally). Nationally, more men than women drink more heavily, and the proportion increases with age. There is also a higher proportion of people drinking in more deprived areas.

In young people, local intelligence comes from the School Health Education Unit (SHEU) survey. This shows alcohol consumption in Year 10 students has reduced from 2019 to 2021, but this data should be treated with caution due to the impact of the Covid-19 pandemic and the self-reporting nature of the survey. Nationally, alcohol consumption in young people has reduced since 2003. Similar to adults, in general, a higher proportion of boys drink earlier, more heavily, and more regularly. Alcohol consumption also increases with age, however a higher proportion of girls than boys drink in the 13-15-year-old group. In addition, young people who smoke, take other drugs, or play truant are more likely to drink alcohol. Where there is parental alcohol consumption in the home, young people are more likely to drink.

With regard to alcohol-specific morbidity in Bromley, there were 1434 admissions in 2021/22, 64.2% of who were men. The 55-64-year-old age group has the highest proportion of admissions, with the most common cause for admissions being mental and behavioural disorders due to use of alcohol and alcoholic liver disease, specifically alcoholic cirrhosis. Alcohol-specific morbidity increases with deprivation, at over 3-times the rate in the most deprived groups compared to the least. With alcohol-specific deaths, there has been a decrease since 2014-16. The majority are in men and in ages 55-64-years old, similar to morbidity. Alcoholic liver disease was the most common cause of death, contributing to 76% of alcohol-specific deaths in 2017-2021.

This needs assessment also evaluated the current alcohol treatment and recovery service. In the last five years, there has been an increase in new alcohol-related presentations in BDAS. Referrals often come from the person themselves or their family/friends, with very few referrals from statutory services even though many service users have significant vulnerabilities. Of note, the percentage of referrals from primary care has reduced since 2018/19, perhaps as a consequence of the Covid-19 pandemic. The majority of service users are men, with the highest proportion of service users being 40-49-years-old. The proportion of service users in the Criminal Justice System has reduced over the last few years, as has the proportion of those employed. 60.5% of service users had a co-occuring mental health issue in 2021/22.

In the young person service, Bromley Changes, alcohol contributes to the second largest proportion of service user presentations, after cannabis, The majority of referrals come from the Youth Justice System and health settings. Unlike adult services, there are very few referrals from “family, friends & self”. In 2021/22 these made up 2% of the referrals. Most service users are male. Many had significant vulnerabilities, with 70% having more than one vulnerability listed.

An important part of this needs assessment was to engage with stakeholders and partners about their perception of unmet need in Bromley. Many stakeholders were also consulted in the SMNA, particularly charitable and voluntary organisations. In speaking to these stakeholders, many themes emerged. These included the vulnerabilities these organisations serve, including mental illness, abuse, isolation,

crime, unemployment, veterans, safeguarding issues, and learning difficulties. The alcohol-related harms were also explored which included significant physical and mental health issues, and social issues such as family breakdown, children going into care, losing housing, neglect, abuse, educational issues, and employment loss. The stakeholders also gave methods to increase BDAS engagement, including outreach work, geographical location, times the service is accessible, and closer work with statutory services. Finally, the relationships between the stakeholders and BDAS was explored and how these could be improved, which included training, partnership working, and reciprocal agreements.

In analysing all the data and information presented in this needs assessment, unmet needs were identified. 21 recommendations were formed, some with significant overlap with the SMNA as clearly stated:

Recommendation 1:

Crossover with SMNA Recommendation 3

To understand alcohol use across the borough and considering the potentially large number of particularly vulnerable residents who need alcohol services, a specifically commissioned data collection exercise may be necessary, using a sample of the population. This should attempt to understand the magnitude of alcohol use (including binge, recreational, and addictive use) in both the general and vulnerable population, demography including gender, age, home location, and employment, and reasons why they may not engage with formal alcohol services. This exercise would be important to identify any emerging or unknown unmet needs, particularly in the recovery from Covid-19.

Recommendation 2:

Crossover with SMNA Recommendation 4

As part of the service specification, there needs to be a requirement for BDAS to share information with other services, including primary care, about the service user's treatment journey.

Additionally, BDAS and LBB need to work with primary care colleagues to ensure they are collecting alcohol consumption data using validated tools, including when patients join the practice, in commissioned health checks, and in consultations that are primarily focused on alcohol.

Recommendation 3:

Crossover with SMNA Recommendation 26

Ensure the service specification is explicit that adequate data collection is a condition of providing the service to accurately monitor trends and needs.

Recommendation 4:

Crossover with SMNA Recommendation 1

A formalised partnership strategy and group should be established to provide strategic oversight on the provision of holistic care and support to service users in alcohol services, as well as identifying emerging needs so strategies can be put in place to meet this need.

Recommendation 5:

Crossover with SMNA Recommendation 15

Formalised Memorandum of Understandings (MoUs) or partnership agreements should be set up with providers of basic needs and support services, particularly within employment and housing for adults, but also mental health services, education services, debt assistance, and social services. This should be a part of the clients' treatment plan, and a shared understanding and responsibility with other services. This agreement should also ensure training is provided to increase awareness of services and the needs of clients with substance dependency.

Recommendation 6:

Crossover with SMNA Recommendation 17

As part of these MoUs or partnerships, BDAS, with the expertise they have on alcohol and substance misuse, should have a programme of education for organisations to raise awareness of the local drug and alcohol services and increase understanding of the issues these individuals face. This would help improve the referral process to BDAS and Bromley Changes and reduce stigma. This should be delivered to statutory services including, but not limited to, housing, social services, children and young people services, and employment services.

Recommendation 7:

Crossover with SMNA Recommendation 18

LBB Public Health should also work with other borough departments, such as health visitors, school nursing, and social services, to ensure partnership work is engrained into everything we do, from commissioning to delivering services. This

includes wider harm reduction methods, such as the use of leisure centres and recreational facilities for those in treatment and recovery.

Recommendation 8:

Crossover with SMNA Recommendation 14

Increased partnership with organisations who work with children. This would include statutory services, but also youth groups, charities, and after school/activity groups, in order to help them identify a child in need of support, and where appropriate provide brief interventions and signposting.

Recommendation 9:

Crossover with SMNA Recommendation 8

There must be a stronger partnership with mental health services, implementing the "*no wrong door"* policy. Many clients need the assistance of both in parallel to recover from addiction. Evidence from the literature, as evidenced in the SMNA, suggests many methods of achieving this, including specialist dual-diagnosis clinics, training of staff, psychoeducational groups, and blended models of care. Better pathways to support people to access mental health services are also needed to reduce the barriers and delays to getting treatment and support.

Recommendation 10:

Crossover with SMNA Recommendation 12

Further work with social services and other agencies is urgently required to identify parents who are dependent on alcohol, to identify children in the household at risk of using alcohol themselves, and to tackle the wider vulnerabilities young people using the service face, to ensure they get the support they need.

Recommendation 11:

Specific support services are needed for parents who drink, for example drop-in clinics with flexible times and support groups where they can meet other parents. This is to improve their own health and wellbeing, but also that of their children.

Recommendation 12:

Crossover with SMNA Recommendation 11

A formalised outreach programme should be resumed with outreach organisations, such as mutual aid groups, youth centres, voluntary organisations, and charities, in

order to engage individuals with an unmet need. They must ensure these relationships are reciprocal, capitalising on the expertise of the organisation and the trust clients put into them.

Recommendation 13:

Crossover with SMNA Recommendation 19

Appoint Complex Needs Officer(s) to work with individuals in BDAS with complex additional issues by liaising with other organisations with the appropriate expertise to help resolve these issues. These officers would provide advice, help make referrals, signpost, and support them in the process.

Recommendation 14:

In the context of higher morbidity and mortality and in the absence of data specific of alcohol use in Bromley (for people not engaged with BDAS), we should ensure that the appropriate outreach is occurring in younger age groups, particularly in men, to ensure treatment needs are met, and prevention strategies are implemented to avoid the increasing morbidity and mortality seen in middle-aged groups. This could be through the form of identification in acute services, such as A&E, or in other services these groups engage with, such as outreach organisations.

Recommendation 15:

In addition to the demographics outlined in *Recommendation 3,* there needs to be focus on prevention and treatment in the most deprived areas of Bromley to prevent the alcohol-specific morbidity and mortality which disproportionately affects these areas. However, in doing this, prevention and treatment in the more affluent areas should not be ignored particularly as the borough-wide alcohol consumption appears to be higher than national and regional averages. Understanding alcohol consumption and morbidity/mortality is key to tackling this and will be helped by carrying out *Recommendation 1.*

Recommendation 16:

In collaboration with partners, such as probation, it is important to ensure those engaged with the CJS and have an alcohol treatment need are captured and engaged by BDAS to meet this need. A better understanding of whether this is an unmet or recently reduced need is required and could be understood better by carrying out *Recommendation 1.*

Recommendation 17:

In collaboration with the police, explore the feasibility of developing a Criminal Behaviour Order (CBO) pilot to include alcohol addiction and mandatory engagement with the alcohol service as part of the post-conviction orders.

Recommendation 18:

In collaboration with partners, such as the Job Centre, it is important to support those in recovery back to work, as appropriate, ensuring that work is not a barrier to successful recovery. A better understanding of whether this is an emerging need is required and could be understood better by carrying out *Recommendation 1*.

Recommendation 19:

Crossover with SMNA Recommendation 20

There is a clear need for alcohol services to be located where the morbidity and mortality is greatest. This should be in the form of BDAS services being physically located there, or in stronger outreach work. This could also be in the form of a "hub and spoke" model, with satellite services being located across the borough that are linked to a centrally located service.

Recommendation 20:

There is a need for increased flexibility and accessibility of the BDAS service offered in terms of longer opening hours, providing a 7 day/week service, with a mixture of appointment-based clinics and drop-in clinics to accommodate for people's needs and increase their likelihood of staying engaged with the services.

Recommendation 21:

Crossover with SMNA Recommendation 25

Due to the perceived lack of parity between young person and adult services, the transitional issues from young people to adult services, and the significant double mental health and alcohol treatment burden, in the next commissioning round, the three separate BDAS services (adult services, young person services, and COMHAD) should be procured as one whole, integrated, and streamlined service.

3. Introduction

Alcohol is consumed widely in the UK as a legal and socially acceptable substance, yet its effects can be incredibly harmful, and is responsible for an increasing number of deaths in the UK each year. In the 2019 Health Survey for England (HSE), it was reported that 80% of participants consumed alcohol in the past year, and 48% drank at least once a week [1]. During the Covid-19 pandemic, there was an increased consumption of alcohol despite the closure of all pubs, clubs, and restaurants, particularly amongst those who were already the heaviest drinkers and living in the most deprived areas [2]. During this time, Public Health England (PHE) also reported a concerning rise in the total number of alcohol-specific deaths, due to a stark increase in alcoholic liver disease deaths; above that of pre-pandemic levels [2].

The latest Health Profile for England in 2021 highlighted the stark differences in drinking patterns by income which has changed little in the past 20 years. Heavy drinking was more prevalent in the highest income households, however hospital admissions due to alcohol-related conditions and alcohol related harm was more than double in low-income households and in the most deprived areas - an alcohol-harm paradox. [3] Over the last 30 years in the UK, alcohol has become 72% more affordable and the average household's expenditure on alcohol has increased by 153%, based on affordability of alcohol index [4].

The impacts to health from alcohol consumption are varied and there are over 200 diseases and conditions, ranging from cancer and liver disease to psychological and behavioural disorders. Alcohol is a contributing factor to an increasing number of hospital admissions and death; in 2019/2020 there were an estimated 280,000 admissions to hospital where the primary reason for admission was attributable to alcohol [5]. This is increasing steadily each year and is 2% higher than in 2018/2019 and 8% higher than the number in 2016/2017 [4].

Alcohol use does not only impact the health of the individual drinking, but it also has a wider impact to others around them, from individual friends, family members, to communities and society at large. [6] It is often intertwined with or is a contributing cause in other social issues, such as homelessness or housing issues, financial

difficulties, unemployment, violence, and crime. By understanding these second-hand effects, we will be able to better estimate the total burden and cost of alcohol on society. While alcohol costs the NHS an estimated £3.5 billion every year, the total social cost of alcohol to society is estimated to be a staggering £21 billion. [7]

Mental health issues are a common co-existing issue in those who consume alcohol. 60% of people in alcohol treatment services reportedly also require mental health treatment, however unfortunately 20% of them have not received treatment for their mental health. [8] The effects of alcohol consumption on children in the household is also important as an estimated 200,000 children in England live with an alcohol dependent parent, and parental alcohol use is frequently an issue in safeguarding cases. In a recent analysis of serious case reviews (local enquiries into the death of, or serious injury to, a child where neglect or abuse is known or suspected), parental alcohol use was present in 37% of reviews. [9]

Local authorities have responsibility for commissioning drug and alcohol treatment and recovery services as part of their public health responsibilities. In 2021, the UK Government published a new drug strategy *From Harm to hope: a 10-year drugs plan* to cut crime and save lives by tackling the drug problem and providing a high-quality treatment and recovery system for those suffering from addiction, including alcohol. [10] To achieve this, the Department of Health and Social care (DHSC) is providing £85.7 million in additional grants to improve drug and alcohol services. [11] However, there has not been a new alcohol-specific policy in the UK since 2013. Due to the extent of harm that can be caused by alcohol consumption, not just to the individual but to others around them, there is a need for further polices to reduce alcohol use across society. Suggestions include restricting alcohol availability, introducing a minimum unit price to effectively reduce the level of alcohol-related harm. [6] The Government's Build Back Better plans aims to tackle geographic health inequalities. A part of this must be to reduce alcohol consumption and alcohol-related harm as it has a great impact on driving these disparities. [2] [12]

This Alcohol Needs Assessment will examine the burden of alcohol use in Bromley and the associated issues, in order to identify gaps in service provision and make recommendations to improve alcohol services in the area.

4. Aim, Objectives, and Methods

The aim of this needs assessment is to provide commissioners with information about the health needs resulting from alcohol use in the Bromley population to direct the commissioning of future alcohol services.

The objectives of this assessment are, for both young people and adults;

1. To establish the prevalence of alcohol use in Bromley;
2. To establish the key at risk populations nationally and in Bromley;
3. To establish the impact of alcohol use on health in Bromley;
4. To assess the current alcohol service provision, including prevention and treatment, in Bromley, and the demography of people engaged with these services;
5. To assess the current level of partnership working between alcohol services and other agencies in Bromley;
6. To assess service provider and partner opinions of current services in Bromley;
7. To identify gaps in the service provision to inform future service commissioning.

The methods used in order to meet these objectives will be;

1. Use national and local data on alcohol use to establish the prevalence of use;
2. Examine the demographics of population groups nationally and in Bromley, and identify which groups are at most risk of alcohol;
3. Examine data for the health impacts, hospital admissions, and mortality due to alcohol use in Bromley;
4. Examine the current alcohol service provision in Bromley and who uses it;
5. Conduct qualitative data collection through interviews to examine service user and provider opinions on alcohol services at present and identify perceived needs;
6. Compare the service provision with the need, including those groups we are not accessing, to identify unmet needs, and therefore make clear to commissioners the requirements for future alcohol services.

5. Prevalence of Alcohol Use in Adults

5.1 Overall Alcohol Use

The Health Survey for England (HSE) is commissioned by NHS Digital and carried out by University College London (UCL) and NatCal Social Research. It provides key statistics on alcohol consumption in **England** on an annual basis**.** The most recent results available are from 2019, although a survey was carried out in 2021 with the results not published until December 2022.[1] [1] Participants are selected using a random probability sample. This ensures that every household in England has an equal chance of being included in the survey each year and that the results are representative of the population living in private households. The survey consists of an interview with household members, followed by a visit from a nurse. [2] [3] [4]

The survey has asked about alcohol consumption since its creation in 1991. In these questions, adults are those aged 16 and older, and so it is these ages that are included in the data below.

In 2019, 8,205 adults and 2,095 children (aged 0 to 15) were interviewed. 4,947 adults and 1,169 children had a nurse visit. [4]

Firstly, examining alcohol use in adults, 80% of respondents reported using alcohol in the previous year, and 48% reported using alcohol at least once a week. [5]

The survey also collects data on the quantity of alcohol consumed. Individuals are categorised into one of four groups: Non-Drinker, Lower Risk, Increasing Risk, and Higher Risk. Table 1 outlines the number of units consumed per week for an individual to fall into each risk group, and Figure 1 demonstrates the units for different alcoholic beverages used in this survey.

Overall, 57% of respondents drank at levels which put them in the Lower Risk category of alcohol-related harm. [5]

[1] The 2021 survey will include data of the impact of alcohol consumption during the Covid-19 pandemic. As these results are not yet available, it should be noted that it is acknowledged that alcohol consumption trends changed during the pandemic, therefore the most up to date trends may not be clear in the data presented here

Risk Group	Number of Units per week
Non-drinker	0 units
Lower Risk	1-13 units
Increasing Risk (men)	15-50 units
Increasing Risk (women)	15-35 units
Higher Risk (men)	51+ units
Higher Risk (women)	36+ units

Table 1: Number of alcohol units consumed per week with risk groups *Source: Health Survey for England 2019* [5]

Type of drink	Measure	Units of alcohol
Normal strength beer, lager, stout, cider, shandy (less than 6% ABV)	Pint	2
	Can or bottle	Amount in pints multiplied by 2.5
	Small cans (size unknown)	1.5
	Large cans or bottles (size unknown)	2
Strong beer, lager, stout, cider (6% ABV or more)	Pint	4
	Can or bottle	Amount in pints multiplied by 4
	Small cans (size unknown)	2
	Large cans or bottles (size unknown)	3
Wine	Small glass (125ml)	1.5
	Medium glass (175ml)	2.0
	Large glass (250ml)	3.0
	Bottle	9.0
Spirits and liqueurs	Glass (single measure)	1
Sherry, martini and other fortified wines	Glass	1
Alcopops	Small can or bottle	1.5

Figure 1: Units of Alcohol in Different Alcoholic Drinks *Source: Health Survey for England 2019* [6]

In **Bromley,** capturing alcohol consumption is challenging. This is because consumption is often done in the comfort of people's homes or in drinking establishments including pubs, bars, clubs, and restaurants. Data on alcohol consumption in these settings on a local basis is not routinely available.

To understand alcohol consumption in Bromley as best as possible, two sources of information have been used.

First, the Office for Health Improvement and Disparities (OHID) provides Local Alcohol Profiles for regions across England also using data from HSE. This has some very limited data about alcohol consumption in Bromley from 2015-18:

1. 12% of adults in Bromley abstain from alcohol. This is the fourth lowest figure in London, behind Havering, Lewisham, and Richmond Upon Thames. The London average is 23.6%, and the local authority with the highest rate of abstinence is Brent at 51.8%. In England, this is 16.2%, meaning the proportion of non-drinkers in Bromley is less than the national and London average.
2. 26.8% of adults in Bromley drink over 14 units of alcohol per week. This is the 10th highest rate in London. The London average is 20.1%, and the local authority with the lowest rate is Barnet at 10%. In England, this is 22.8%, meaning the proportion is higher in Bromley than nationally and across London. [7]

Secondly, primary care data has been used. Primary care uses validated tools called the Alcohol Use Disorders Identification Test Consumption (AUDIT-C) developed by the World Health Organisation, and the Fast Alcohol Screening Test (FAST) to screen for alcohol consumption related risk. AUDIT-C consists of three questions about their alcohol use. If an individual scores 5 or more, they should have the full AUDIT screening, which is an additional 7 questions. [1] In the FAST test, if a patient scores three or more across four questions, they should also have the full AUDIT screening. If a patient has an AUDIT score of over 20, they should be referred to specialist alcohol and drug services.

This data has been extracted from the GP (General Practice) electronic patient record management system (EMIS), for 2019/20 and 2021/22 for adults aged 18 and over in Bromley. These years were chosen to represent “pre-Covid-19” drinking habits (2019/20), as well as current as possible (2021/22). Only AUDIT-C and AUDIT data has been analysed as data was most complete for these, and only a small proportion of screening was performed by FAST. In addition, only AUDIT scores for

those who scored 5 or more in the AUDIT-C screen were analysed, and referrals to services whose AUDIT score was 20 or higher.

The Standard Medical General Contract states that all patients should have an alcohol consumption screening test performed within one year of them signing up to the GP practice. [13] In addition, AUDIT-C should also be completed as part of the NHS Health Check, Severe Mental Illness (SMI) Physical Health Check, and Learning Disability Annual Health Check. Finally, patients can have a screening as part of a normal consultation. Therefore, it is hoped this data gives us a picture of alcohol consumption locally.

AUDIT-C and AUDIT categorise people broadly into the same risk categories as the HSE, except:

1. There is formally no non-drinker group,
2. There is no split for men and women in the Increasing and Higher risk groups, and
3. There is a "Possible dependence" group.

For the purposes of this needs assessment, anyone with a score of "0" will be categorised as a non-drinker. These groups are shown in Table 2.

Risk Group	AUDIT-C Score	AUDIT Score
Non-drinker	0	0
Lower Risk	1-4	1-7
Increasing Risk	5-7	8-15
Higher Risk	8-10	16-19
Possible Dependence	11-12	20-40

Table 2: AUDIT and AUDIT-C risk groups *Source: UK Government* [7]

Table 3 shows the data for 2019/20. From the AUDIT-C screening, there were 19.2% Increasing Risk drinkers, 5.9% Higher Risk, and 0.9% Possible Dependant drinkers. The AUDIT screening tool was performed in 49.3%, 61.4% and 63.2% of these groups respectively, even though guidance is that all patients should have this screening performed. Interestingly in those who did have an AUDIT screen, 57.9% were categorised as Lower Risk drinkers and 3.8% as Non-Drinkers, which is challenging to understand when these individuals were found to be at least of increasing risk in the AUDIT-C. Only 3 people with an AUDIT score of over 20 were

referred to alcohol services, which is the threshold for referral, representing a 7.5% referral rate. 46 of patients who had an AUDIT-C screening had scores recorded over 12 which is not possible, so were excluded from analysis.

	AUDIT-C		AUDIT Completion Rate	AUDIT Score		Alcohol Service Referral
	Number	Proportion		Number	Proportion	
Non-drinker	3879	*21.3%*		95	*3.8%*	
Lower Risk	9586	*52.7%*		1433	*57.9%*	
Increasing Risk	3494	*19.2%*	*49.3%*	847	*34.2%*	
Higher Risk	1066	*5.9%*	*61.4%*	56	*2.3%*	
Possible Dependence	155	*0.9%*	*63.2%*	43	*1.7%*	*7.5%*
TOTAL	18 180			2474		
Excluded	46			*0*		

Table 3: AUDIT-C and AUDIT Scores in Bromley Patients in 2019/20 *Source: EMIS Data*

The AUDIT-C data for 2021/22 demonstrates that the proportion of Bromley residents who are non-drinkers has increased from 2019/20, with the proportion of heavier drinkers decreasing (Table 4). However, the AUDIT completion rate reduced for all the three highest risk groups, possibly reflecting increasing GP workload. In contrast to the AUDIT-C screening tool, the proportion of Increasing Risk, Higher Risk, Possible Dependant drinkers was higher in 2021/22 than 2019/20 at 37.8%, 3.2%, and 3.0% respectively. Only 3 people were referred to specialist services, like in 2019/20.

	AUDIT-C		AUDIT Completion Rate	AUDIT Score		Alcohol Service Referral
	Number	Proportion		Number	Proportion	
Non-drinker	4002	*28.9%*		18	*1.5%*	
Lower Risk	7136	*51.5%*		636	*54.5%*	
Increasing Risk	1982	*14.3%*	*39.6%*	442	*37.8%*	
Higher Risk	617	*4.5%*	*52.2%*	37	*3.2%*	
Possible Dependence	124	*0.9%*	*50.0%*	35	*3.0%*	*8.6%*
TOTAL	13 861			1168		
Excluded	72			0		

Table 4: AUDIT-C and AUDIT Scores in Bromley Patients in 2021/22 *Source: EMIS Data*

Figures 2 and 3 demonstrate the differences of the proportion of people in each risk group by screening tool. As can be seen, these show slightly different trends with AUDIT-C indicating higher risk drinking has decreased, but AUDIT screening indicating it has increased from 2019/20 to 2021/22.

Figure 2: Proportion of Bromley residents in each alcohol risk category by AUDIT-C score in 2019/20 and 2021/22 *Source: EMIS*

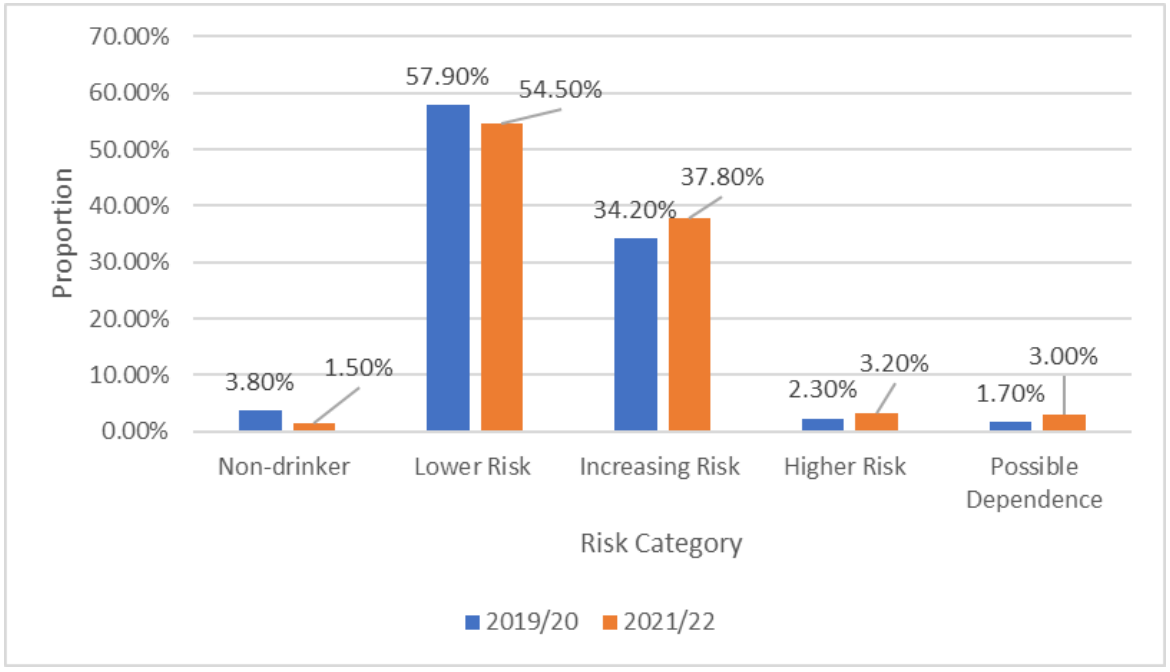

Figure 3: Proportion of Bromley residents in each alcohol risk category by AUDIT score in 2019/20 and 2021/22 *Source: EMIS*

However, there are issues with using AUDIT and AUDIT-C as a measurement of Bromley alcohol consumption. Firstly, only those who have had contact with their GP practice will be included. There may be a selection bias, with different groups of

people accessing GP services more than others (e.g., deprivation groups, ethnicity), meaning the data is not representative. Secondly, there may be an issue with the accuracy of the tool with respect to patients under- or over-reporting their alcohol consumption, or not reporting it accurately. Finally, in 2019/20, 54% of people were not offered an AUDIT or FAST screen within the first year of them signing up to a GP practice in Bromley (ranging from 13% in one practice to 93% in another), which includes anyone who declined a screening, but this was not recorded. In 2021/22, this was 48% (range of 4 % to 96%). Therefore, even where AUDIT-C or FAST screening is supposed to happen (within the first year of being a patient), it often does not, meaning this is not likely to be representative even of those who do engage with GP services.

5.2 Alcohol Use by Age and Gender

In **England**, the proportion of people who drink alcohol at least once a week increases as the age group increases, from 30% in 16-24-year-olds to 58% of 55-74-year-olds (this is except for the 75+ year old group, which is 44%). This is shown in Figure 4. 55% of men reported drinking alcohol at least once a week, compared to 41% of women. [5]

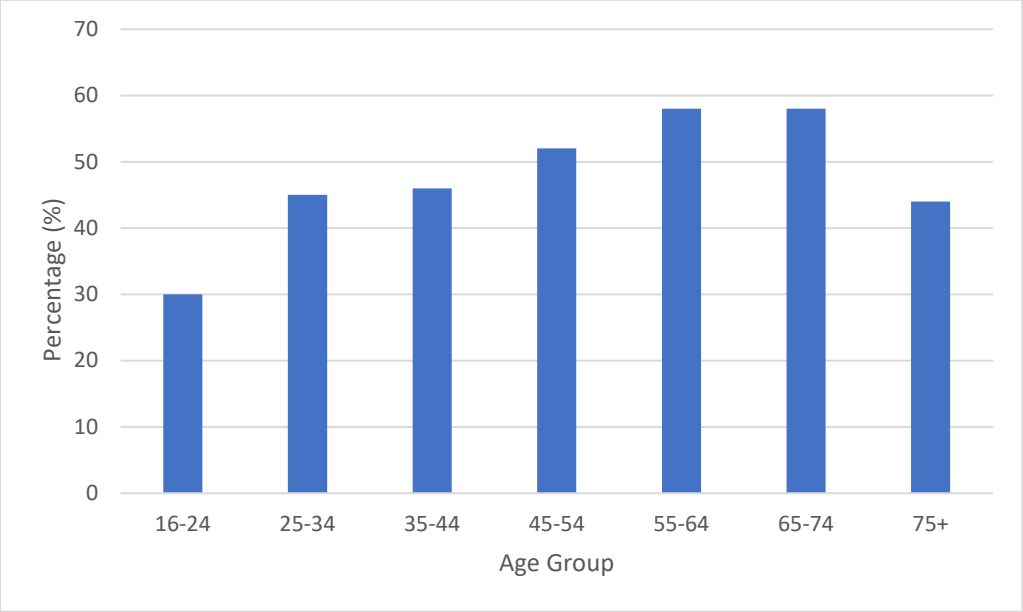

Figure 4: Proportion of people in England who use alcohol at least once a week by age group *Source: Health Survey for England 2019* [5]

Focusing on intensity of drinking, it was reported that a higher proportion of men are drinking quantities that put them at a higher risk, with 30% of men drinking more than 14 units of alcohol, and 15% of women. Since 2011, in men this has reduced from 34% and 18% in women. However, those in the higher risk group has remained constant at 5% since 2011 in men and has been between 3-4% in women (note the differences in definition for "Higher Risk" in men and women as shown in Table 1, where the higher risk for men is defined as 51+ units per week and the higher risk for women is 36+ units per week).

The proportion of non-drinkers in women decreases as age increases, from 31% in 16-24-year-olds to 18% in 65-75-year-olds (increasing again to 31% in over 75s). In men, the same pattern is broadly seen, but with a drop in the 25-34-year-olds at 15%. This is shown in Figure 5. At a regional level, London has the highest rate of non-drinkers in men and women, at 21% and 32% respectively. [5]

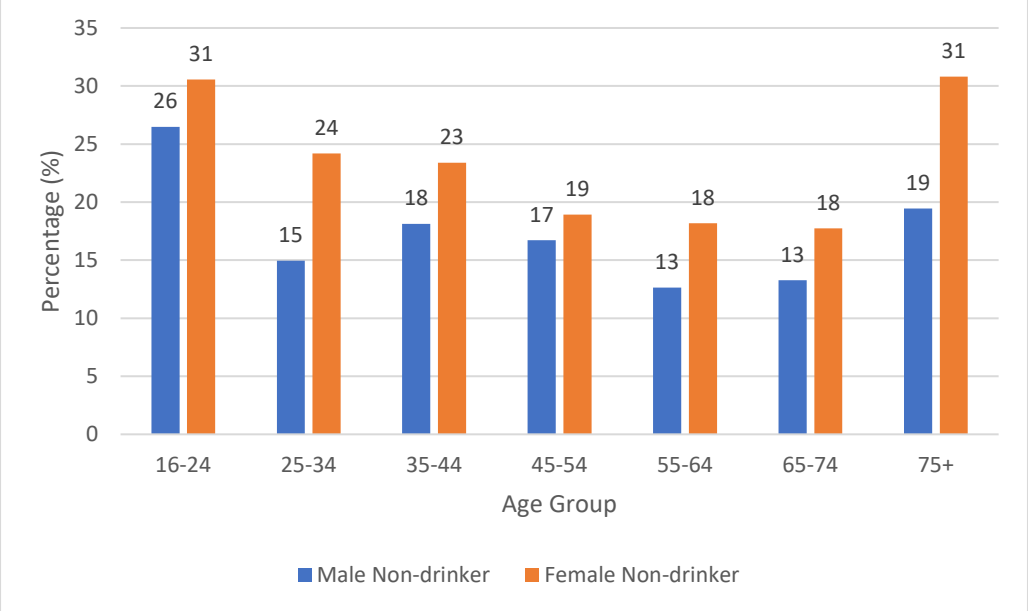

Figure 5: Proportion of people in England who are non-drinkers by age and gender *Source: Health Survey for England 2019* [5]

Looking at Lower Risk drinkers, in women, this is relatively stable over different age groups. In men, there are higher proportions of lower risk drinkers in 16-44 and 75+ year olds (54 to 57%), and lower proportions in 45-74-year-olds (48 to 49%). In all age groups, there is a higher proportion of women in this risk group than men. This is shown in Figure 6. [5]

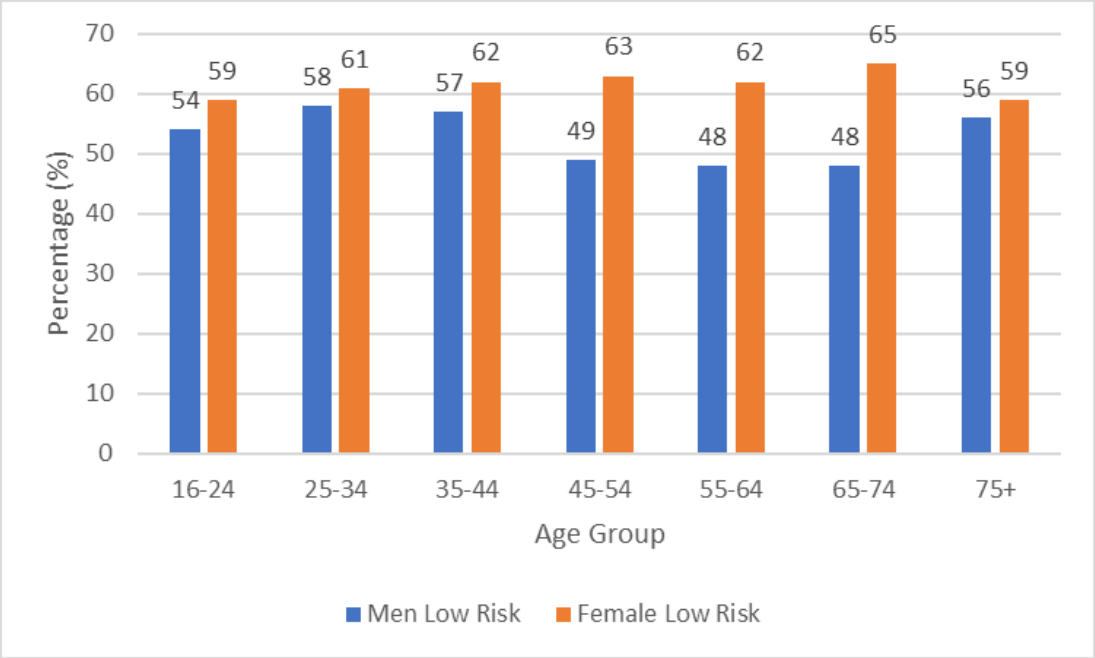

Figure 6: Proportion of people in England who are Lower Risk drinkers by age and gender *Source: Health Survey for England 2019* [5]

Regarding Increasing Risk drinkers, the proportion of men in this group is higher than women in all age groups, in contrast to Lower Risk. In men, the proportion increases as age groups increase, from 15% in 16-24-year-olds to 32% in 55-74-year-olds. The exception is in 35-44-year-olds and 75+ year olds. The trend is the same in women (9% in 16-24-year-olds to 16% in 55-54-year olds), but declines from 65-year-olds. This is shown in Figure 7. [5]

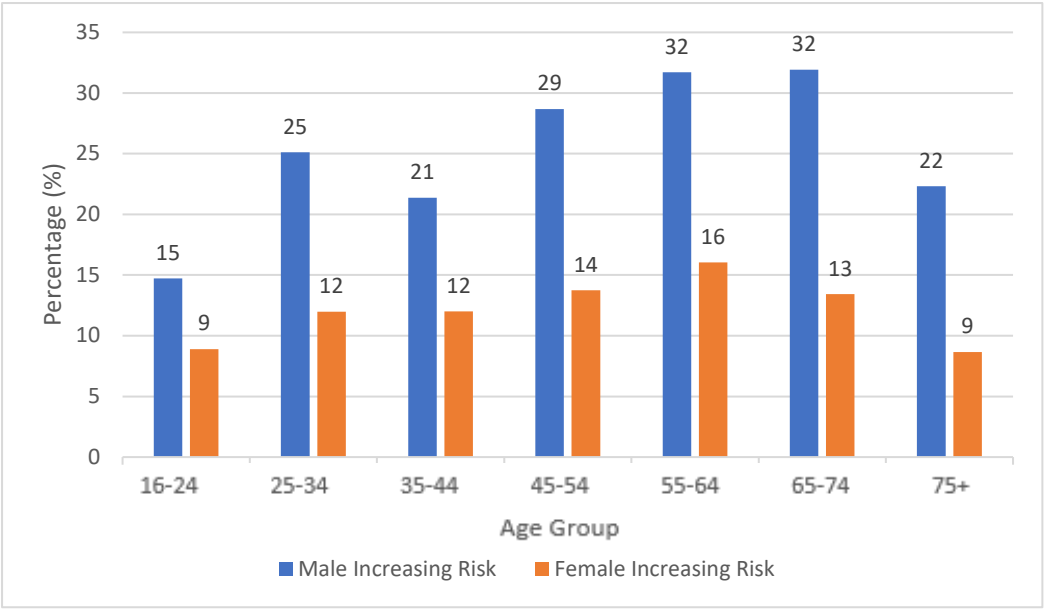

Figure 7: Proportion of people in England who are Increasing Risk drinkers by age and gender *Source: Health Survey for England 2019* [5]

Finally, in Higher Risk drinkers, men have a higher proportion of higher risk drinkers in all age groups, except the 25-34-year-old age group, the difference of which is more prominent in 16-24 and 55+ year olds. 5% of men in the 16-24-year-old age group are higher risk drinkers. This drops to 2% in 25-34-year-olds, and then gradually increases again until 55-64-year-olds. In women, this increases until 45-54-year-olds, then plateaus before dropping to 1% in 75+ year olds. This is shown in Figure 8. [5]

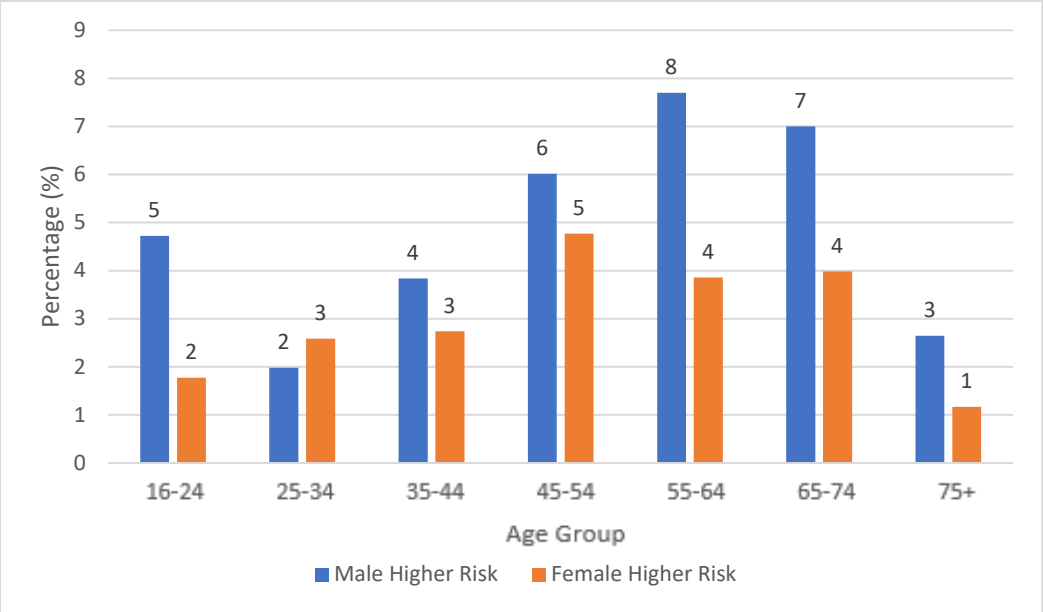

Figure 8: Proportion of people in England who are Higher Risk drinkers by age and gender *Source: Health Survey for England 2019* [5]

Figure 9 demonstrates a summary of the data available on intensity of drinking from the Health Survey for England. There is a higher proportion of Increasing and Higher Risk drinkers in men than women, and in middle aged groups than younger or older groups. Therefore, while it is important to consider these groups when planning alcohol treatment and recovery services, a better understanding of consumption patterns specific to Bromley is also indicated.

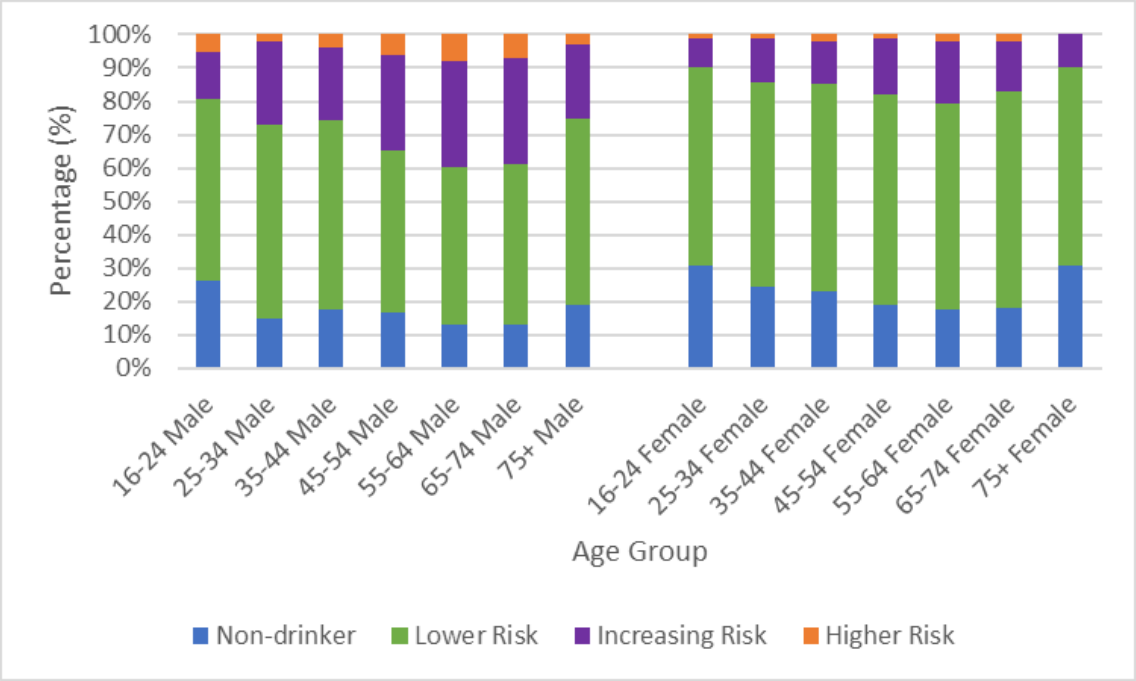

Figure 9: Intensity of Drinking by Age and Gender in England *Source: Health Survey for England 2019* [5]

5.3 Alcohol Use by Deprivation

Figure 10 shows the intensity of alcohol consumption by deprivation quintile in **England**. As can be seen, the proportion of people who are non-drinkers increases as the area becomes more affluent (10% in the most deprived areas, and 33% in the least deprived areas).

Interestingly, the 1-14 units group (lower risk) remains stable across the deprivation quintiles (ranging between 51 and 55% in the lowest and highest deprived areas respectively), with higher values in the 2nd-4th quintiles (61-63%).

For the increasing risk group, in the most deprived areas, 30% were in this group, and 11% in the least.

Finally, for the higher risk group, the proportion is similar across all four groups, with the lowest being the 3rd quintile at 3% and the highest proportion in the most deprived quintile at 5%. [5] Again, a better understanding of consumption patterns specific to Bromley is indicated.

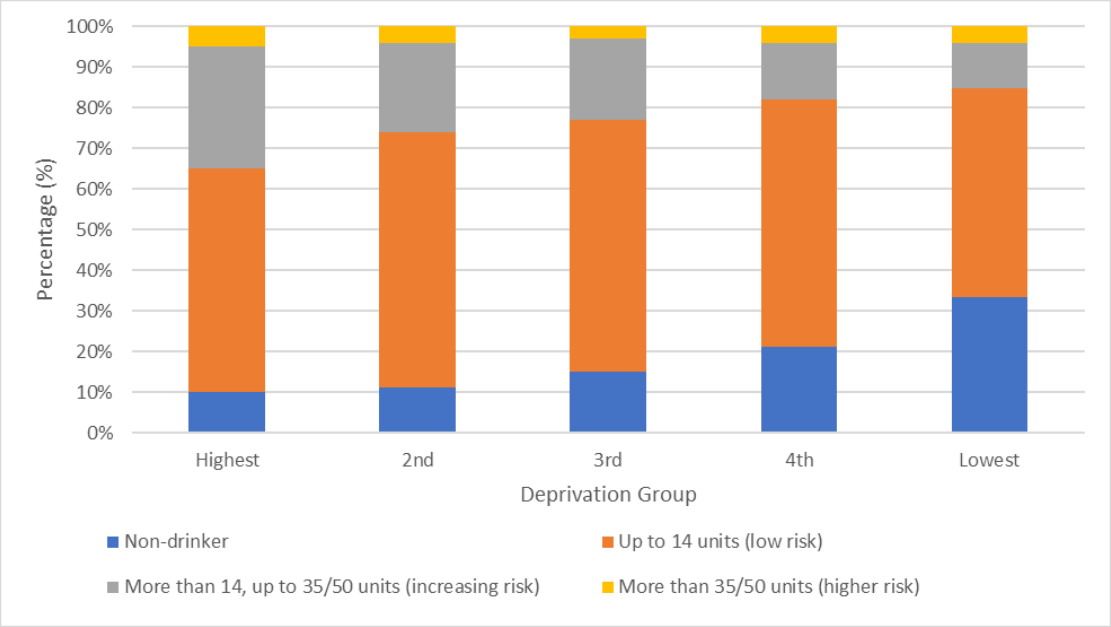

Figure 10: Drinking intensity by deprivation group in England *Source: Health Survey for England 2019* [5]

5.4 Estimates of Alcohol Dependence

Public Health England (PHE), as it was known until October 2021, releases annual estimates of alcohol dependence by local authority. The estimates are based on the 2014 Adult Psychiatric Morbidity Survey. In March 2021, the dataset was updated for 2018/19 estimates. During this period, it was estimated that there were 2560 alcohol dependant individuals in **Bromley** (95% CI 1906 to 3528). This equates to around 1.0 alcohol dependant adults per 100 Bromley adult population (95% CI 0.74 to 1.38), which is shown by the orange bar in Figure 11. This has not changed dramatically since the earliest point on the dataset, which was 2015/16 (rate was 1.02 per 100). [1]

In 2018/19, the highest estimated of alcohol dependant people was 1.83 per 100 adults in Hackney. The lowest was 0.91 per 100 adults, in Richmond upon Thames. Havering, one of Bromley's statistical neighbours, had a rate of 1.16 per 100 adults (shown in yellow in Figure 11). Across all London boroughs, Bromley had the fourth lowest estimated prevalence of alcohol dependence. [1]

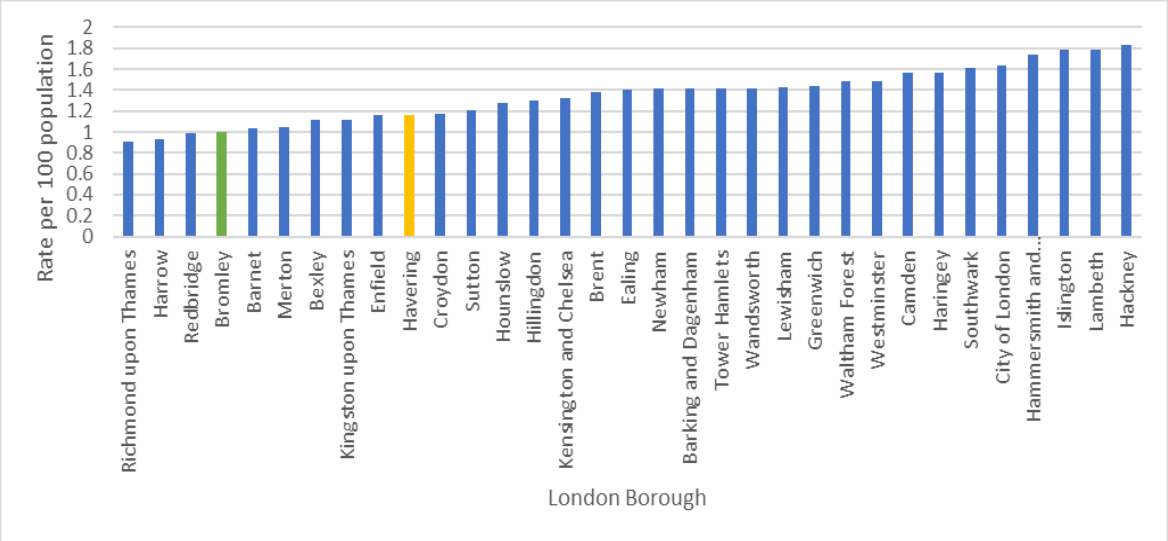

Figure 11: Estimated rates of alcohol dependant adults by London borough in 2018/19 *Source: PHE Alcohol Dependence Prevalence in London* [8]

5.5 Estimates of Unmet Need

In addition to estimating alcohol dependence, PHE also estimate the proportion of these who have an unmet need – that is they are in need of specialist alcohol treatment services but are not currently accessing these.

In **England**, there were estimated to be 602,391 alcohol dependant people, with 107,428 in treatment, representing an 82% unmet need (CI 78%-86%).

As stated in section 5.4, there were estimated to be 2560 alcohol dependant people in **Bromley**. The number of people in services for alcohol only and alcohol/non-opiate treatment in 2020/21 was 363, meaning the estimated unmet need was at least 86% (95% CI 81%-90%) given this number includes those in treatment for harm reduction as well as dependency.

5.6 Binge Drinking

As well as alcohol-dependency, it is also important to consider binge drinking which can also contribute to alcohol-related disease. The definition of binge drinking, according to the Office for National Statistics, is 6 or more units of alcohol in a single sitting for women, and 8 units for men. [2] According to the HSE in 2019, 13% of women had a “binge” on at least one day in the previous week. In men, this was 21%.

Figure 12 shows the trend of binge drinking in men since 2006 in **England**, and Figure 13 for women. Both show a clear downward trend in the 14 years, but this decline has slowed down in both genders in the last six years.

When examining these trends by age group, there are clear differences. The data in Section 5.2 indicated that, overall, 16-24-year-olds are the lightest or lowest risk drinkers, and 55-64-year-olds are the heaviest or highest risk drinkers. Figures 14 and 15 show the trends of binge drinking from 2006 to 2019 for men and women in these age groups respectively. As can be seen, there is a dramatic downward trend in 16-24-year-olds, from 31% to 17% in men and 28% to 13% in women. However, for the 55-64-year-old group, there is no real change. In men, this has remained 21% and in women at 11% (with some fluctuation between 2006 and 2019).

This indicates that binge drinking was once seen mainly in the young, but this has become less common, and now matches older groups. In fact, in men, the proportion of 16-24-year-olds binge drinking is now less than that of 55-64-year-olds, even though the proportion of those binge drinking in the latter group has remained the same. [5]

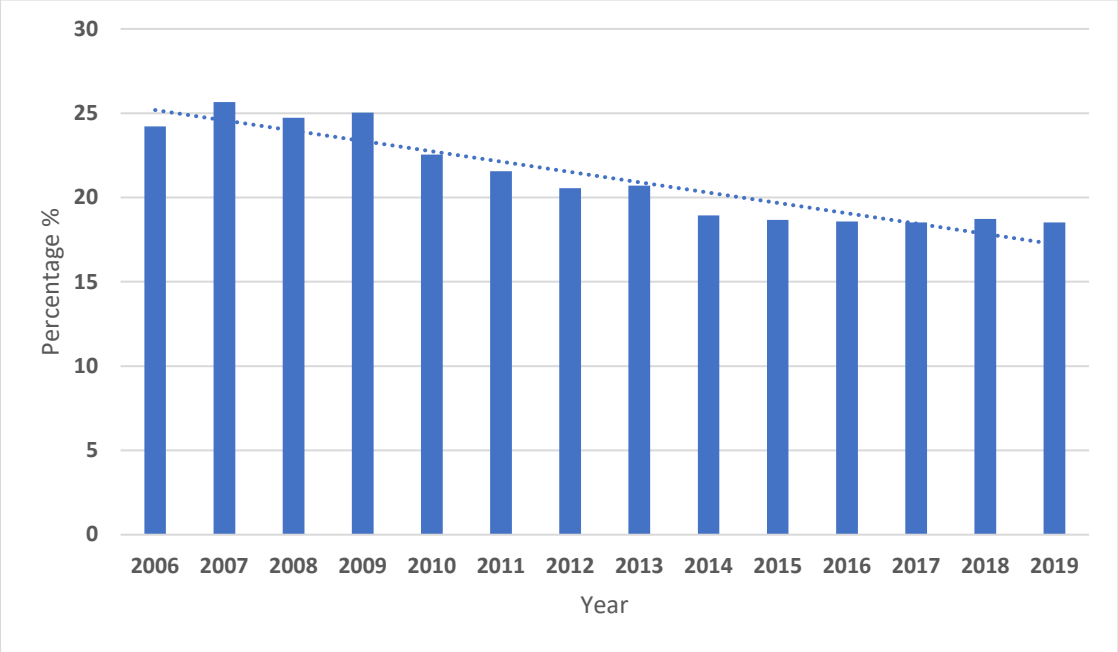

Figure 12: Proportion of men who had a "binge" on at least one day in the previous week in England between 2006 and 2019 *Source: Health Survey for England 2019* [5]

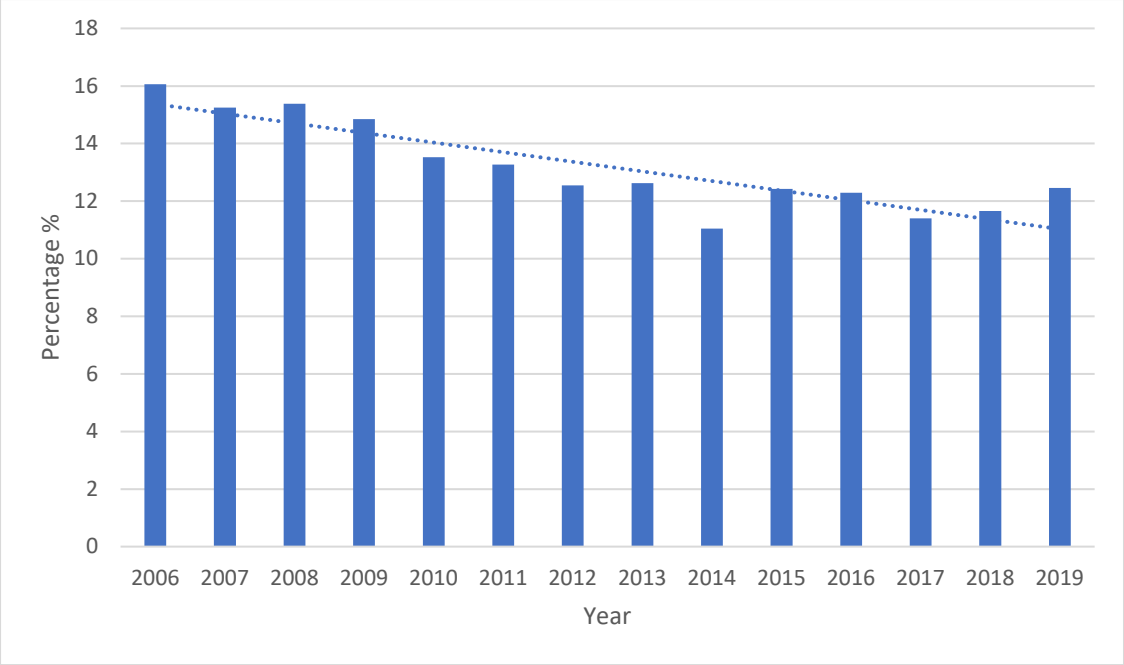

Figure 13: Proportion of women who had a "binge" on at least one day in the previous week in England between 2006 and 2019 *Source: Health Survey for England 2019* [5]

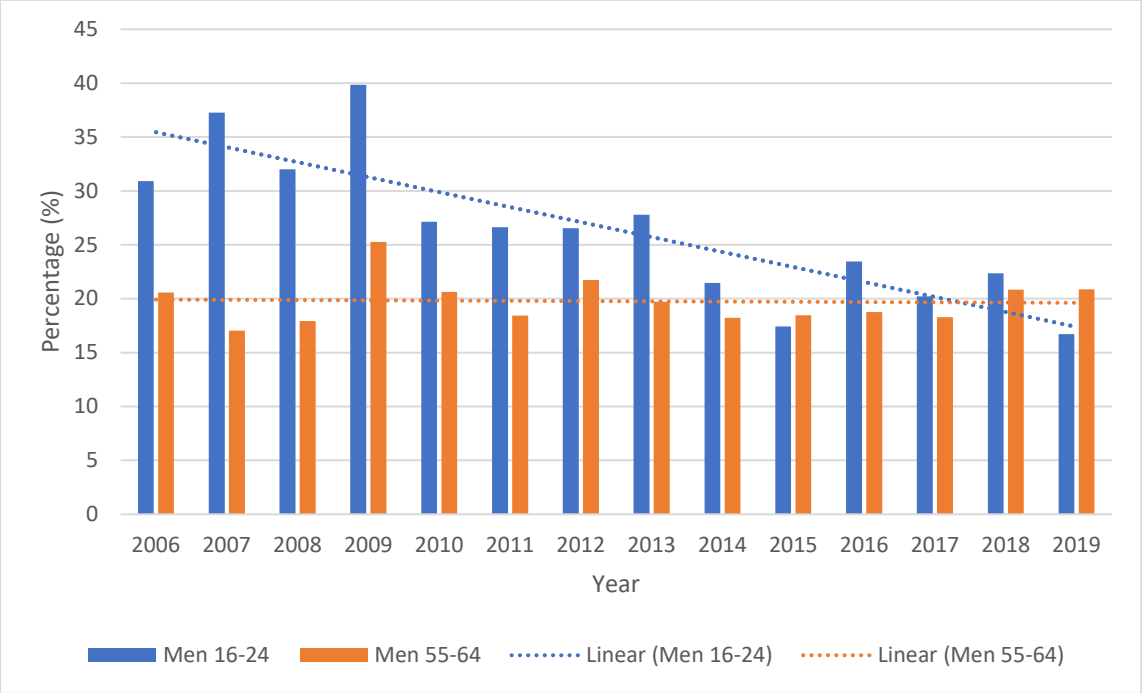

Figure 14: Proportion of 16-24-year-old and 55-64-year-old men who had a "binge" on at least one day in the previous week in England between 2006 and 2019 *Source: Health Survey for England 2019* [5]

Figure 15: Proportion of 16-24-year-old and 55-64-year-old women who had a "binge" on at least one day in the previous week in England between 2006 and 2019 *Source: Health Survey for England 2019* [5]

In **Bromley,** the OHID Alcohol Profiles report that 14.2% of adults binge drink on their heaviest drinking day. The London average is 14.6%. [7]

Key Points of the Chapter:

England

- In 2019, 80% of Health Survey for England (HSE) respondents reported using alcohol in the previous year, and 48% reported using alcohol at least once a week
- In general, the proportion of people who drink alcohol at least once a week increases as the age group increases, from 30% in 16-24-year-olds to 58% of 55-74-year-olds
- 55% of men reported drinking alcohol at least once a week, compared to 41% of women, with 30% of men drinking more than 14 units of alcohol, and 15% of women – declining in proportion since 2011
- There is a higher proportion of Increasing and Higher Risk drinkers in men than women, and in middle aged groups than younger or older groups. A higher proportion of women are Lower Risk drinkers
- Those in the Higher Risk group has remained constant at 5% since 2011 in men and has been between 3-4% in women
- Across deprivation quintiles, the proportion of drinkers in the Increasing Risk group is highest for the most deprived quintile. For the Low Risk and Higher Risk groups, the proportions are broadly similar across the quintiles
- In 2018/19, there were estimated to be 602,391 alcohol dependant people, with 107,428 in treatment, representing an 82% unmet need
- Binge drinking was once seen mainly in the young, but this has become less common, and now matches the proportions seen in older groups. In fact, in men, the proportion of 16-24-year-olds binge drinking is now less than that of 55-64-year-olds, even though the proportion of those binge drinking in the latter group has remained the same

Bromley

- From 2015-2018, 12% of adults in Bromley abstained from alcohol, but 26.8% of adults in Bromley drink over 14 units of alcohol per week
- Although there are limitations, general practice AUDIT-C and AUDIT data illustrates alcohol consumption trends in Bromley

- However, AUDIT-C screening tools has shown an increase in non-drinkers and decrease in the highest alcohol risk groups from 2019/20 to 2021/22, with AUDIT indicating an opposite trend. Therefore, this data should be taken with caution
- In both years, the proportion of appropiate AUDIT screening after a high AUDIT-C score is far below expected (with a significant worsening in 2021/22), and the number of referrals to specialist services is also exceptionally low
- In 2018/19, it was estimated that there were 2560 alcohol dependant individuals, or 1.0 alcohol dependant adults per 100 Bromley adult population
- The number of people in services for alcohol only and alcohol/non-opiate treatment in 2020/21 was 363, meaning the estimated unmet need was at least 86%
- From 2015-18, it was estimated 14.2% of adults binge drink on their heaviest drinking day.

6. Prevalence of Alcohol Use in Young People

6.1 Overall Alcohol Use

Data about alcohol use in young people in **England**, from ages 8-15, is also provided by the HSE. For the survey, this age group filled in a self-completion booklet about their drinking behaviour, rather than a computer-based survey in adults. In addition, interviews for children aged 8 to 12 are carried out with a parent; children aged 13 to 15 are interviewed directly. [2] [4] The data, particularly in the 8-12-year-old group, may therefore be affected by the presence of their parents.

In 2019, 15% of children aged 8-15-years-old reported they had ever had an alcoholic drink. Figure 16 shows that this proportion has dramatically reduced since 2003, when it was 45%. [10] There is no further data about regularity of drinking or the types of alcohol consumed.

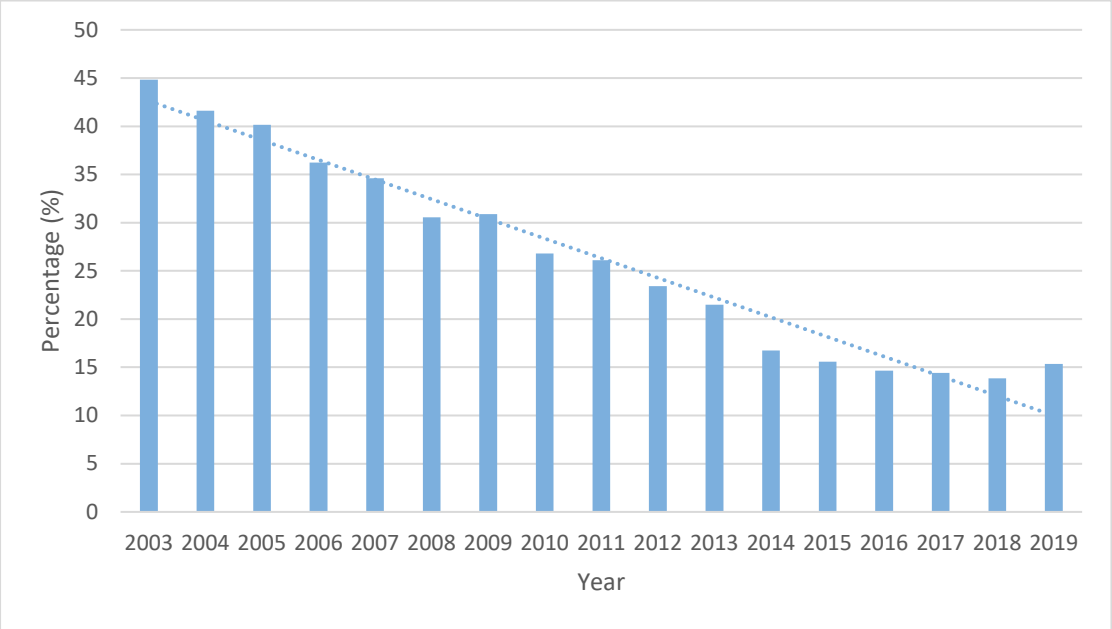

Figure 16: Proportion of 8-15-year-olds who reported they had ever had an alcoholic drink in England from 2003 to 2019 *Health Survey for England 2019* [10]

In addition, there is a biennial survey of secondary students in England about their attitudes and habits of smoking, drinking, and drug use. This is caried out for Years 7-11 students (mostly aged 11-15-years old). However, the last survey was carried out in 2018. [14] In this, 10% of pupils reported they had drunk alcohol in the last week. In 2008, this was 18%, however data from 2016 is not comparable with previous years due to a change in the wording of the question pupils were asked.

The survey asks about usual frequency of drinking. 62% of students reported they do not drink, up from 52% in 2008. However, this is a decrease from 2014 levels. This is shown by the blue bar in Figure 17. This graph also shows the usual frequency of alcohol consumption. As can be seen, heavier drinking (once a week, once a fortnight) has reduced over the last 10 years. However, the proportion of children engaging in more casual drinking, such as a few times a year, has remained largely stagnant (19% in 2008 to 20% in 2018). [15] It should be noted that data from 2016 is not comparable with previous years due to a change in the wording of the question pupils were asked.

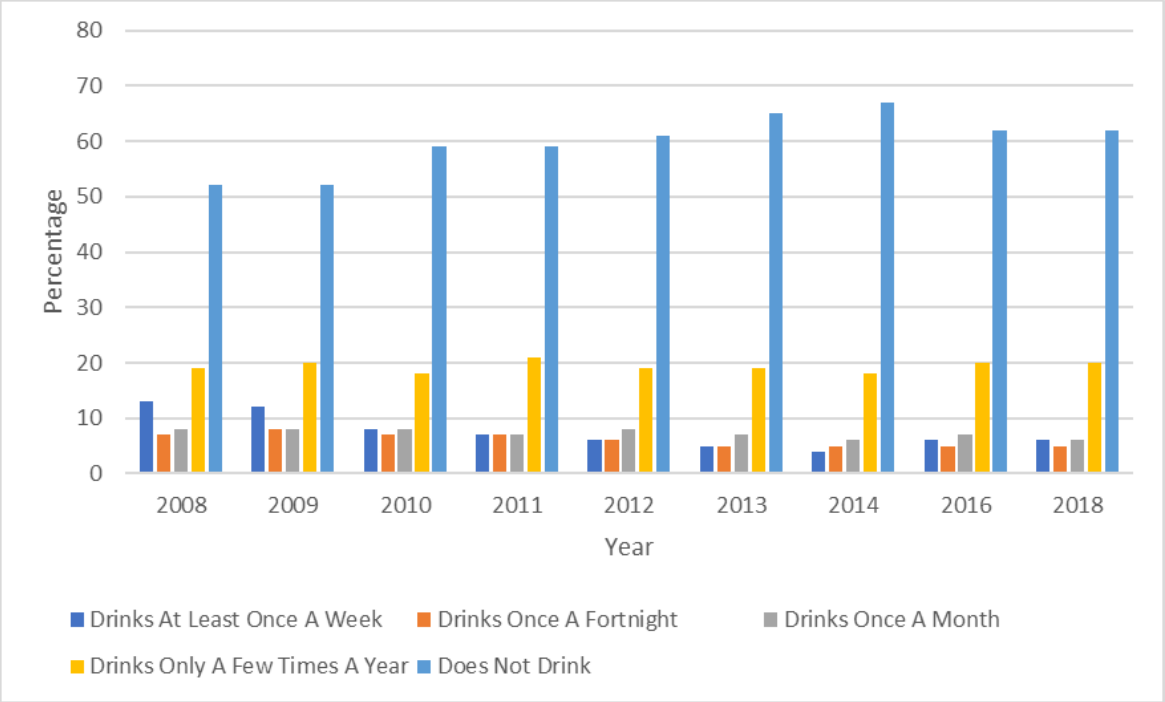

Figure 17: Usual frequency of drinking in Year 7-11 pupils in England from 2008 to 2018 *Source: Smoking, drinking and drug use among young people – Drinking prevalence* [15]

For pupils who reported they had drunk in the last week, the mean number of units consumed was 10.3 units. Figure 18 shows the number of units consumed by those who had drunk in the last week. As can be seen, the highest proportion is in the 15 Units or more group (21%), followed by 2 to <4 units (18%). [15]

Figure 18: Number of units consumed by Year 7-11 pupils if they drank in the last week in England (2018) *Source: Smoking, drinking and drug use among young people – Drinking prevalence* [15]

Looking at alcohol type, of those pupils who drunk alcohol in the last week, 76% drank beer, lager, or cider. 60% drank spirits, 43% wine, martini or shandy, and 34% alcopops. Interestingly, the consumption of alcopops is the only type of alcohol which has dramatically changed in the last 10 years. In 2008, this was 61%. Going even further back, in 2003 this was 68%.

Of the children aged 15 who have drunk alcohol, 9% reported they first drank alcohol at 10 years or under. The most common age to have first had alcohol was 14 years old (31%), followed by 13-years-old (23%). In addition, the most common age of first being drunk was also 14 years old at 41%, followed by 15 years old (37%). This is summarised in Figure 19. [15]

Figure 19: Age that 15-year-olds who drink alcohol first had a drink or first got drunk in England (2018) *Source: Smoking, drinking and drug use among young people – Drinking prevalence* [15]

28% of respondents in London reported they had never drunk alcohol. This is the lowest proportion across England, with the highest being in Yorkshire and the Humber at 53%. This was 5% in London for alcohol drunk in the last week, and again is the lowest with the highest also being in Yorkshire and the Humber at 14%. [15]

There is no data available for all age groups in **Bromley,** but section 6.2 will cover data available for 14-15-year-olds in Bromley.

6.2 Alcohol Use by Age and Gender

In **England** in 2019, 14% of boys and 16% of girls said they had ever had an alcoholic drink. Examining this by age group, a higher proportion of boys reported alcohol use than girls in the 8-10 and 11-12-year-old groups, but in the 13-15-year-old group, more girls reported use compared to boys (39% vs 31%). [10] This is shown in Figure 20. This may indicate boys have riskier decision making at a younger age, while girls are more risk adverse until older age groups.

Figure 20: Proportion of boys and girls who had ever drunk an alcohol drink by age group in England *Source: Health Survey for England 2019* [10]

When examining the trend since 2003, there has been a large reduction in alcohol consumption– a more than halving of the use of alcohol in all groups. Figure 21 shows this trend, with the proportion of children in each age group who had consumed alcohol in 2003 and 2019 displayed to demonstrate the change. Whilst not demonstrated here, these trends are also apparent in both boys and girls when split by gender [10]

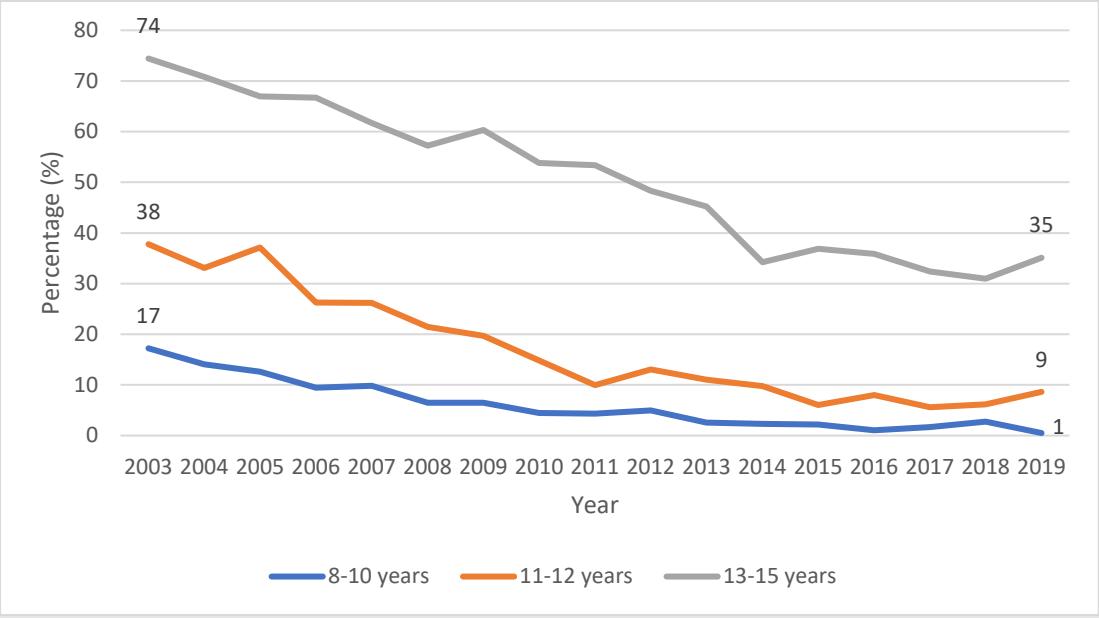

Figure 21: Alcohol usage by age from 2003 to 2019 in England *Source: Health Survey for England 2019* [10]

The secondary school survey provides further insight to alcohol use by gender and age. In 11, 12, and 13 year olds, more boys report that they had ever had an alcoholic drink. By 14, the proportion is higher in girls. [15] This is shown in Figure 22.

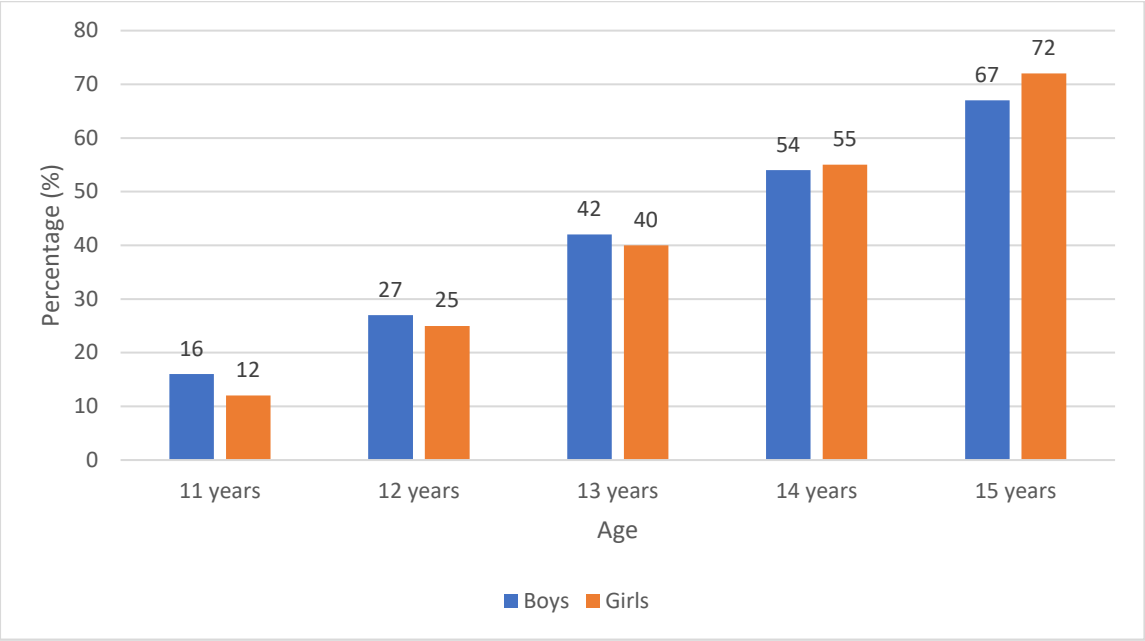

Figure 22: Proportion of boys and girls who had ever drunk alcohol by age in England (2018) *Source: Smoking, drinking and drug use among young people – Drinking prevalence* [15]

In terms of frequency of drinking, the difference between boys and girls is minimal. Overall, there are slightly more girls drinking once a fortnight or month, and slightly more boys drinking only a few times a year, as shown in Figure 23. [15]

Figure 23: Frequency of drinking by pupils by gender in England (2018) *Source: Smoking, drinking and drug use among young people – Drinking prevalence* [15]

Further analysing this by age, there are some interesting observations, Firstly, in the lightest drinking category ("Only a few times a year"), there is a gradual increase in the proportion of each age group drinking this regularly. However, for the other drinking frequencies, being 15 years old means the respondent was more likely to drink that frequency, which includes once a week, once a fortnight, or once a month. [15] The proportion of boys and girls in each drinking frequency is shown in Figure 24.

Figure 24: Frequency of drinking by pupils by age and gender in England (2018) *Source: Smoking, drinking and drug use among young people – Drinking prevalence* [15]

The survey also calculated the odds ratio of drinking alcohol in the last week by age. Compared to being 11 or 12 years old, 13-year-olds are 2.06 more likely to have drunk in the same period, 3.72 times in 14-year-olds, and 4.66 in 15-year-olds. These are all statistically significant at the 95% level. [15]

Figure 25 demonstrates the number of units consumed in the last week in pupils who drank alcohol in the last week by gender. There appears to be no trend by gender, with the proportion of people consuming a certain number of units being roughly similar between boys and girls (except 2 to <4 units, where 20% of girls and 16% of boys consumed this much alcohol). [15]

Figure 25: Proportion of boys and girls who drank different units of alcohol in the last week in England (2018) *Source: Smoking, drinking and drug use among young people – Drinking prevalence* [15]

Types of alcohol consumed also differ by gender. In pupils who drunk alcohol in the last week, 87% of boys drunk beer, lager, or cider, and 65% of girls. In contrast 55% of girls drank wine, martini, or sherry, and 27% of boys. This is shown in Figure 26.

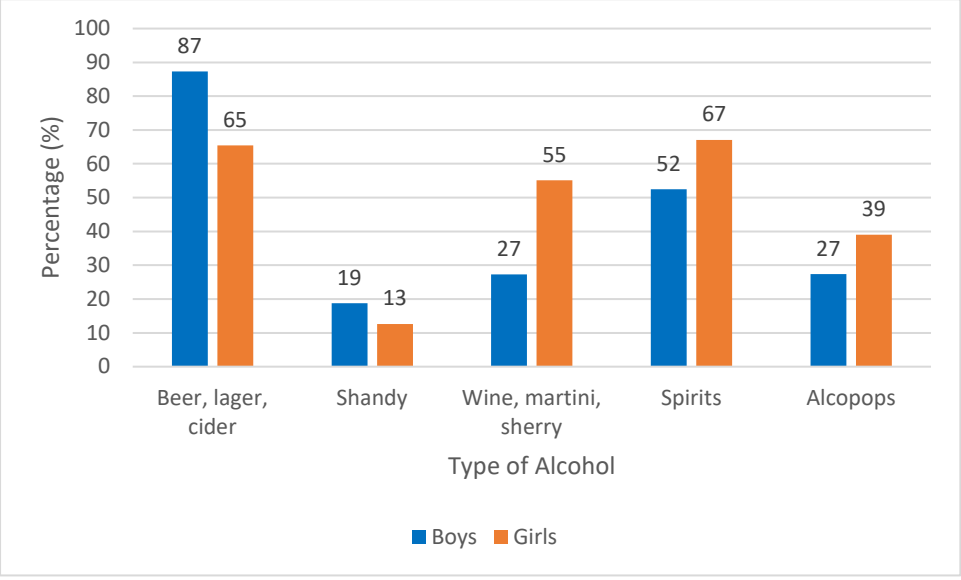

Figure 26: Proportion of different types of alcohol drunk in the last week by gender in England (2018) *Source: Smoking, drinking and drug use among young people – Drinking prevalence* [15]

Figure 27 shows the age 15-year-olds reported they first drank alcohol by gender. As can be seen, more boys reported they started drinking at earlier ages – 11- and 12-year-olds. Alcohol debut at 13 and 14 years old is more common in girls. If they had not drunk alcohol until 15 years old, this is roughly similar for boys and girls – 19% for boys and 18% for girls. [15]

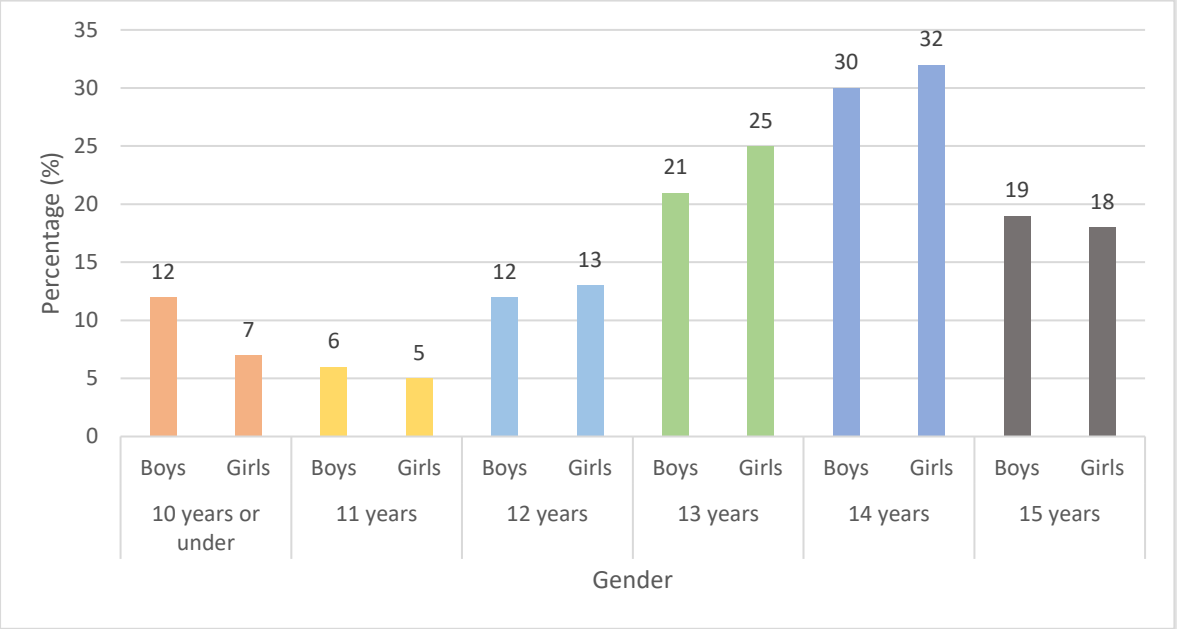

Figure 27: Age that 15-year-olds had their first alcoholic drink by gender in England (2018) *Source: Smoking, drinking and drug use among young people – Drinking prevalence* [15]

The age a 15-year-old first got drunk by gender is shown in Figure 28. This shows that there is some difference between boys and girls, but there is not a trend between ages by gender. However, considering age alone, it was far more common to be drunk first at 14 and 15 years old for both boys and girls. [15]

Therefore, alcohol consumption debut was in younger children, but being drunk did not occur for most young people until 14-years-old.

Figure 28: Age that 15-year-olds first got drunk by gender in England (2018)
Source: Smoking, drinking and drug use among young people – Drinking prevalence [15]

To examine alcohol use and attitudes in **Bromley**, the School Health Education Unit (SHEU) was used. This survey took place across the country, with the two most recently in 2019 and 2021/22. This is a survey which asks Year 10 pupils (14- and 15-year-olds) about their attitudes, beliefs and uses of many issues, including alcohol. In Bromley in 2019, seventeen schools took part, including 2122 students. In 2021/22, all 21 providers took part with a sample of 2969 students. Both survey years have been included for comparison purposes, particularly to assess any changing attitudes or uses over the Covid-19 pandemic (noting potential methodological limitations for comparing the two years).

In 2019, 18% of respondents reported consuming an alcoholic drink in the last 7. days. This ranged from 6% to 28% depending on the school. In 2021/22, this was 14%. 7% of pupils in 2021/22 reported they got this alcohol from parents, and 4% from friends. Although there appears to be a reduction in alcohol consumption, this must be treated with caution due to the possible changes in consumption habits during Covid-19.

By gender, in 2019, 21% of boys and 23% of girls reported they had an alcoholic drink in the last 7 days. In 2021/22, this was 13% for boys and 14% for girls.

There is further detail available in the 2021/22 results. 19% of respondents reported they did drink alcohol (in general), and that their parents/guardians knew about this. 8% said their parents usually knew, and only 3% said their parents never knew.

19% reported that they drunk alcohol at home, and of those, 53% said their parents knew, 22% that they usually knew, and 25% said they never knew.

71% of boys never drink alcohol **or** don't drink it at home. This is 60% for girls. This may indicate that a higher proportion of girls drink outside the home setting than boys (there was no break down available of how this was split between those who don't drink vs those who don't drink at home). Of those girls that do drink at home, 20% said their parents always knew and 11% said they never or sometimes knew. For boys, this was 17% and 6% respectively.

Interestingly from an alcohol education perspective, only 33% found lessons about alcohol at school useful, and 18% found them "not at all" useful. 19% could not recall receiving such lessons.

6.3 Alcohol Use by Deprivation

In the HSE, the data of alcohol consumption in **England** by deprivation for children is based on household income quintiles. Again, the question asks if the child has ever drunk alcohol.

Figure 29 demonstrates that there is very slight difference in alcohol consumption between the highest and lowest quintiles in 2019 – 18% in the highest and 14% in the lowest for boys, and 16% in the highest and 13% in the lowest for girls. However, for the 2nd-4th quintiles, this slight trend is more unclear. There is also very little difference between boys and girls in each group, with only a 1-2% difference. [10]

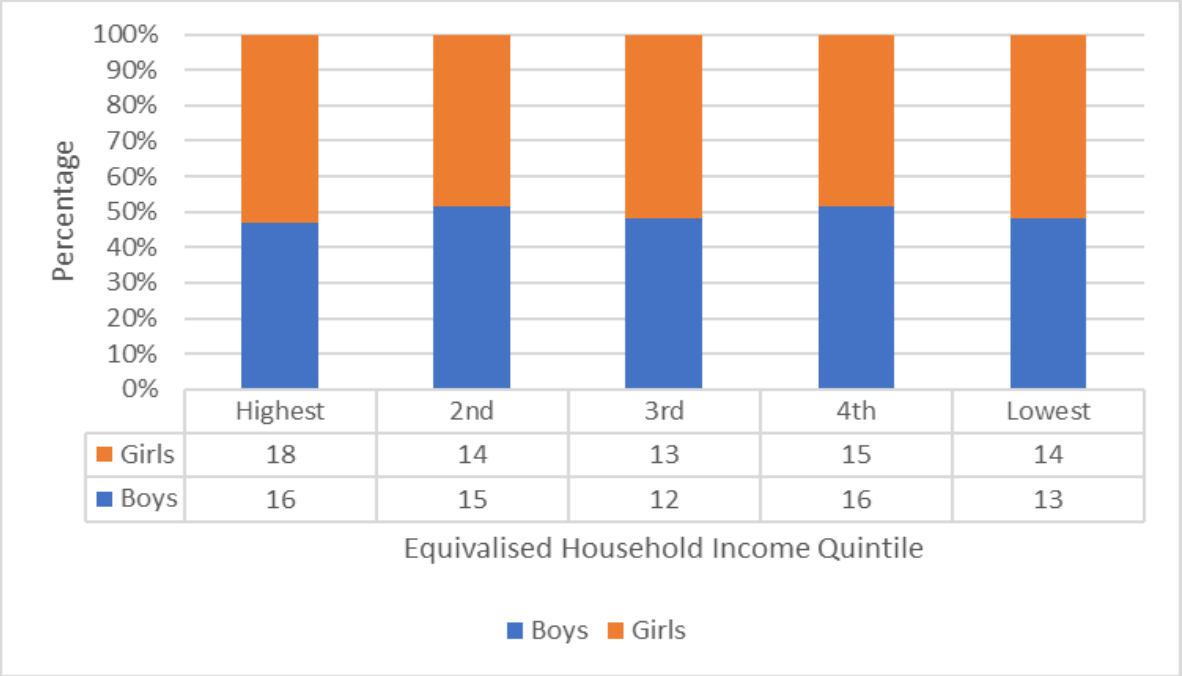

Figure 29: Alcohol consumption in children by household income quintiles in 2019 in England *Source: Health Survey for England 2019* [10]

6.4 Alcohol Consumption by Ethnicity

The secondary school survey in **England** collects data on alcohol consumption by ethnicity. In the 2018 survey, 52% of White pupils had ever drunk alcohol. This was 40% for the Mixed group, 23% for the Black group, 10% for Asian group, and 25% for others.

For alcohol consumption in the last week, it is also the White group with the highest proportion of consumption at 13%. [15] These are summarised in Table 5.

Ethnic Group	Proportion of those who drank alcohol ever	Proportion of those who drank alcohol in the last week
White	52%	13%
Mixed	40%	7%
Asian	10%	1%
Black	23%	3%
Other	25%	5%

Table 5: Proportion of pupils who had drunk alcohol ever or in the last week by ethnicity in England (2018) *Source: Smoking, drinking and drug use among young people – Drinking prevalence* [15]

Compared to the White group, the Asian group is 0.16 as likely to have drunk alcohol in this time, and 0.33 if you are Black. These are statistically significant at the 95% level, but other ethnic groups are not. [14]

6.5 Alcohol Use by Other Risk Factors

As previously mentioned, odds ratios have been calculated for alcohol consumption in the last week. These have also been calculated for smoking status, drug use, and truancy.

Nationally, pupils who are regular smokers are 5.32 more likely to have drunk alcohol in the past week than a non-smoker. This is 1.88 in occasional smokers. These are statistically significant at the 95% level.

Pupils who had taken drugs in the last year and month were 2.59 and 3.67 more likely to have drunk alcohol in the past week respectively. These are statistically significant at the 95% level. However, if a pupil has taken a drug but not in the past year, there is no statistically significant effect.

Pupils who have played truant are 1.58 more likely to have drunk alcohol in the past week than a child who has never played truant. This is also statistically significant at the 95% level. [15]

6.6 Alcohol Consumption Based on Parental Alcohol Consumption

The HSE also captures data on alcohol consumption in children based on their parents' alcohol consumption, in **England**. This is also based on whether the child has ever had an alcoholic drink.

In 2019, the data shows that a higher proportion of children drank alcohol if their mother or father drunk more alcohol. For example, 5% of children reported they had ever drunk alcohol if their mother did not drink any alcohol, and 6% of children if their father did not. This was 16% and 11% respectively if the parent drunk 1-14 units, and 26% and 23% respectively if they drank over 14 units. [10] This is shown in Figure 30.

Figure 30: Child alcohol consumption by their mother's and father's alcohol consumption in England *Source: Health Survey for England 2019* [10]

This data is also broken down by gender. As can be seen in Figure 31, more girls tend to have had an alcohol drink if their mother drinks any quantity of alcohol, than if their father did. This is true for boys where their mother consumed 1-14 units per week, but not for heavier drinking where there appears to be no impact.

In addition, 28% of girls and 23% of boys will have consumed alcohol in the past if their mother drunk over 14 units per week. This is 23% and 22% respectively if their father drinks the same number of units, possibly meaning girls are more impacted by if their mother is a heavier drinker. [10]

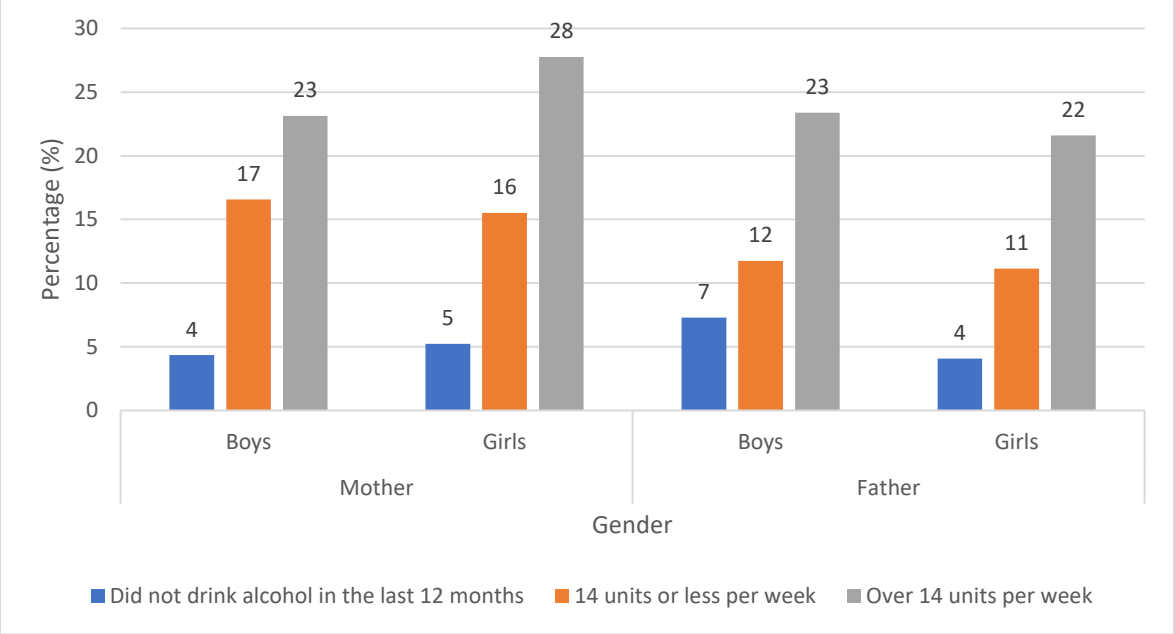

Figure 31: Child alcohol consumption by their mother's and father's alcohol consumption, by gender in England *Source: Health Survey for England 2019* [10]

Key Points of the Chapter:

England

- In the 2019 HSE, 15% of children aged 8-15-years-old reported they had ever had an alcoholic drink, which has dramatically reduced since 2003. This was 14% of boys and 16% of girls
- A higher proportion of boys reported alcohol use in the 8-10 and 11-12-year-old groups, but in the 13-15-year-old group, more girls reported use
- When examining the trend since 2003, there has been a large reduction in alcohol consumption in all groups – a more than halving of the use of alcohol in all groups
- In Year 7-11s in 2018, 10% of pupils reported they had drunk alcohol in the last week. In 2008, this was 18%
- Heavier drinking (once a week/once a fortnight) has reduced over the last 10 years. However, the proportion of children engaging in more casual drinking, such as a few times a year, has remained largely stagnant
- Compared to being 11 or 12 years old, 13-year-olds are 2.06 more likely to have drunk in the last week, 3.72 times in 14-year-olds, and 4.66 in 15-year-olds
- When asked at 15-years-old, more boys reported they started drinking at earlier ages – 11- and 12-year-olds. Alcohol-consumption debut at 13 and 14 years old is more common in girls
- With the first age of getting drunk, it was far more common to be drunk first at 14 and 15 years old for both boys and girls
- In 2018, 52% of White pupils had ever drunk alcohol. This was 40% for the Mixed group, 23% for the Black group, 10% for Asian group, 25% for others
- Compared to the White group, the Asian group is 0.16 as likely to have drunk alcohol in this time, and 0.33 if you are Black
- Pupils who are regular smokers are 5.32 more likely to have drunk alcohol in the past week than a non-smoker. This is 1.88 in occasional smokers
- Pupils who had taken drugs in the last year and month were 2.59 and 3.67 more likely to have drunk alcohol in the past week respectively

- Pupils who have played truant are 1.58 more likely to have drunk alcohol in the past week than a child who has never played truant
- In 2019, the data shows that a higher proportion of children drank alcohol if their mother or father drunk more alcohol
- More girls tend to have had an alcohol drink if their mother drinks any quantity of alcohol, than if their father did. This is true for boys where their mother consumed 1-14 units per week
- The data suggests girls are more likely to have drunk alcohol if their mother is a heavier drinker, and boys if their father is

Bromley

- In 2019, 18% of Year 10 students reported consuming an alcoholic drink in the last 7 days. This ranged from 6% to 28% depending on the school. In 2021/22, this was 14% (although there appears to be a reduction in alcohol consumption, this must be treated with caution due to the possible changes in consumption habits during Covid-19)
- In 2019 21% of boys and 23% of girls reported they had an alcoholic drink in the last 7 days. In 2021/22, this was 13% for boys and 14% for girls.
- In 2020/21, the data suggests that a higher proportion of girls drink outside the home setting than boys

7. Alcohol-Related Morbidity and Mortality

7.1 Alcohol-Specific Hospital Admissions

Every year, NHS Digital publish the number of hospital admissions due to alcohol-specific conditions. Hospital episode statistics (HES) can also give further information about individuals admitted, including gender, age, ethnicity, and home location.

The reason for hospital admission is identified by coding via the international classification of diseases 10 (ICD-10). [16] Table 6 shows the relevant codes used during this search for hospital admissions due to alcohol-specific conditions. [17] Following a consultation in 2017 the ONS and PHE/OHID now use the same definition of alcohol specific mortality. It was agreed that the alcohol specific conditions in table 6 accounted for all causes of alcohol specific admissions which are wholly attributed to alcohol. However, T51, Y90 and Y91 have been removed from alcohol specific mortality following this consultation.

ICD-10 code	Description of condition
E24.4	Alcohol-induced pseudo-Cushing's syndrome
F10	Mental and behavioural disorders due to use of alcohol
G31.2	Degeneration of nervous system due to alcohol
G62.1	Alcoholic polyneuropathy
G72.1	Alcoholic myopathy
I42.6	Alcoholic cardiomyopathy
K29.2	Alcoholic gastritis
K70	Alcoholic liver disease
K85.2	Alcohol-induced acute pancreatitis
K86.0	Alcohol-induced chronic pancreatitis
Q86.0	Fetal-induced alcohol syndrome (dysmorphic)
R78.0	Excess alcohol blood levels
T51.0	Ethanol poisoning
T51.1	Methanol poisoning
T51.9	Toxic effect of alcohol, unspecified
X45	Accidental poisoning by and exposure to alcohol
X65	Intentional self-poisoning by and exposure to alcohol
Y15	Poisoning by and exposure to alcohol, undetermined intent
Y90	Evidence of alcohol involvement determined by blood alcohol level
Y91	Evidence of alcohol involvement determined by level of intoxication

Table 6: ICD-10 codes relating to admissions due to alcohol specific conditions. *Source: ICD-10 and ONS*

7.1.1 Overall Admissions and by Gender

In 2021/22, there were 1434 admissions in Bromley where alcohol-specific conditions were mentioned as a reason for admission in any diagnosis field. This includes all admissions where alcohol-specific conditions have been mentioned, including those where alcohol-specific conditions were not the primary cause of admission.

Since 2017/18 there has been a steady increase in the number of hospital admissions where alcohol specific conditions have been mentioned. The exception was 2020/21 where there was a decrease in both male and female admissions.

Men consistently comprise almost two thirds of all admissions due to alcohol-specific conditions in Bromley compared to women. In 2021/22, 64.2% of all Bromley admissions due to alcohol-specific conditions were men, 921 out of 1,434 admissions.

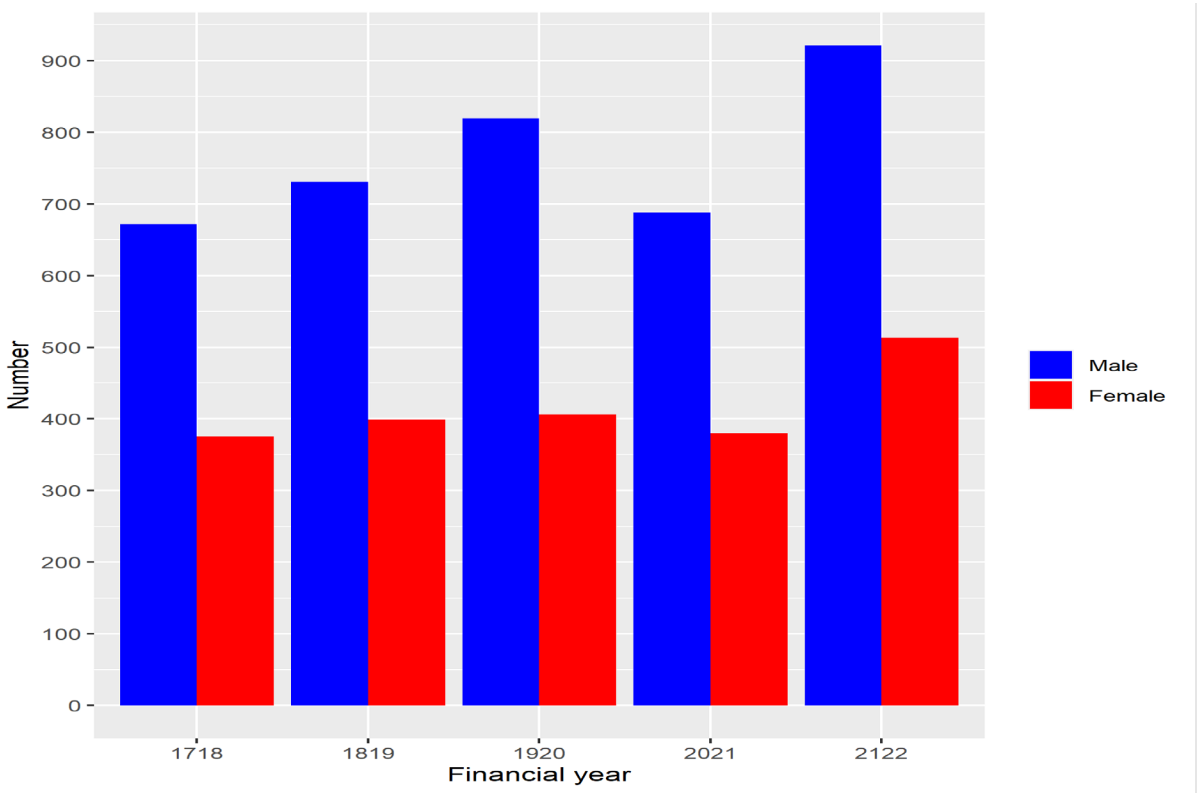

Figure 32: Number of admission episodes by sex for alcohol-specific conditions (primary or secondary diagnosis): Bromley. Source: NHS Digital

As well as comparing to London and England, another useful comparison is to a statistical neighbour. These are benchmark local authorities that have similar characteristics to the local authority in question. The London Borough of Havering (LBH) is a statistical neighbour for LBB.

Figure 33 displays the rates of admission episodes and the comparison to LBH, as well as London and England from 2012/13 to 2021/22. Rates of admission due to alcohol-specific conditions are lower in Bromley compared with London and England and comparable to LBH. The rate of admission among men is generally more than twice that for women in all areas shown although that difference is less exaggerated in Bromley. Rates have increased in 2021/22 in all areas shown and for both sexes.

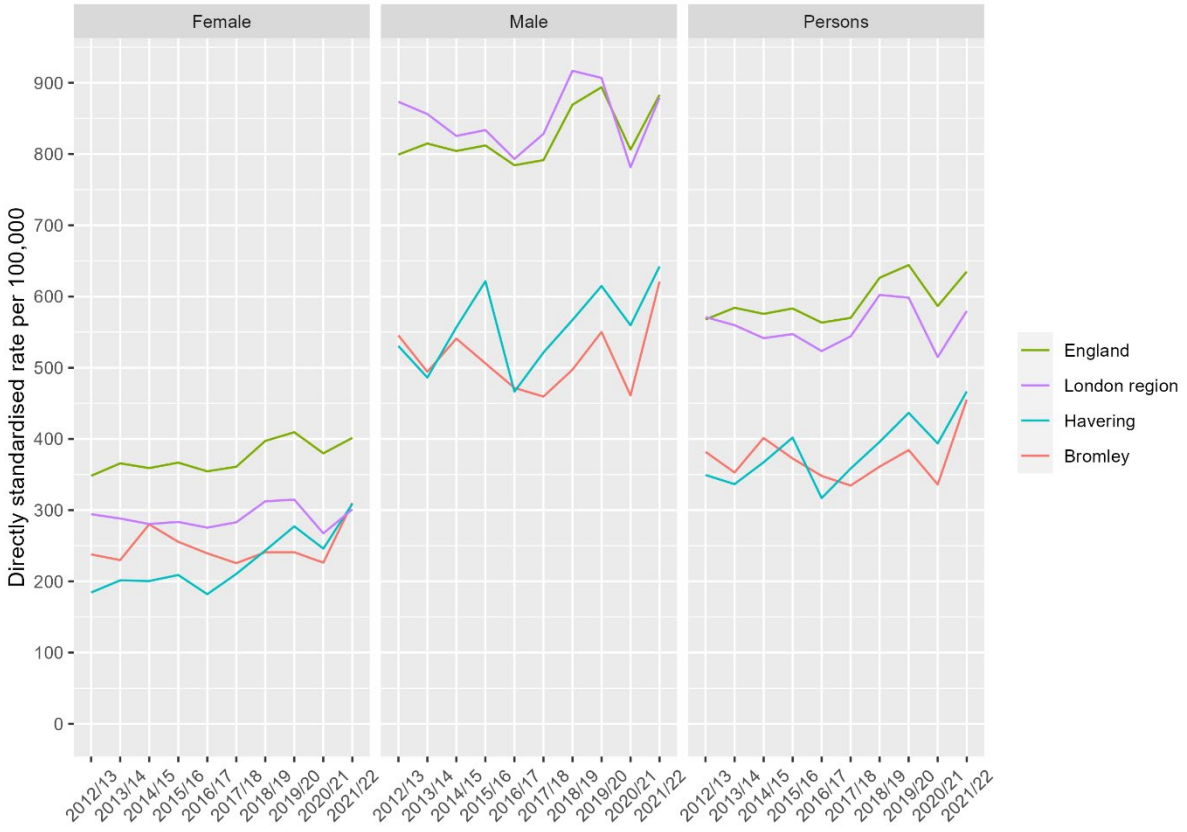

Figure 33: Directly age standardised rates of admission episodes for alcohol-specific conditions (primary or secondary diagnosis). Source: OHID Fingertips

7.1.2 Admissions by Condition

In 2019/20 to 2021/22, across the three years there were 747 admissions where the primary cause was due to alcohol specific conditions. In 2021/22 this was highest at 298 primary admissions and lowest in 2020/21 at 206 primary admissions.

Admissions due to alcohol-specific conditions can also be broken down into individual conditions as per the ICD-10 codes given in Table 6. As seen in figure 34, the most common alcohol-specific conditions for primary cause of admission are F10.3 (F103), followed by K70.3 (K703). These are mental and behavioural disorders due to use of alcohol - withdrawal state and alcoholic liver disease - alcoholic cirrhosis of liver respectively.

Figure 34: Number of total admission episodes from alcohol specific conditions containing each 4 character ICD10 code at primary diagnosis level: Bromley 1920-2122. Source: NHS digital (*numbers under 5 suppressed)

Whilst primary admissions allow us to identify that the main cause for admission was due to alcohol-specific conditions, in order to better understand alcohol specific morbidity, we must look at all fields of diagnosis. Figure 35 shows the number of admissions in Bromley in 2019/20-2021/22 where alcohol-specific conditions were mentioned in any diagnosis fields, primary or secondary. This demonstrates that the most common alcohol-specific morbidities are mental and behavioural disorders due to the use of alcohol (F10), followed by alcoholic liver disease (K70). F10.1 (F101) and F10.2 (F102) were the most common alcohol-specific conditions which presented during diagnosis during hospital admission. These are mental and behavioural disorders due to use of alcohol; harmful use and dependence syndrome respectively. During the three years there were 33 episodes involving accidental poisoning by and exposure to alcohol (X45) and 185 episodes involving intentional self-poisoning by and exposure to alcohol (X65).

Figure 35: Number of admission episodes by alcohol-specific ICD10 code (primary or secondary diagnosis): Bromley 2019/20-2021/22. Source: NHS digital (*numbers under 5 suppressed)

Figure 36 shows the rates of admission by ICD-10 code for Bromley, Havering, London, and England. In all areas the highest rates of admission were for mental and behavioural disorders due to the use of alcohol. However, the rate was lowest in Bromley, when compared to the 3 other areas, statistically significantly so. Bromley has comparable rates in all other areas to LBH. The rate of alcoholic liver disease (K70) and intentional self-poisoning by and exposure to alcohol (X65) was higher in England compared to the other three areas.

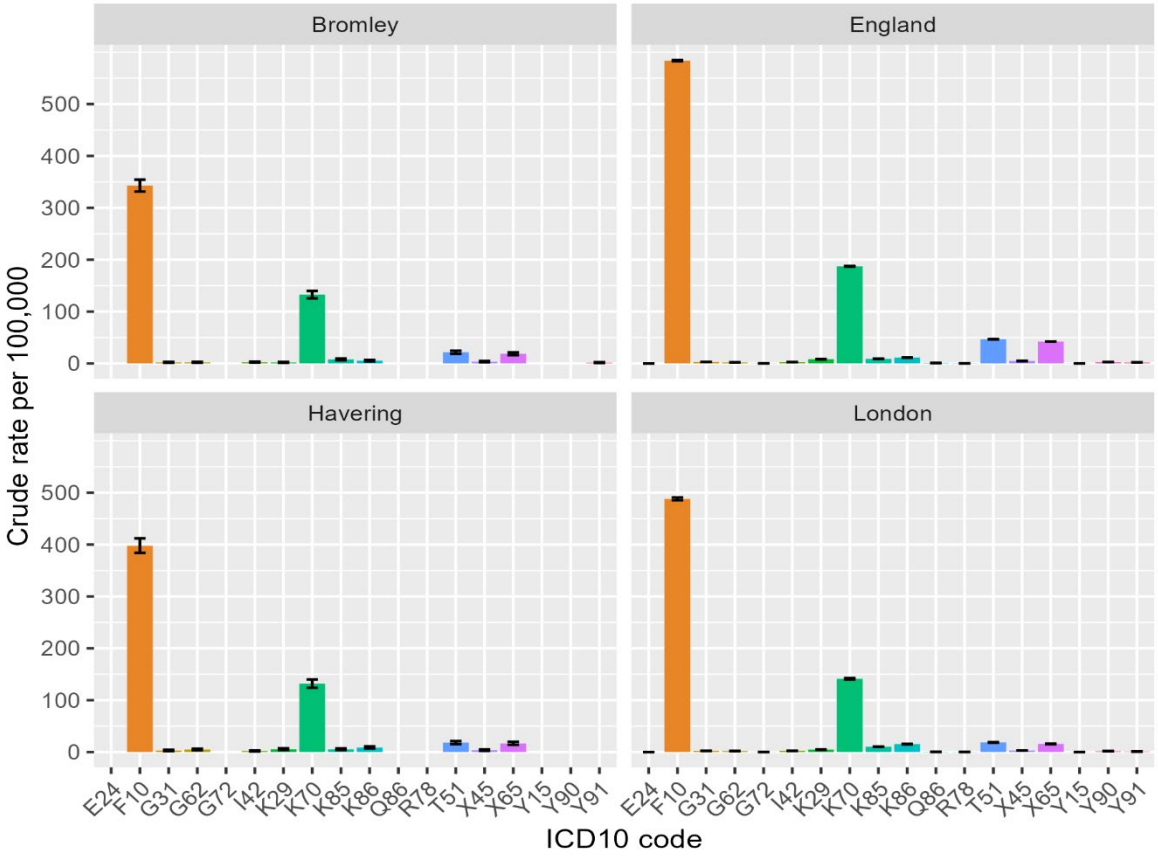

Figure 36: Crude rate of admission episodes by alcohol-specific ICD10 code (primary or secondary diagnosis): 2019/20-2021/22 in Bromley, Havering, London, and England. Source: NHS Digital

7.1.3 Admissions by age

Figure 37 demonstrates the number of Bromley admission episodes for alcohol specific conditions by age group in 2019/20 – 2021/22. The highest number of admissions for alcohol-specific conditions in Bromley over 2019/20 to 2021/22 are in the 55-64 age group where there were 862 admission episodes or nearly a quarter (23.1%) of all admissions (3,728) over that period. In Bromley, there were 17 admissions among those aged 0-16 in the three-year period and 117 admissions among those aged 17-24.

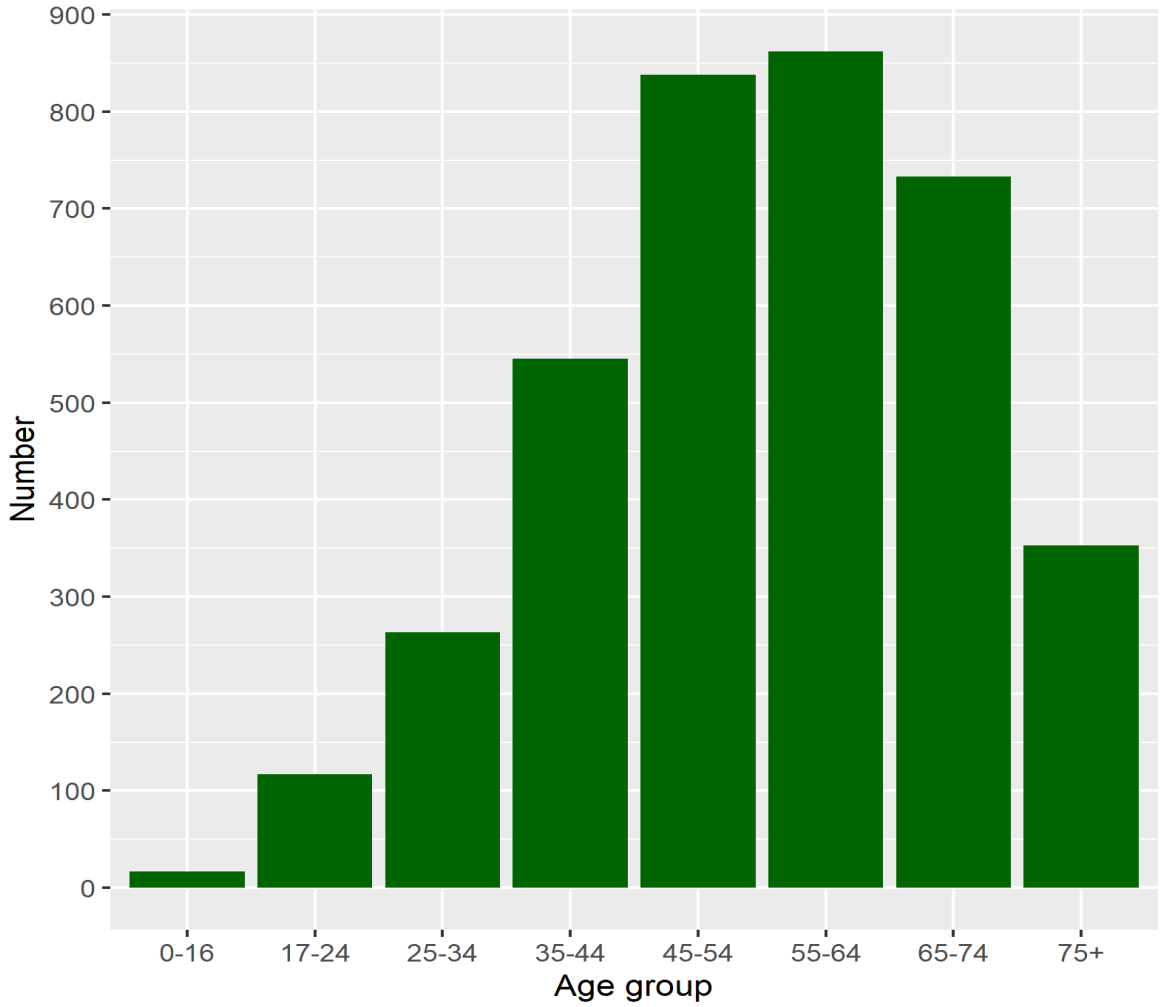

Figure 37: Number of admission episodes for alcohol specific conditions (primary or secondary diagnosis) by age group: Bromley 2019/20 - 2021/22.
Source: NHS Digital

Looking at the percentage of all admission episodes for alcohol specific conditions, by area and age group, generally there are higher proportions of admissions in older age groups from 35 up to the age of 74. This may reflect the cumulative effect of lifelong use of alcohol but also the combined effect of alcohol use and other comorbidities. Nearly three quarters (74.7%) of all admissions were among those 45 and over in Bromley, slightly higher than the other areas shown. All areas show an increase in percentage of admissions as the age band increases until those aged 55-64 (approximately 23% in all 4 areas shown), following this the percentage of all admissions decreases with age.

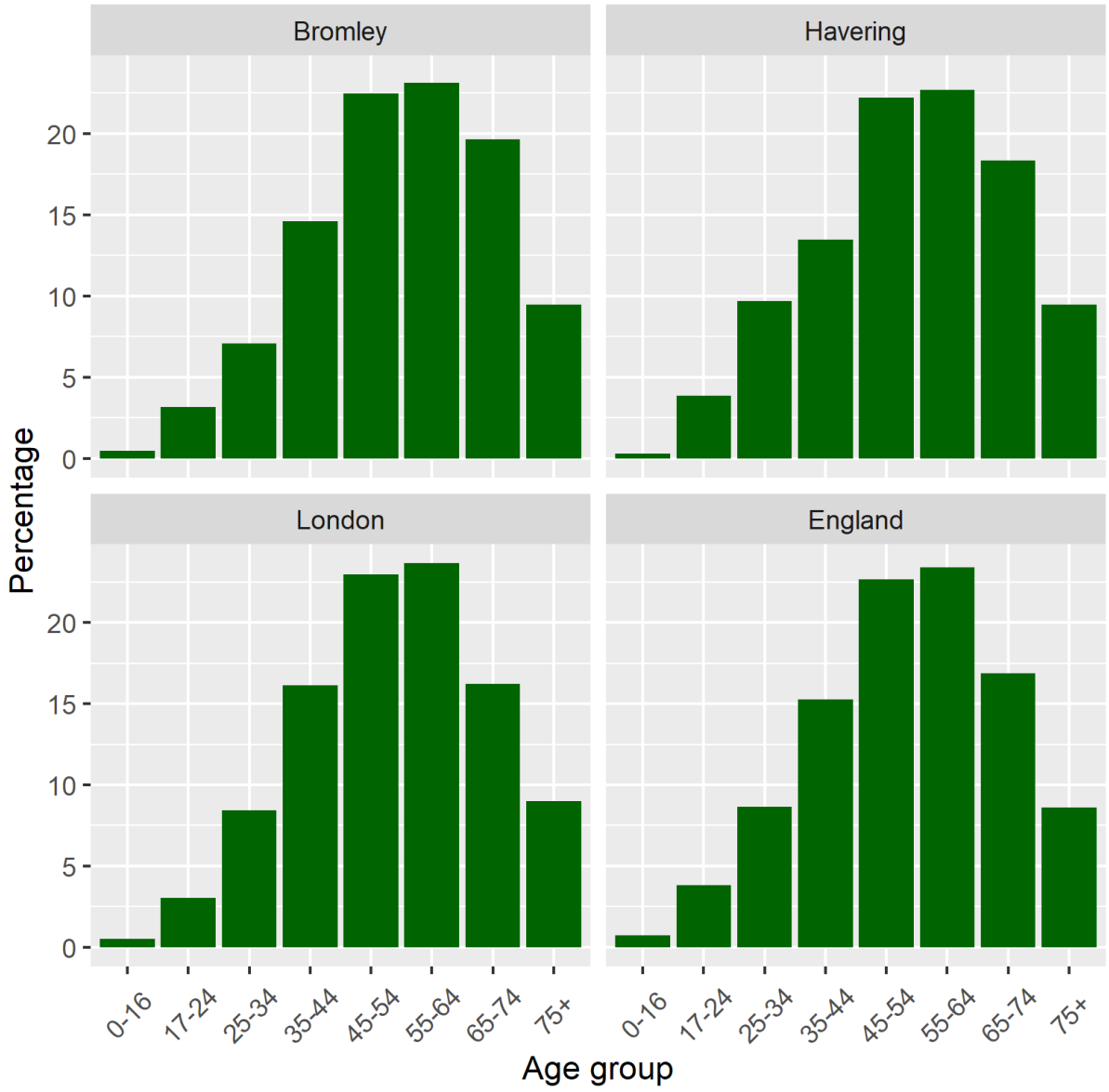

Figure 38: Percentage of total admission episodes for alcohol specific conditions (primary or secondary diagnosis) by age group: 2019/20 - 2021/22 in Bromley, Havering, London, and England. Source: NHS Digital

Crude rates shown in Figure 39 show a similar picture, although in Bromley the highest rate of admissions for alcohol-specific conditions is among those aged 65-74. The picture is similar in the other areas shown although in England the rate for the 55-64 age group is highest. Rates in Bromley are statistically significantly lower than London and England for those age groups 35-44 and older and while lower than Havering (Bromley's closest statistical neighbour) in all age groups apart from those 65 and over, these differences are generally not statistically significantly different.

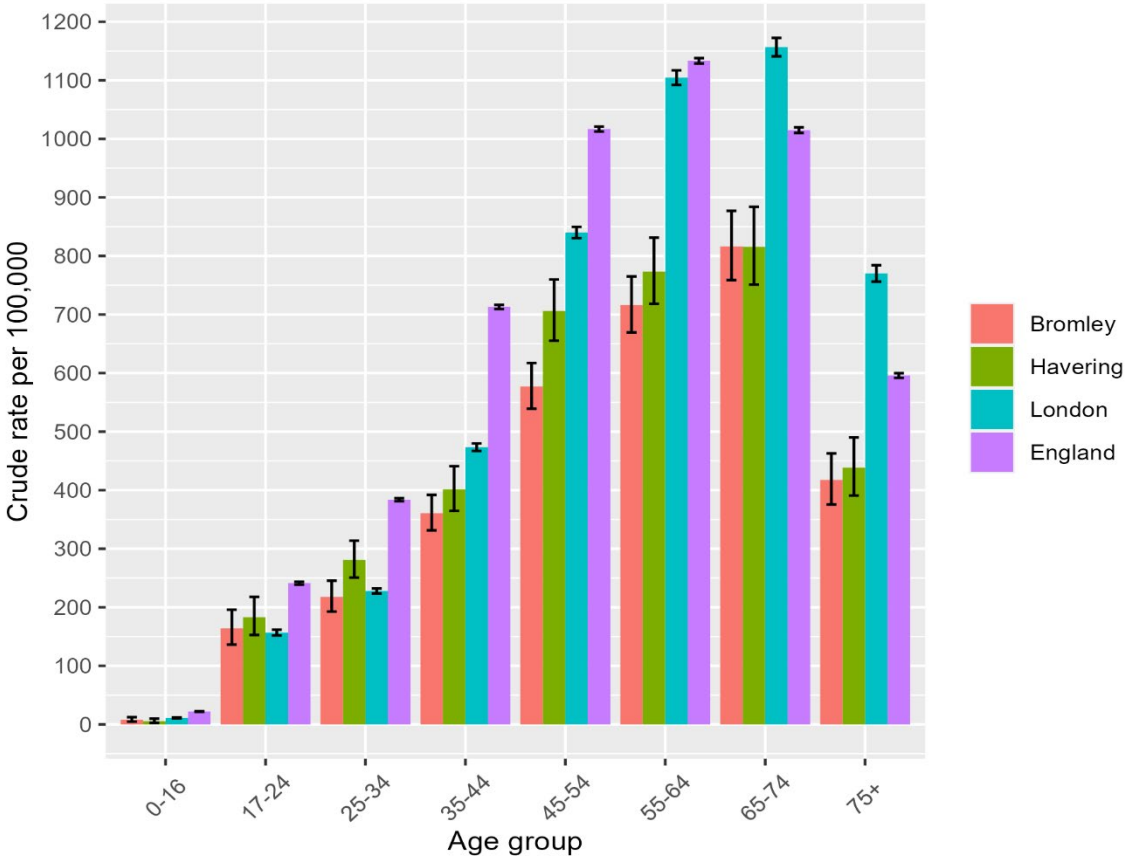

Figure 39: Crude rate of admission episodes for alcohol specific conditions (primary or secondary diagnosis) by age group: 2019/20 - 2021/22 in Bromley, Havering, London, and England. Source: NHS Digital

7.1.4 Admissions by Ethnicity

Figure 40 shows the crude rate of admission episode for alcohol related conditions by broad ethnic group between 2019/20 and 2021/22.

The “Other ethnic” group had the highest rate of hospital admissions for alcohol-specific conditions in 2019/20 – 2021/22 in Bromley and its comparators, statistically significantly so in comparison to Asian, Black and Mixed ethnic groups. Bromley has the lowest rate of the three areas in this ethnic group although this difference is not statistically significant, and most of the other ethnic groups except for the mixed ethnic group where it is higher than Havering but not significantly so. The white ethnic group has the second highest admission rates in Bromley and among its comparators.

In Bromley, the ethnicity of 519 admissions out of 3,727 in total (13.9% of admissions) in the 2019/20 – 2021/22 period was not recorded or known (these have

been excluded from the analysis in Figure 40), which may impact the results if these are not proportionately distributed amongst the ethnic groups. This rate of unknown ethnicity is higher than both LBH (5.2%) and London (13.3%). It should also be considered as to how ethnicity is allocated to the various ethnic groups.

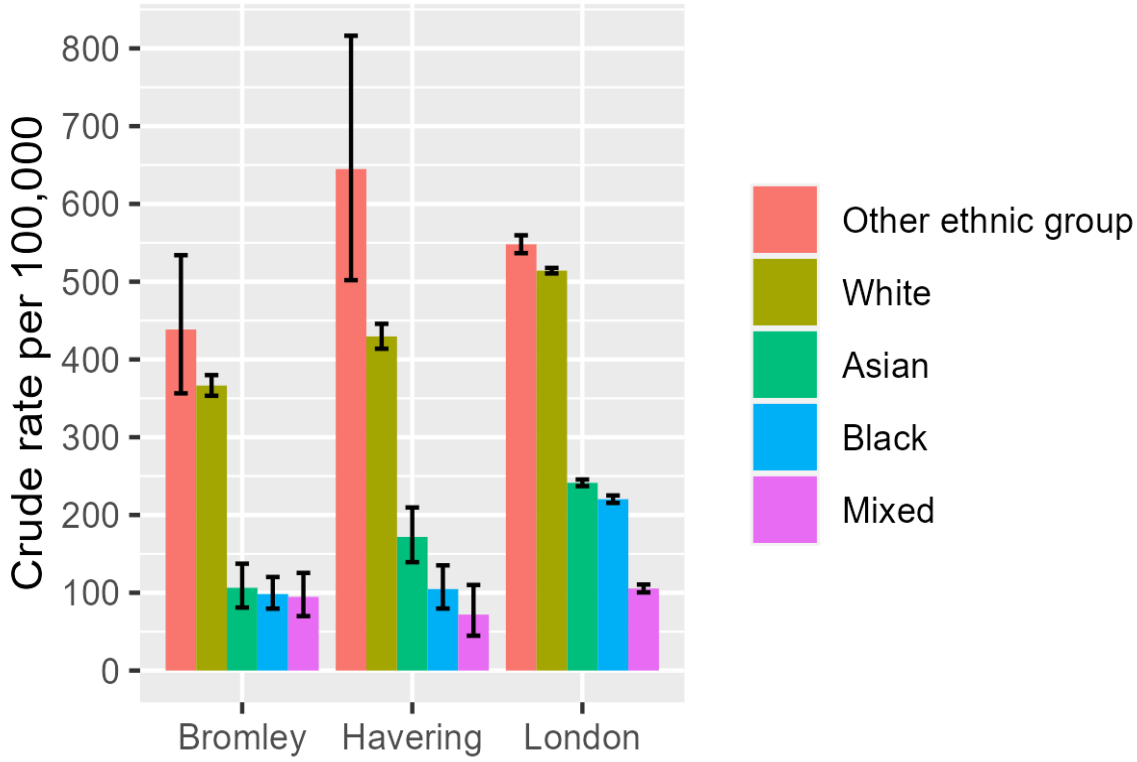

Figure 40: Crude rate of admission episodes for alcohol specific conditions (primary or secondary diagnosis) by broad ethnic group: 2019/20 - 2021/*22 in Bromley, Havering and London*. Source: NHS Digital

7.1.5 Admissions by Ward and Deprivation

Across Bromley there are different rates of admission by ward, which can be observed from the ward map (Figure 41). The map is shaded by IMD Quintile (with red being among the most deprived 20% of areas in the UK, and blue being the least). Also shown are the rates of hospital admissions in each ward due to alcohol-specific conditions, with the biggest circle representing the highest rate. Penge and Cator has the highest alcohol specific hospital admission rate at 561.8 people per 100,000 population, two and a half times the rate for Hayes and Coney Hall at 219.9 per 100,000. Penge and Cator is in the North West of the borough and has some of the most deprived Lower Super Output Areas (LSOAs) in Bromley located within it.

Figure 41: Crude rate of admission episodes for alcohol specific conditions (primary or secondary diagnosis) by Bromley ward against LSOA national deprivation quintile: 2019/20 - 2021/22 Source: NHS Digital; IMD 2019

An analysis looking at alcohol-specific hospital admissions by deprivation indicates that the most deprived areas have the highest rates. To describe this relationship, the Index of Multiple Deprivation (IMD) is used. Each small area in England has an IMD score, which is a measure of deprivation in local areas. It uses seven domains comprising of income, employment, education, skills and training, health and disability, crime, barriers to housing services, and living environment. The admission

data is split according to the IMD decile of the LSOA in which the admitted person is resident, where decile 1 is the most deprived 10%, and 10 is the least deprived, and admission rates calculated for the LSOAs in each decile.

The relationship between IMD decile and rate of admission is shown in Figure 42. Rates of admission in England are around 3.6 times higher in the most deprived decile compared to the least deprived decile. This difference is almost the same in Bromley and slightly less pronounced in London as a whole.

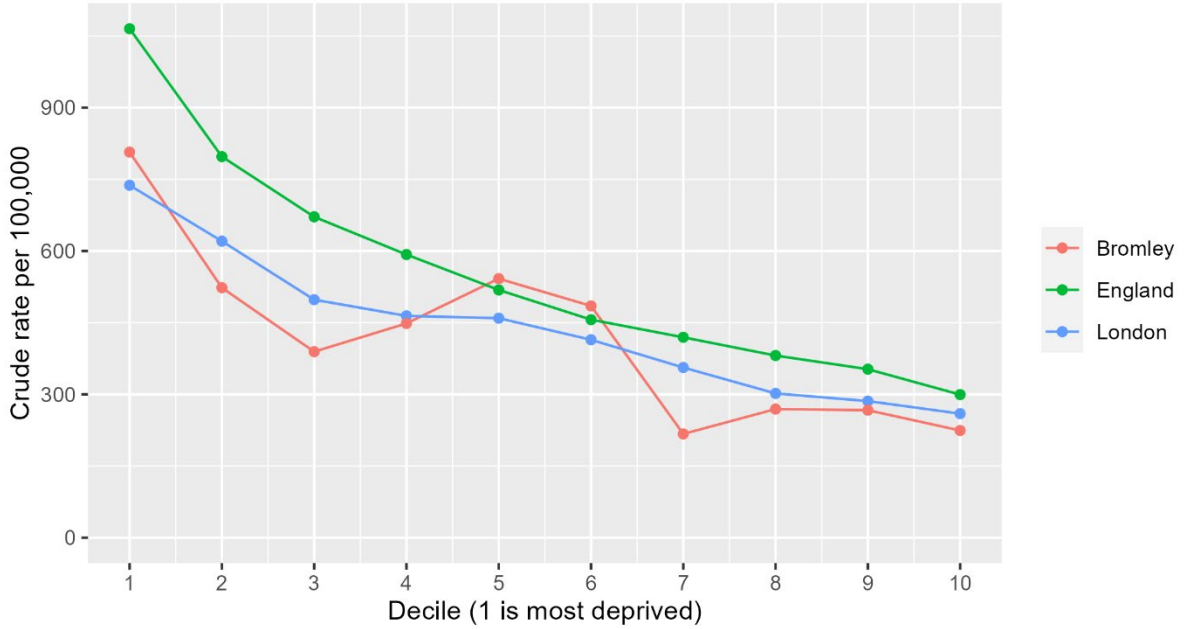

Figure 42: Crude rate of alcohol-specific admission (primary or secondary diagnosis) by IMD decile (2020-2021) Source: NHS Digital; IMD 2019

The scattergram (Figure 43) indicates a fairly strong relationship between rates of admission and the average ward deprivation scores in Bromley shown by the R value of 0.82. The regression model indicates around two thirds of the variation in admission rates is explained by deprivation (R2 = 0.67). This scattergram, compared to that showing lower tier local authorities in England, may show a stronger relationship between admission rates and deprivation as the wards are smaller areas so the variation in deprivation within them may be less.

Figure 43: Crude rate of admission episodes for alcohol-specific conditions (primary or secondary diagnosis) by Bromley ward (2019/20 - 2021/22) against ward average deprivation score Source: HES; OHID; ONS (Rates use mid-2020 population estimates multiplied by 3 for denominators)

7.2 Alcohol-Specific Mortality

Alcohol mortality can be categorised into two groups of deaths: alcohol-specific and alcohol-related deaths.

Alcohol-specific deaths only include those health conditions where each death is a direct consequence of alcohol misuse (wholly attributable causes). The ICD-10 codes that are wholly attributed to alcohol-specific deaths are listed in Table 7. Alcohol-specific deaths exclude causes of death where there is evidence showing that only a proportion of the deaths for a given condition are caused by alcohol. These are known as partially attributed deaths or alcohol-related deaths. The proportion of disease attributable to alcohol is calculated using a relative risk specific

to each disease, age group and sex, combined with the prevalence of alcohol consumption in the population. All mortality records containing an attributable disease are extracted, and the age and sex-specific fractions are applied.

ICD-10 code	Description of condition
E24.4	Alcohol-induced pseudo-Cushing's syndrome
F10	Mental and behavioural disorders due to use of alcohol
G31.2	Degeneration of nervous system due to alcohol
G62.1	Alcoholic polyneuropathy
G72.1	Alcoholic myopathy
I42.6	Alcoholic cardiomyopathy
K29.2	Alcoholic gastritis
K70	Alcoholic liver disease
K85.2	Alcohol-induced acute pancreatitis
K86.0	Alcohol-induced chronic pancreatitis
Q86.0	Fetal-induced alcohol syndrome (dysmorphic)
R78.0	Excess alcohol blood levels
X45	Accidental poisoning by and exposure to alcohol
X65	Intentional self-poisoning by and exposure to alcohol
Y15	Poisoning by and exposure to alcohol, undetermined intent

Table 7: ICD-10 codes relating to alcohol specific deaths. Source: ICD-10 and ONS.

The Primary Care Mortality Database (PCMD) allows authorised users to access mortality data provided at death registration. Data is released monthly and is managed by NHS Digital. From the underlying cause of death in the PCMD, ICD-10 codes can be used to identify the cause of death, including alcohol specific (using the ICD-10 codes in table 7) and alcohol-related deaths.

In 2020 and 2019, there were 85 alcohol-related deaths each year. The rate of alcohol-related deaths for these two years was 27.1 per 100,000; this is lower than the London and England rates. The alcohol-specific mortality rates, as expected, are lower than the alcohol-related rates for these years. Figure 44 shows there has been a decline in mortality rates since 2014/16 in Bromley and its closest statistical neighbour Havering. Alcohol-specific mortality rates are lower in Bromley than in England and generally lower than in London, although there has been some variability over recent years. The decrease in alcohol-specific deaths in recent years does not appear consistent with the increasing hospital admission rates, indicating an increase in harmful alcohol use. This requires further investigation. However, this may result from delays in the registration of deaths during the Covid-19 pandemic.

Alcohol-specific mortality rates are higher in men than women in all areas investigated. This matches similar observations in the rates of hospital admissions, whereby there are higher admissions rates in men.

Interestingly, there has been a rapid incline and decrease in male alcohol-specific mortality rates in both Bromley and Havering between 2010-12 and 2019-21. During this period, Bromley's male alcohol-specific mortality rate increased from 9 per 100,000 to 12.7 per 100,000 in 2014-16 and dropped to 8.7 per 100,000 in 2019-21. There were no significant increases in the rate of alcohol-specific mortality for women during this period.

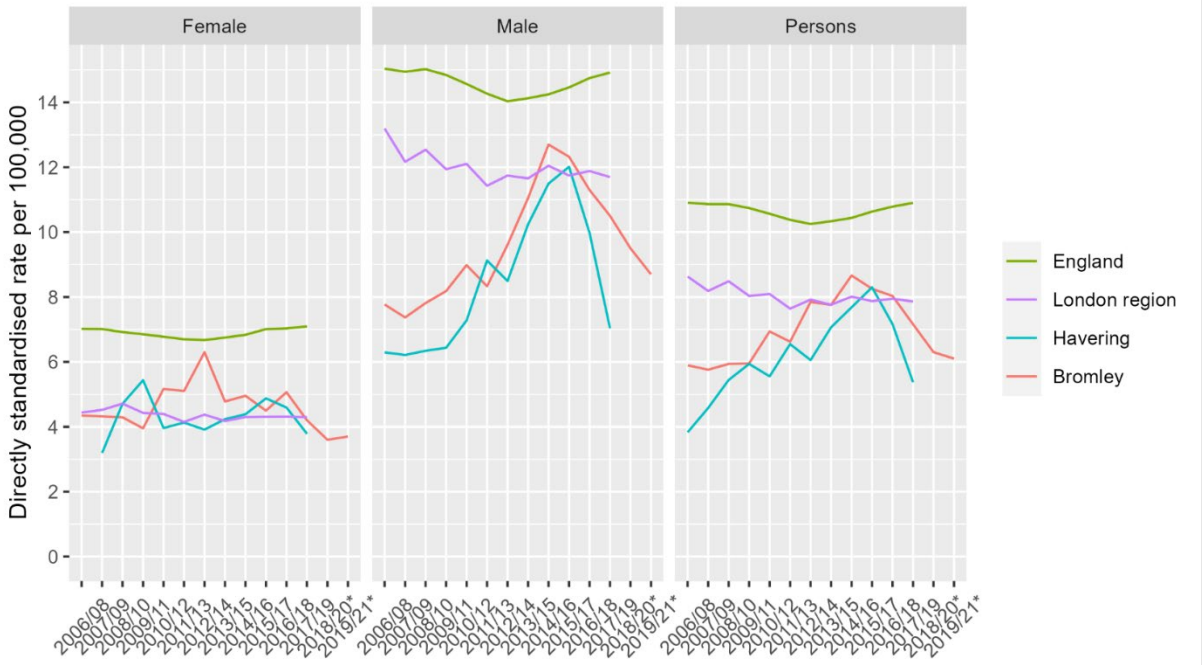

Figure 44: Directly age standardised rates of alcohol-specific mortality*. Source: Fingertips, ONS. (* 2019/21 rates calculated inhouse using mid 2020 ONS population estimates. Rates for 2018/20 and 2019/21 may differ slightly to those when officially published)

7.2.1 Overall Mortality and by Gender

Figure 45 shows there were 59 alcohol-specific deaths in Bromley in 2019-21. Since 2014-16 there has been a decrease in alcohol-specific deaths. This can be largely attributed to the reduction of male deaths.

Around two-thirds of all deaths in Bromley from alcohol-specific conditions are among men. This reflects the picture of hospital admissions seen in section 7.1.1, where men nearly account for two-thirds of alcohol-specific morbidity. There has been a steady decrease in the number of female deaths in Bromley since 2012-14. There was a peak in female alcohol-specific deaths in 2016-18. The number of male alcohol-specific deaths increased from 2012-14 to 2015-17 and decreased from 2015-17 to 2019-21.

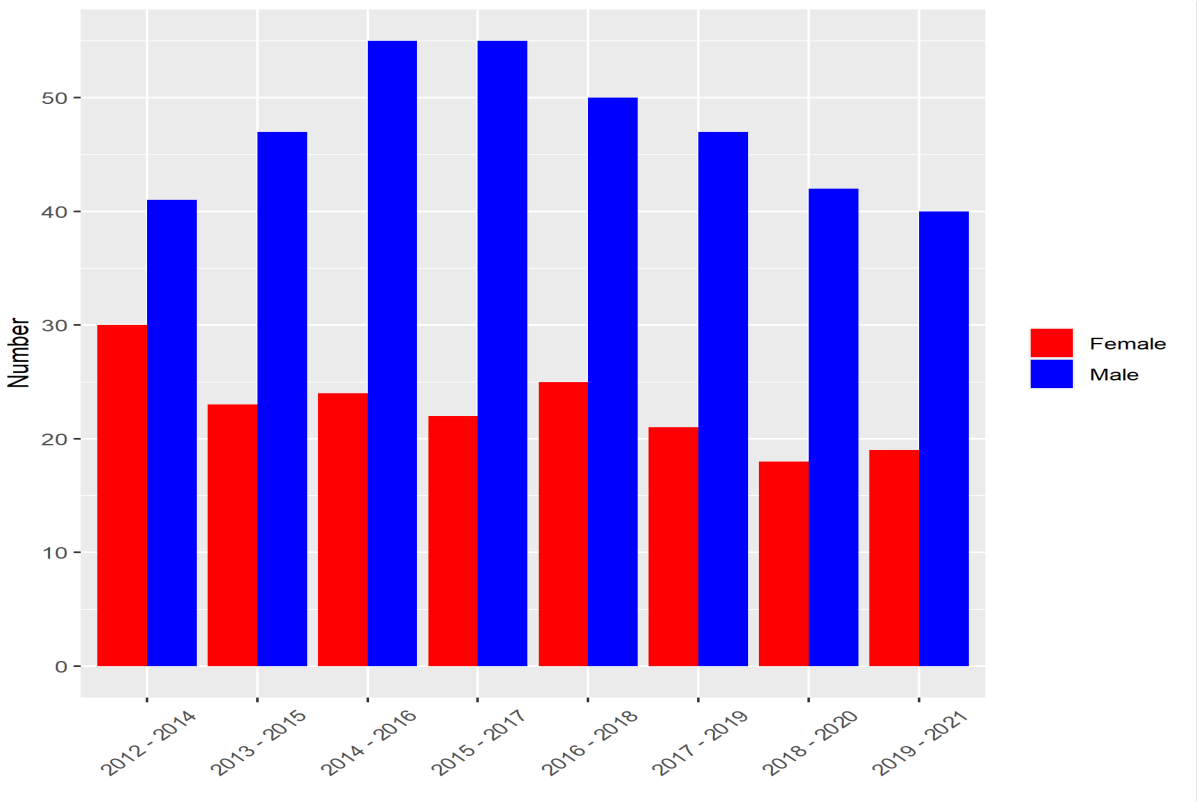

Figure 45: Number of deaths from alcohol-specific conditions by Gender: Bromley (2012-14 to 2019-21). Source: PCMD

7.2.2 Mortality by age

Figure 46 shows the number of alcohol-specific deaths by age group. The highest number of fatalities from alcohol-specific conditions in Bromley during 2017-2021 were among the 55-64 age group. This age group contributed to 41 (38%) out of the total 108 alcohol-specific deaths between 2017 and 2021. 85% of deaths were among those aged 45 and over. There were no deaths among those under 25 in the five years. This reflects a similar picture in hospital admissions: nearly three-quarters (74.7%) of all admissions were among those 45 and over in Bromley.

Similarly to hospital admissions for alcohol-specific conditions, alcohol-specific deaths likely reflect the cumulative effect of lifelong use of alcohol but also the combined impact of alcohol use and other comorbidities.

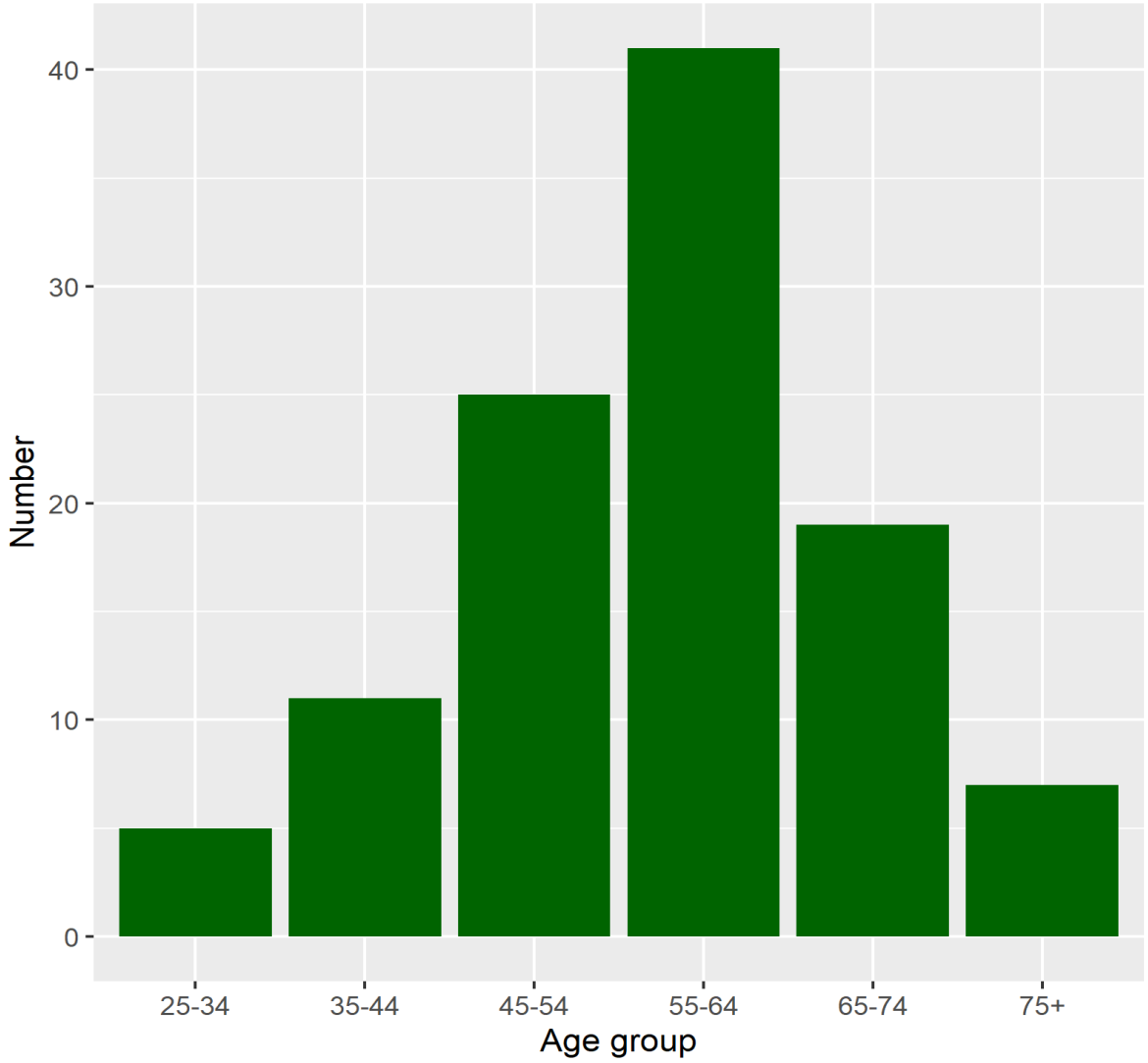

Figure 46: Number of deaths from alcohol-specific conditions by age group: Bromley 2017-2021. Source: PCMD

Crude rates shown in figure 47 show a similar picture, where the highest rate in Bromley is in those aged 55-64 years. The rate of alcohol-specific deaths increases from 25-34 to 55-64 years and then decreases.

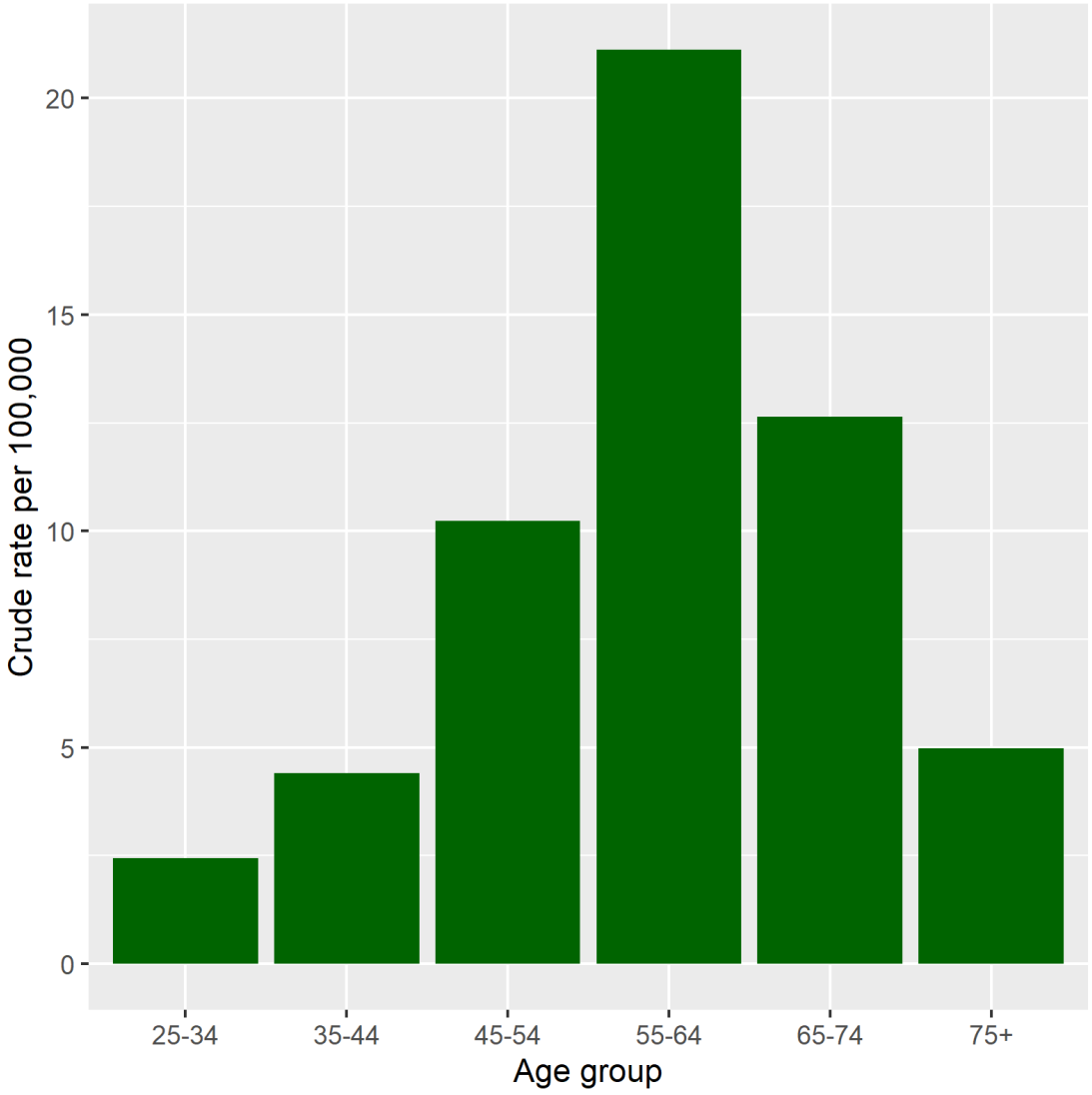

Figure 47: Crude rate of deaths from alcohol-specific conditions by age group: Bromley 2017-2021. Source: PCMD

7.2.3 Mortality by ward

Across Bromley there are different rates of mortality by ward, which can be observed from the ward map (figure 48). The map is shaded by IMD Quintile (with red being among the most deprived 20% of areas in the UK, and blue being the least). Also shown are the rates of mortality in each ward due to alcohol-specific conditions, with the biggest circle representing the highest rate.

Copers Cope has the highest alcohol-specific death rate at 12 per 100,000, followed by Penge and Cator and Cray Valley West at 10 per 100,000. Penge and Cator and Cray Valley West have some of the most deprived LSOAs in Bromley located within them.

Figure 48: Crude rate of deaths per 100,000 from alcohol-specific conditions in Bromley wards against LSOA national deprivation quintile: 2017-2021 Source: PCMD; IMD 2019 (Rates use mid-2019 population estimates multiplied by 5 for denominators)

Numbers are too small, and many wards don't have any deaths in the five years to draw specific conclusions regarding the impact of deprivation on alcohol-specific mortality.

7.2.4 Mortality by condition

Figure 49 shows the percentage of alcohol-specific deaths (2017-21) attributed to Bromley's ICD-10 codes of interest. The ICD-10 codes represent most but not all of the deaths in Bromley in that period.

Alcoholic liver disease was Bromley's most common cause of death (K70) in the five years 2017-2021, attributed to 76% of deaths from alcohol-specific conditions. Of the

four-character ICD-10 codes that make up K70, K70.3 (K703) and K70.4 (K704) had the highest number of deaths. Interestingly, while most hospital admissions were due to mental and behavioural disorders due to the use of alcohol (F10), this only accounted for 11.1% of all alcohol-specific deaths.

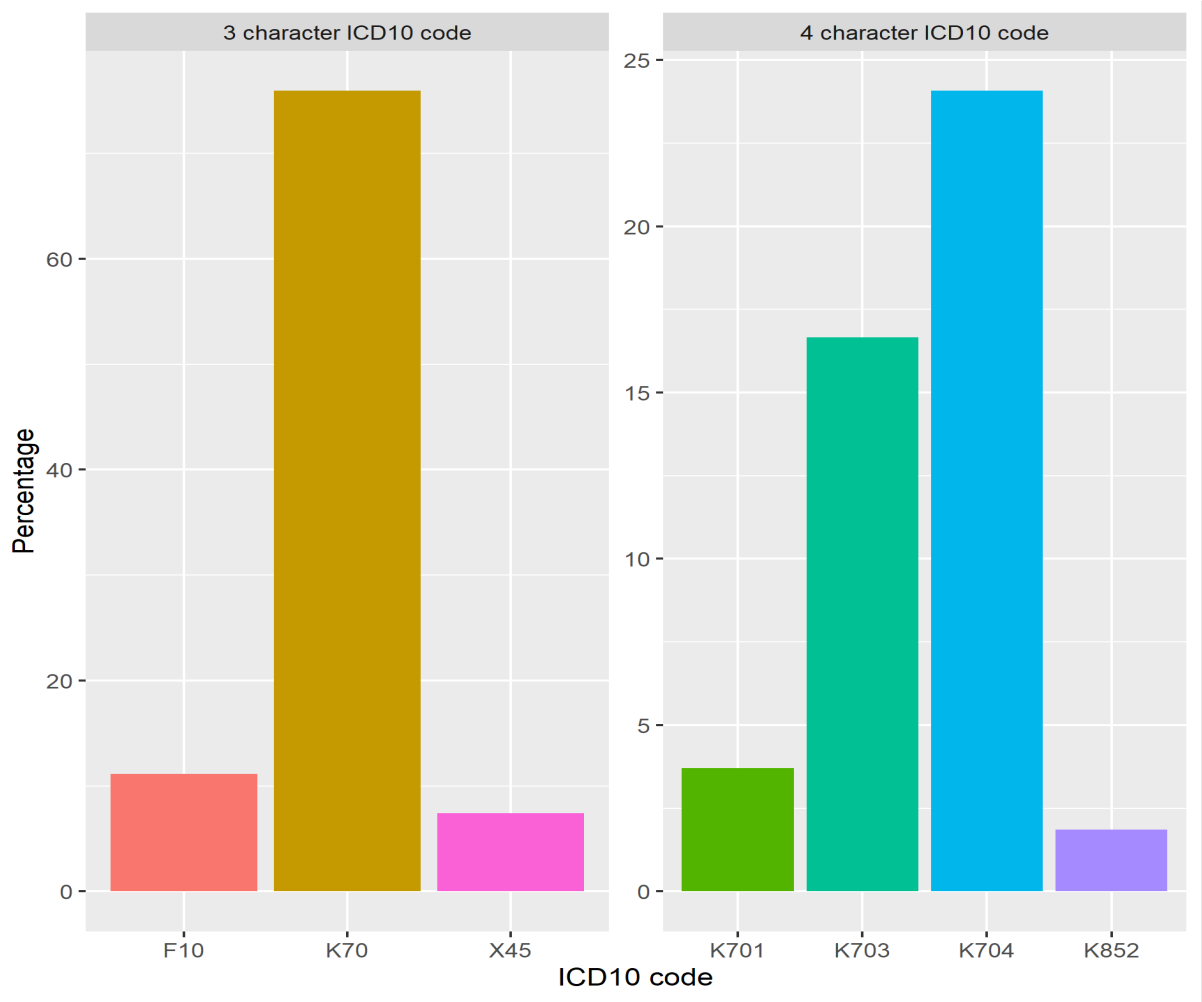

Figure 49: Percentage of deaths from ICD-10 codes of interest: Bromley 2017-2021. Source: PCMD

Key Points of the Chapter:

- In 2021/22, 64.2% of all Bromley admissions due to alcohol-specific conditions were men, 921 out of 1,434 admissions.
- The highest number of admissions for alcohol-specific conditions in Bromley over 2019/20 to 2021/22 are in the 55-64 age group where there were 862 admission episodes or nearly a quarter (23.1%) of all admissions (3,728) over that period.
- The most common alcohol-specific condition for primary cause of admission in Bromley is F10.3 (mental and behavioural disorders due to use of alcohol withdrawal state), followed by K70.3 (alcoholic cirrhosis of the liver). F10.1 and F10.2 (mental and behavioural disorders due to use of alcohol, harmful use and dependence syndrome respectively) were the most common alcohol-specific conditions which presented during diagnosis during hospital admission.
- Penge and Cator has the highest alcohol specific hospital admission rate at 561.8 people per 100,000 population, two and a half times the rate for Hayes and Coney Hall at 219.9 per 100,000.
- Rates of admission in England are around 3.6 times higher in the most deprived decile compared to the least deprived. This difference is almost the same in Bromley and slightly less pronounced in London as a whole.
- Since 2014-16 there has been a decrease in alcohol-specific deaths.
- Around two-thirds of all deaths in Bromley from alcohol-specific conditions are among men.
- The highest number of deaths from alcohol-specific conditions in Bromley during 2017-2021 were among the 55-64 age group.
- Alcoholic liver disease was Bromley's most common cause of death (K70) in the five years 2017-2021, attributed to 76% of deaths from alcohol-specific conditions.
- Interestingly, while most hospital admissions were due to mental and behavioural disorders due to the use of alcohol (F10), this only accounted for 11.1% of all alcohol-specific deaths.

8. Alcohol Services for Adults and Young People

The Bromley Drug and Alcohol Service (BDAS) is currently provided by Change, Grow, Live (CGL). This is for both adults and young people, but these are separately commissioned services by LBB. The adult services are based out of two locations in Bromley, whilst the young person service, Bromley Changes, has one location. There is also a satellite service based at Broomwood Surgery in Cray Valley West.

In addition to the treatment services described below, Primary Care practice staff deliver Identification and Brief Advice to their patients or as part of the National Health Checks programme.

8.1 Structure of Services

8.1.1 Adult Service – Bromley Drug and Alcohol Service (BDAS)

Referrals into the adult services can come from any source, including self-referrals and referral by friends and family. To refer, a referral form is filled out. This is then assessed at the team briefings each morning and allocated to a worker. The individual should have an assessment within 5 days of their case being allocated. During assessment it is identified if the service user has alcohol dependence and subsequently requires detox or if the individual is not alcohol dependent and requires harm reduction treatment.

Due to Covid-19, many initial assessments and subsequent follow ups are being completed over the telephone. However, if a service user needs to be seen then face to face consultations are still going ahead. This can include seeing the specialist nurse, doctor, having bloods for Blood Borne Virus (BBV) screening, immunisations, and supervised consumption of medications. To allow flexibility, BDAS are still offering initial assessments either virtually or in person.

Service users will enter a programme of treatment. Structured treatment is locally defined as a service user who has had an initial consultation and two subsequent follow ups. They will then enter effective treatment either for detox or harm reduction treatment, both treatment programmes usually last 12 weeks, and then aftercare takes over. Treatment is often community-based.

Those who are alcohol dependent or thought to be alcohol dependent on initial assessment will undergo a nurse alcohol assessment, followed by blood test, identify

carer, GP summary obtained, community detox and then subsequent aftercare options. Those undergoing harm reduction treatment from the initial assessment will undergo pod work with a keyworker and subsequent aftercare options.

Those that require detox are often prescribed medication to help achieve abstinence. This treatment plan includes 7 days of medication (7-day detox from Monday to Sunday) and subsequent support groups and psychosocial interventions. Those that aren't alcohol dependent and don't require abstinence from alcohol, are supported to reduce their alcohol content and the harm this may cause. Harm reduction interventions include support groups and psychosocial interventions.

Community support groups and psychosocial interventions have adopted hybrid working, where sessions are available online and in person.

Similar to substance misuse, there are also residential or inpatient substance misuse services that BDAS funds (Tier 4). These services are usually reserved for service users who have repeatedly found that community treatment does not work, or for those with extreme social circumstances that require admission. At present, BDAS holds the budget to fund these placements, but the decision is made by the Substance Misuse Practice Review Group (SMPRG). This is a panel led by the local authority, where applications for Tier 4 funding are discussed and approved or rejected. This panel is being reviewed in a separate piece of work, which will provide both short- and long-term recommendations to improve the process.

The service will also link in with other services and charities, offering holistic support.

The services are commissioned by LBB, therefore there are quarterly contract monitoring meetings. At these meetings, key performance indicators (KPIs) as agreed in the service specification are reviewed, alongside the budget.

8.1.2 Co-Occurring Mental Health, Alcohol and Drugs (COMHAD) Service– Oxleas NHS Foundation Trust

The COMHAD service works with adults with any alcohol and/or drug use and co-occurring mental health conditions with the intention of supporting both Bromley mental health and Bromley substance misuse services. The service aims to enable the long-term recovery, rehabilitation and social re-integration of people in Bromley affected by co-occurring substance use and mental ill health.

The COMHAD Service consists of specialist practitioners. The team is managed by the COMHAD Consultant Nurse in Adult Mental Health, and the service is located within Oxleas Mental Health Services.

The COMHAD team offers the following services:

- Screening and assessment
- Care plan developed with the client with agreed review dates
- Time limited treatment specific joint work with BDAS
- Joint case working with BDAS with attendance at weekly clinical meetings
- Referral on for clients with a substance misuse problem, who are not appropriate for mental health services
- Consultancy and advice on individual crisis plans in relation to substance use for mental health services
- Substance misuse training to Bromley adult mental health services.

The key service priorities are as follows:

- To improve the identification and assessment of problematic drug and alcohol use within Bromley Primary Care Plus/IAPT and Bromley Mental Health Crisis Services
- Support engagement with appropriate treatment services for those identified with a co-occurring mental health and substance use need
- Increase access to BDAS through established care pathways
- Reduce admissions for (purely) detoxification in Oxleas Mental Health inpatient services
- Ensure evidence-based practice in relation to the care and treatment of clients with co-occurring mental health and substance use need is delivered in a consistent manner.

The services are commissioned by LBB, therefore there are quarterly contract monitoring meetings. Here, key performance indicators (KPIs) as agreed in the service specification are reviewed, alongside the budget.

8.1.3 Young People Substance Misuse Services in Bromley

The young people's substance misuse service for under 18's in Bromley is called Bromley Changes. Their provision includes treatment for young drug and alcohol users, and an offer of early intervention support around resilience and recovery. In addition, they also identify and support children and young people living with, and affected by, parental and/or other household members' substance use.

Treatment in Bromley Changes mainly focuses around psychosocial and harm reduction techniques. Very few young people who access Bromley Changes for alcohol purposes require alcohol detox. There is currently no use of pharmacological interventions in young people's services.

Young people referred to Bromley Changes for alcohol harm reduction are offered an initial brief intervention as part of their initial assessment. Following this the service user is offered a structured intervention for either alcohol dependency or harm reduction. This structured intervention unlike for adults is open ended with many people accessing services for 12-24 months. If young people require clinical assessment this intervention is managed by BDAS.

Training and support are also provided by Bromley Changes to partners to help front line practitioners better understand alcohol use. The training provided focuses on behaviour change strategies that help build resilience in young people with an overall aim of promoting healthy behaviours and reducing risk behaviours.

8.2 Service Users in BDAS

The analysis for section 8.2 has been completed on all clients in treatment with BDAS where alcohol is listed as a problem substance.

8.2.1 New Service Users

As of the end of July 2022, the detox pathway caseload for BDAS stands at 56 clients (38%) in treatment and the harm reduction/drink-down pathway caseload stands at 93 clients (62%).

In the year ending March 2022, 185 new alcohol-only service users engaged with BDAS and 66 new alcohol and non-opiate users. The total number of new presentations in 2021/22 for all substances where one of the problem substances is

alcohol ("opiate and alcohol", "opiate, alcohol, and non-opiate", "alcohol only", "alcohol and non-opiate only") is 262.

Throughout the last five years, there has been an increase in the number of new presentations at BDAS related to alcohol. This increase in alcohol presentations is mainly due to the number of new alcohol-only presentations to the service, with a continuous increase across the five reported years. In the last three years, there has been no increase in the annual number of new presentations for alcohol and non-opiate only users.

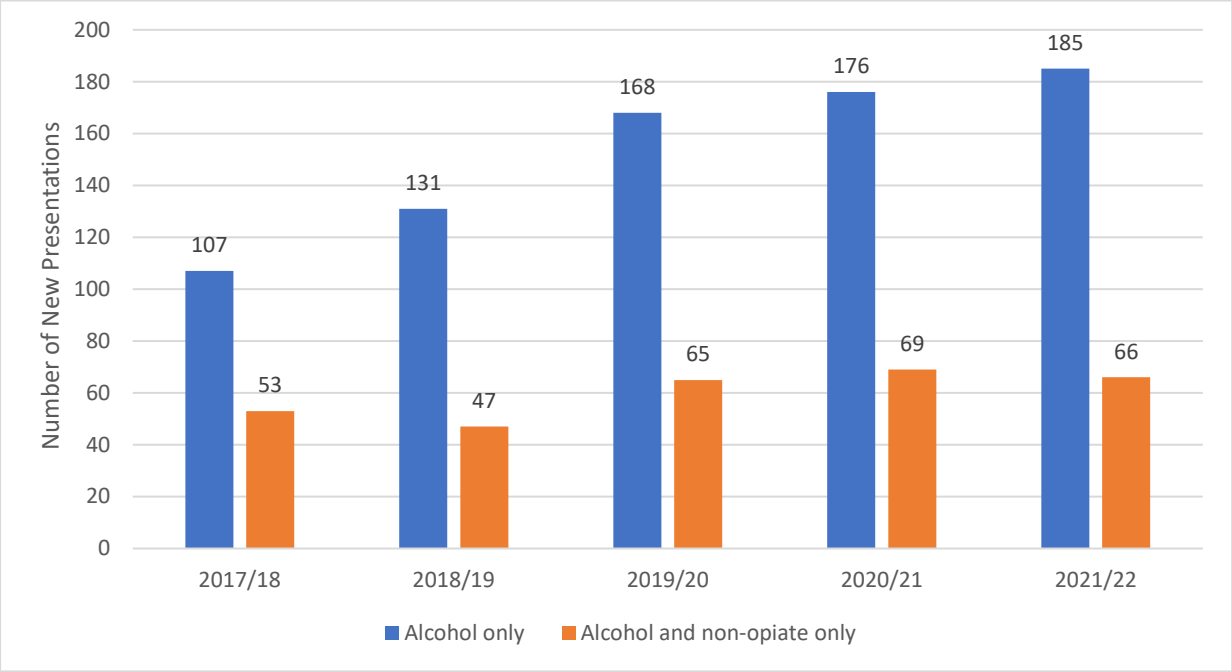

Figure 50: Number of new alcohol only and alcohol and non-opiate only presentations by year (2017/18 to 2021/22) Source: NDTMS

8.2.2 Total Service Users

There were 245 alcohol-only service users in BDAS during the 2021/22 period (ending 31 March 2022) and 86 alcohol and non-opiate-only service users. The total number of people in treatment in 2021/22 where alcohol is listed as a problem substance is 376.

As shown in Figure 51, over the five years reported there have been two periods of a notable increase in the number of alcohol-only service users in treatment. These included between 2018/19 and 2019/20 (an increase of 41 people) and then between 2019/20 and 2020/21 (an increase of 28 people). In the last two years,

there has been no significant change in the number of service users in treatment for alcohol-only and alcohol and non-opiate-only.

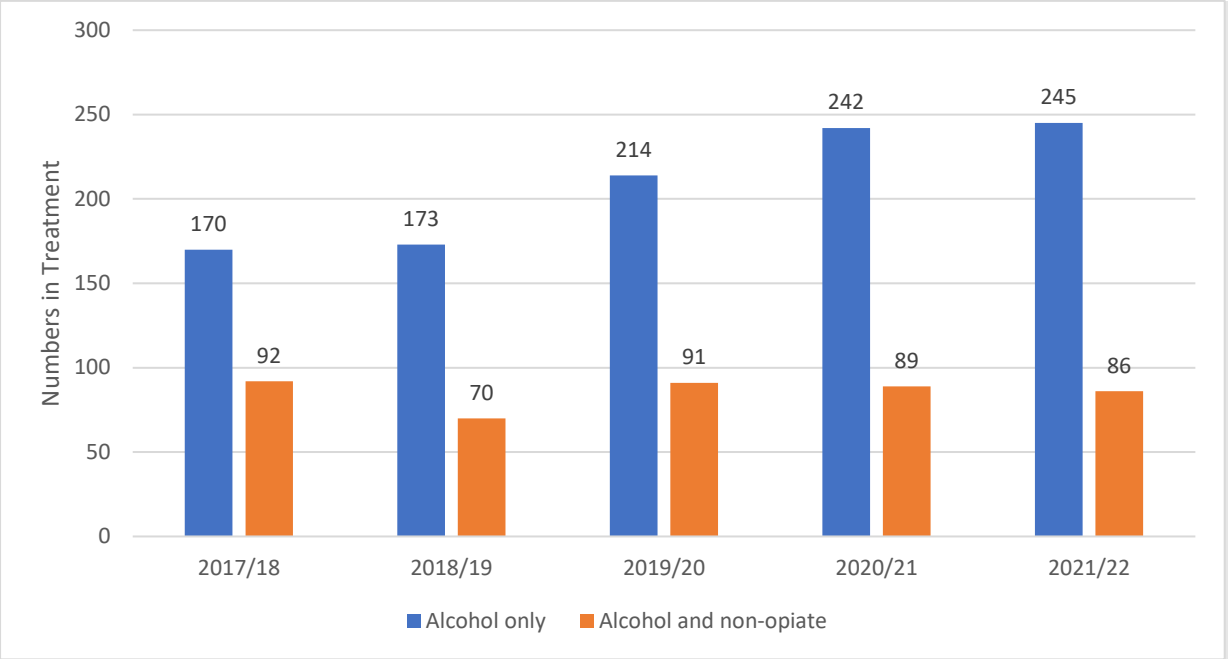

Figure 51: Number of clients in treatment, alcohol only and alcohol and non-opiate only presentations by year (2017/18 to 2021/22) Source: NDTMS

In 2021/22, most people in treatment where alcohol is mentioned as a problem substance were predominately in treatment for alcohol only (n=245, 65%), followed by alcohol and non-opiate only (n=86, 23%). This is shown in Figure 52. In 2021/22, the other substances cited in treatment by alcohol users were predominantly cannabis, cocaine and opiates and crack, as seen in Figure 53.

Figure 52: Number of clients in treatment, breakdown of where alcohol is mentioned as a problem substance in treatment (2017/18 to 2021/22). Source: NDTMS

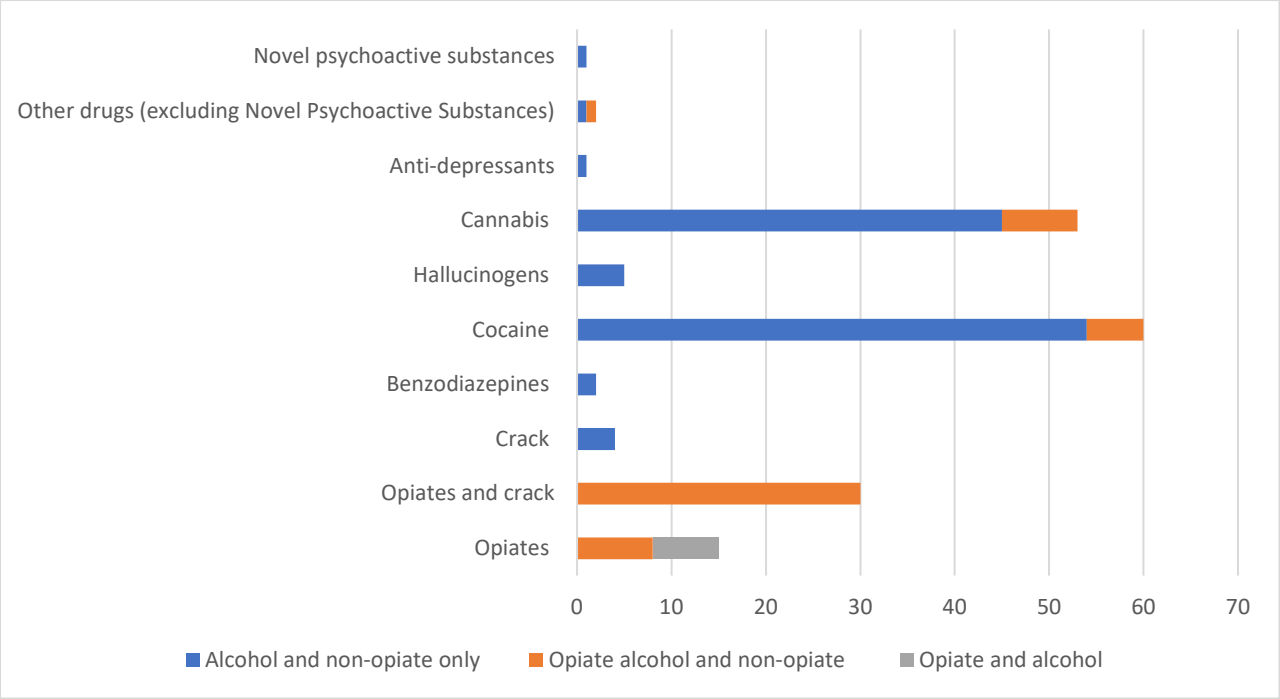

Figure 53: Number of clients in treatment, problem substances cited where a client is in treatment for alcohol use (2021/22). Source: NDTMS

8.2.3 Service Users by Referral Source

The most common referral source for BDAS is “Self, Family and Friends”. The percentage of referrals from “Self, Family and Friends” has increased following Covid-19 from 52% in 2018/19 to 84% of referrals in 2021/22. Whilst the percentage of referrals from “Self, Family and Friends” has increased, the percentage of “GP” referrals into BDAS has decreased since 2018/19. In 2018/19, 24% of the referrals were from “GPs”; in 2021/22, this dropped to 5%. The decrease in GP referrals may be due to Covid-19 and the changing priority of primary care to manage patient advice and symptoms of Covid-19. Additionally, the reduced number of GP appointments and increased triaging and virtual consultations may have also impacted service referrals. The increased self-referrals may also be due to Covid-19, resulting from multiple service closures and reduced appointments at services, meaning that people had to self-refer to BDAS.

We must consider whether the low and decreasing numbers of referrals to BDAS from local services, including GPs, hospitals, mental health, and housing, reflects need or issues with access to services and/or referral pathways. The trends are summarised in Figure 54.

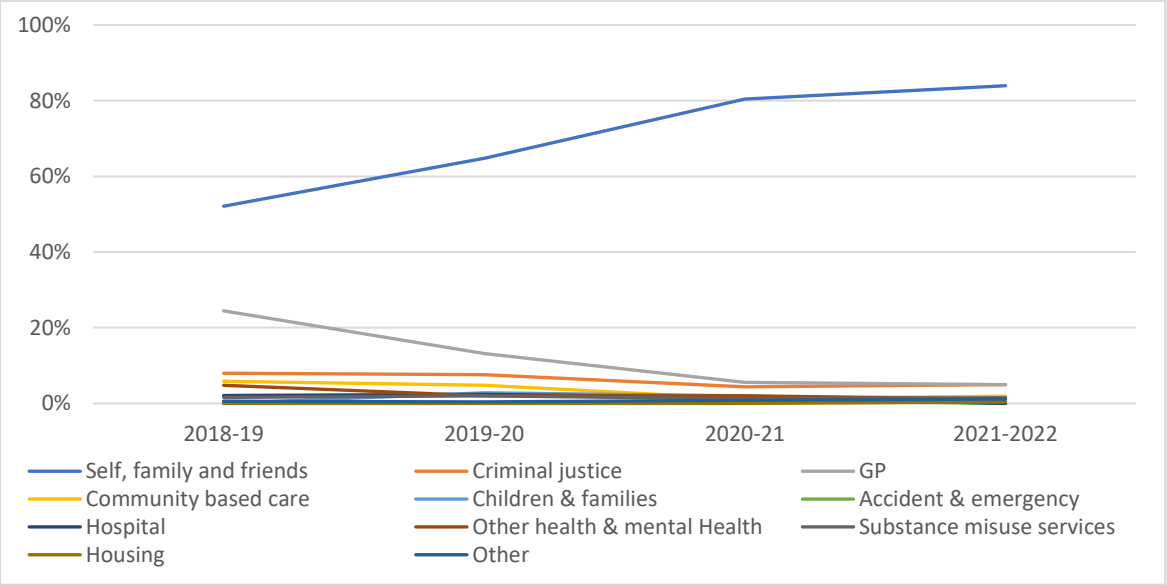

Figure 54: Percentage of all referrals by year (2018/19 to 2021/22). Source: NDTMS

8.2.4 Service Users by Age and Gender

The majority of people engaging in treatment for alcohol at BDAS are men. In 2021/22, the percentage of all clients who were engaged in treatment at some stage, 57.7%, were men (n=217). A similar percentage of male clients were seen for 2020/21 (n=215, 57.8%). There has been an increase in the number and percentage of female clients engaging in treatment for alcohol at BDAS over the last five years (2017/18, 39.3% of clients were female).

Regarding age, in 2021/22, the 40-44 age group made up the highest proportion of service users engaged with BDAS at 18.9%. In 2020/21, it was the 45-49 age group (16.1%).

Figure 55 shows the age distribution for 2020/21 and 2021/22 years. As can be seen, most service users in both years are between 30-59 years (81% for both years). We must be cautious that the low number of people in treatment in younger and older age groups is a true reflection of need or whether we need to improve our engagement with younger and older people who use substances.

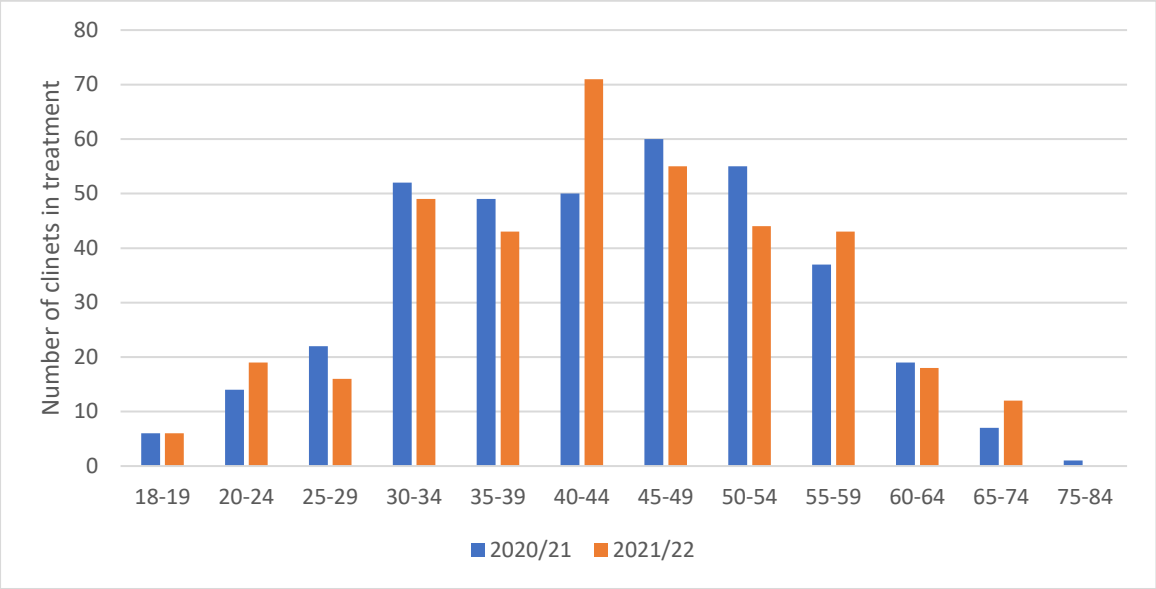

Figure 55: Number of clients in treatment where alcohol is mentioned as a problem substance by age (2020/21 and 2021/22). Source: NDTMS

8.2.5 Service Users by Ethnicity

Table 8 illustrates the proportion of different ethnic groups engaged with BDAS. Alongside this is the GLA estimate for ethnicity breakdown in Bromley in 2020. [18] This was calculated by summing the population projection for each group in 2020

and then calculating the proportion. This data is based on 2011 Census data. It is difficult to draw conclusions and compare the percentage of ethnic groups of alcohol service users at BDAS to that of Bromley residents due to the completeness of the BDAS data. In 2020/21 and 2021/22, over 20% of the data is Not Stated/Missing/Inconsistent.

In 2021/22, most of all service users in treatment were White British. The following most prominent groups were Other White and White Irish. The caveat is that a high number of service users with ethnicity data was missing in 2021/22.

	GLA 2020 Bromley Estimate (%)	**2019/20 Treatment (%)**	**2021/22 Treatment (%)**
White British	72.3	74.8	54.5
White Irish	1.7	2.3	3.5
Other White	7.8	6.5	5.6
White and Black Caribbean	1.2	1.4	2.1
White and Black African	0.4	0	0.8
White and Asian	0.8	0	0.0
Other Mixed	0.7	0.5	0.5
Indian	2.6	0.9	0.8
Pakistani	0.3	0	0.0
Bangladeshi	0.6	0.5	0.0
Chinese	1.1	0	0.0
Other Asian	1.7	3.3	0.3
Caribbean	2.5	2.3	1.9
African	4.6	0	1.9
Other Black	0.7	0	0.8
Other	1.1	0.5	0.5
Not Stated/Missing/Inconsistent	N/A	7	26.9

Table 8: Number of clients in treatment by ethnicity (2019/20 and 2021/22).
Source: NDTMS; GLA

In 2019/20, the ethnic data is better reported (7% Not Stated/Missing/Inconsistent) and therefore has been used to compare notable differences between the population and BDAS ethnicity proportions:

- 4.6% of the population is projected to be African, but in 2019/20, there were no service users engaged with BDAS, and this group only made up 1.9% of service users in 2020/21
- 1.1% of the population is projected to be Chinese. In both years, there were no service users engaged with BDAS
- 2.6% of the population were projected to be Indian, but in 2019/20, this group only made up 0.9% of service users engaged with BDAS, and this group only made up 0.8% of service users in 2020/21
- Other Asian are over-represented in BDAS, with 3.3% in 2019/20, compared with a population average of 1.7%

The reasons for these observations, whether by chance or those ethnic groups use alcohol in varying amounts or issues exist with access to services, need to be understood.

8.2.6 Service User by Place of Residence

In addition to the information collected and uploaded to NDTMS, CGL also collect other demographic information. This includes place of residence. The data cannot be represented here for reasons of confidentiality but it does show there are increased numbers of individuals in treatment for alcohol-only in the North-West of Bromley including Crystal Palace, Penge and Cator, and in the North of Bromley including Mottingham and Chislehurst North which are more deprived areas of the borough.

8.2.7 Service Users by Sexuality

The data by sexuality is largely incomplete for BDAS, with 48% in 2021/22 being either “Not Stated” or “Missing”. In 2021/22, of those we do have data for, 47.3% were heterosexual, 2.3% gay/lesbian, and 2.3% were bisexual.

National statistics gathered by charities and NHS digital indicate that a more significant proportion of LGB adults surveyed drink than heterosexual people. LGB individuals drink more frequently and in greater amounts, with a higher proportion drinking over the national guidelines of 14 units per week. [19]

The percentage of clients at BDAS for alcohol who identify as gay/lesbian and bisexual is higher than the proportion of LGB in London. [20] Further investigation is required to ensure that BDAS supports LGBQ+ individuals.

8.2.8 Service Users by Disability

In 2021/22, 77.9% of all alcohol new service users reported having no disability, as seen in Figure 56. The most common disability reported across the five years was "Behaviour and emotion". The second most common was "Mobility/Gross Motor". The proportion of disabled service users appears to be decreasing.

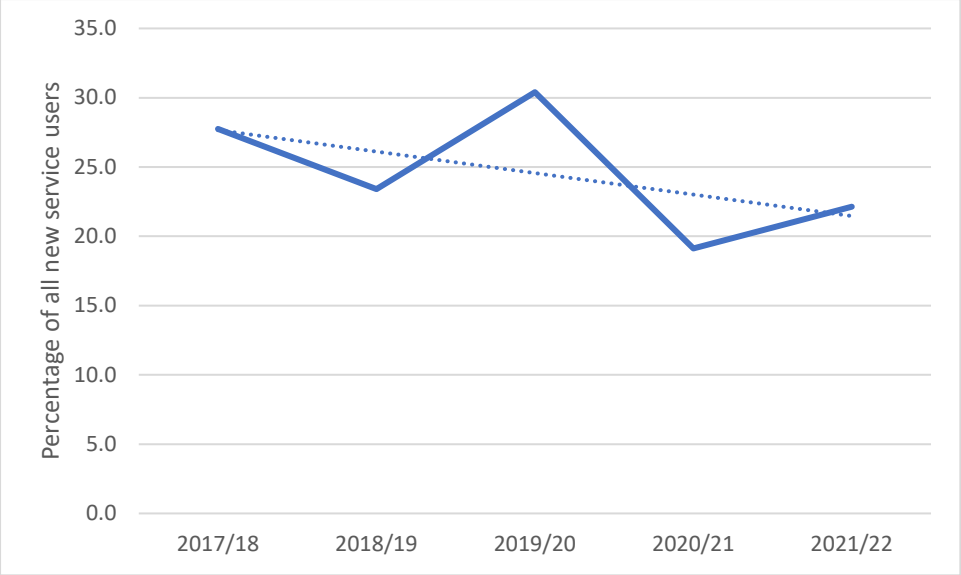

Figure 56: Percentage of all clients entering treatment who have a disability (2017/18 to 2021/22). Source: NDTMS

8.3 Interventions in Treatment and Risk Reduction - BDAS

Section 8.3 focuses on the interventions used during the treatment of alcohol-only service users. This allows us to identify the interventions used specifically for alcohol users.

8.3.1 Pharmacological Interventions

Pharmacological interventions are provided to support clients in treatment. These interventions are given in addition to psychosocial interventions. Therefore, none of those who received pharmacological interventions received only this intervention since the start of the treatment journey. Pharmacological interventions are offered or required by alcohol users undergoing detoxification due to alcohol dependence.

In 2021/22, 50 pharmacological interventions were delivered to alcohol-only service users, and in 2020/21, 36 pharmacologic interventions were delivered. This is significantly higher than pre-pandemic years, where 8 pharmacological interventions were delivered in 2019/20 and 5 in 2018/19.

Interventions are provided in the community in Bromley unless for circumstances that deem them inappropriate. In 2021/22, 94% of pharmacological interventions were delivered through the community. In 2021/22, the pharmacological interventions can be categorised by medication:

- 12 interventions of chlordiazepoxide for alcohol withdrawal,
- 9 interventions of acamprosate for alcohol relapse prevention, and
- 41 interventions of vitamin B and C supplements to prevent/treat Wernicke's encephalopathy/Wernicke-Korsakoffs.

8.3.2 Psychosocial Interventions

Psychosocial interventions are provided to service users undergoing detoxification due to alcohol dependency and those receiving alcohol harm reduction treatment. During 2021/22, a total of 190 psychosocial interventions were delivered to alcohol-only service users. 96.8% of these have been delivered through the community. The most common psychosocial intervention was motivational interventions followed by cognitive/behavioural relapse prevention.

8.3.3 Inpatient Detoxification or Residential Rehabilitation

In 2021/22, three clients (1.5% of all clients) received interventions in inpatient units for alcohol-only use. Similarly, in 2020/21, four clients (1.6%) required inpatient treatment for alcohol-only use. Compared to all clients where alcohol is listed as a problem substance, five clients in 2021/22 and seven in 2020/21 required inpatient treatment.

8.3.4 Smoking Cessation

Alcohol misuse and smoking tobacco commonly co-exist, and whilst it is often better to deal with one addiction at a time, there is an opportunity to provide smoking cessation as part of the treatment programme. The percentage of clients being treated for alcohol use only who identified as smokers before starting treatment is above the national average in both 2020/21 and 2021/22.

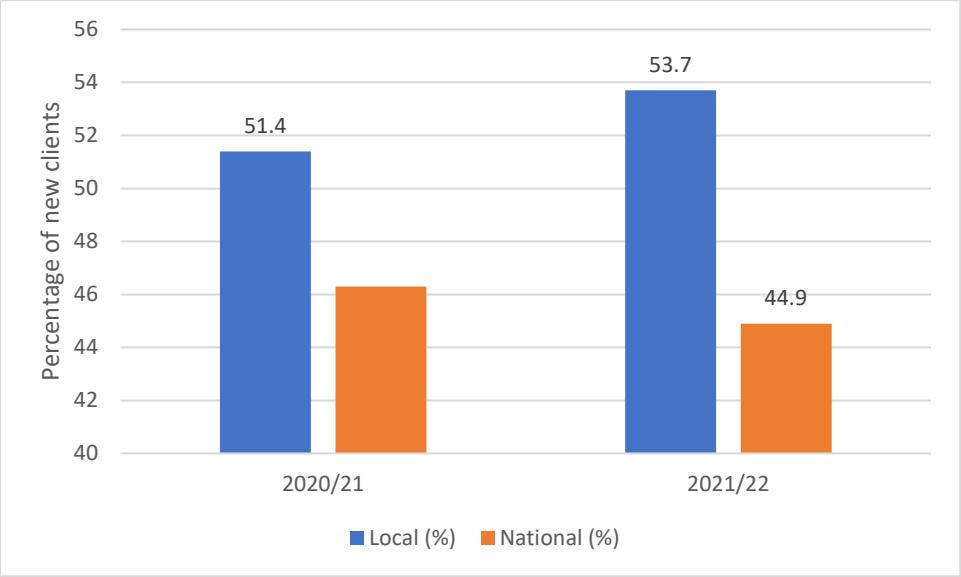

Figure 57: Percentage of all clients entering treatment who smoke (2020/21 and 2021/22). Source: NDTMS

In 2021/22, 53.7% of alcohol-only clients in BDAS smoked. This percentage is higher than the national average of 44.9%. Of these clients who smoke, nobody received smoking cessation interventions locally or nationally. Locally this is complicated due to the commissioning arrangements of smoking cessation, which does not fall under the substance misuse service specification. It is also not a statutory service that local authority public health departments need to provide.

8.4 Vulnerable Groups - BDAS

The 2017 UK Government Drug Strategy highlighted high-priority groups that required a targeted approach as they are at higher risk of misusing drugs. [21] Examining these groups, including the data (where available) about the number of drug users in these high-priority groups in treatment, will help us understand where the need is most.

Section 8.4 focuses purely on the vulnerabilities of alcohol-only service users. This allows LBB to identify vulnerabilities specific to alcohol.

8.4.1 Service Users with Children at Home

Of those in treatment at BDAS for alcohol only in 2021/22, 32.7% reported they were a parent (n=80). The majority of these service users' children lived with the client (n=56, 67.5%), and 26.5% of clients with children said they did not live with the client.

In 2021/22, 27% of new presentations stated they lived with children or in the same household as children. Over the last five years, there has been no significant change in the proportion of new presentations living with children.

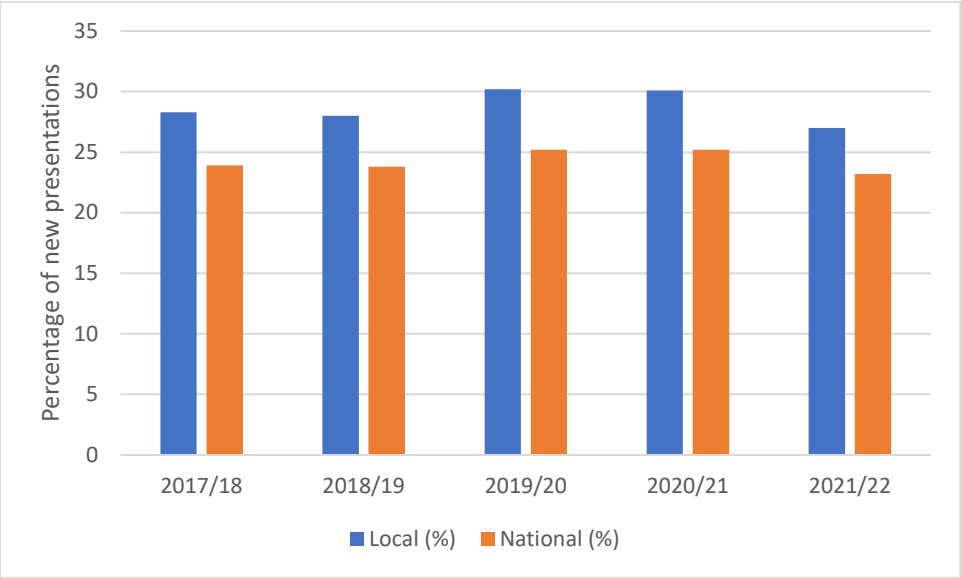

Figure 58: Percentage of all new presentations living with children or in the same household as children (2017/18 to 2021/22). Source: NDTMS

Over the last five years, locally, the percentage of successful completions of total clients in treatment for alcohol only living with children or in the same household as children has been higher than the national percentage. Since 2019/20, the number of successful completions has decreased. In 2021/22, the percentage of successful completions was 48.5%. This is similar to the percentage of successful completions as a proportion of all in treatment.

Figure 59: Percentage of successful treatments out of the total new presentations living with children or in the same household as children (2017/18 to 2021/22). Source: NDTMS

Of those service users engaged with BDAS, 18% of those who had a child at home were a child in need in 2021/22 and 14.5% in 2020/21. Each year, the Government releases data on the number of children in need nationally, regionally, and locally. This data comes from the Children in Need census collected by local authorities. In 2020/2021 (ending 31 March 2021), 16.6% (n=494) of children in need in Bromley had a parent that misused alcohol. [22] This clearly has significant implications on the children involved. This likely indicates that there are more children in need, in alcohol-using households in Bromley than those engaged with services. Of those service users who reported they had children at home in 2021/22, 19.7% had a child protection plan in place. This was 11.6% in 2020/21.

8.4.2 Offenders

In Bromley, the percentage of service users engaged with BDAS for alcohol only and are in contact with the criminal justice system (CJS) has decreased from 2017/18 to 2021/22. This is defined as clients taken onto the BDAS caseload within 42 days of the earliest triage, or the first referral source of the treatment journey is a criminal justice referral route. Figure 60 demonstrates the change in those engaged with the CJS between 2017/18 and 2021/22. In 2021/22, only 1.2% of individuals are engaged in BDAS and the CJS. This is significantly lower than the national percentage, which increased from 2019/20 (5.9%) to 2021/22 (6.5%).

Figure 60: Percentage of clients engaged with the criminal justice system (2017/18 to 2021/22). Source: NDTMS

Unfortunately, there is a high level of unsuccessful treatment completion for those service users engaged with the CJS. In Bromley, the percentage of successful treatments for those in contact with the CJS is higher than that nationally (except in 2021/22).

In 2021/22, there were no successful treatments. However, this should be viewed with caution due to the low number of people (n=3) in contact with both BDAS and the CJS in 2021/22. In 2020/21, 55.6% of those in contact with the CJS successfully completed treatment with BDAS. This success rate is lower than the percentage of all those in treatment.

Figure 61: Percentage of successful completions as a proportion of total Criminal Justice clients in treatment decreases for both alcohol and non-opiate only service users (2017/18 to 2021/22). Source: NDTMS

8.4.3 Homeless

In 2021/22, 0% of BDAS service users reported they were of no fixed abode (NFA) and therefore had an urgent housing problem (accommodation needed at the start of their treatment journey). This was 1.7% in 2021/22, and there has been no significant change since 2017/18. Since 2017/18, there has been a decrease in the percentage of patients reporting housing problems (excluding urgent) at the start of their treatment journey. In 2021/22, 5.4% of service users reported having housing problems.

Figure 62: Percentage of clients having housing problems at the start of their treatment journey (2017/18 to 2021/22). Source: NDTMS

There are very few referrals to BDAS from housing teams in 2021/22; there was one referral made. In 2020/21 and 2019/20, no referrals were made from housing teams to BDAS. Improved working is required by the housing teams to identify those that need substance misuse support and to refer these individuals.

8.4.4 Unemployed

Nationally the unemployment rate had generally been falling since late 2013 up until the start of the Covid-19 pandemic, where it increased between December 2019 to February 2020. It increased since then but has now returned to pre-Covid levels.

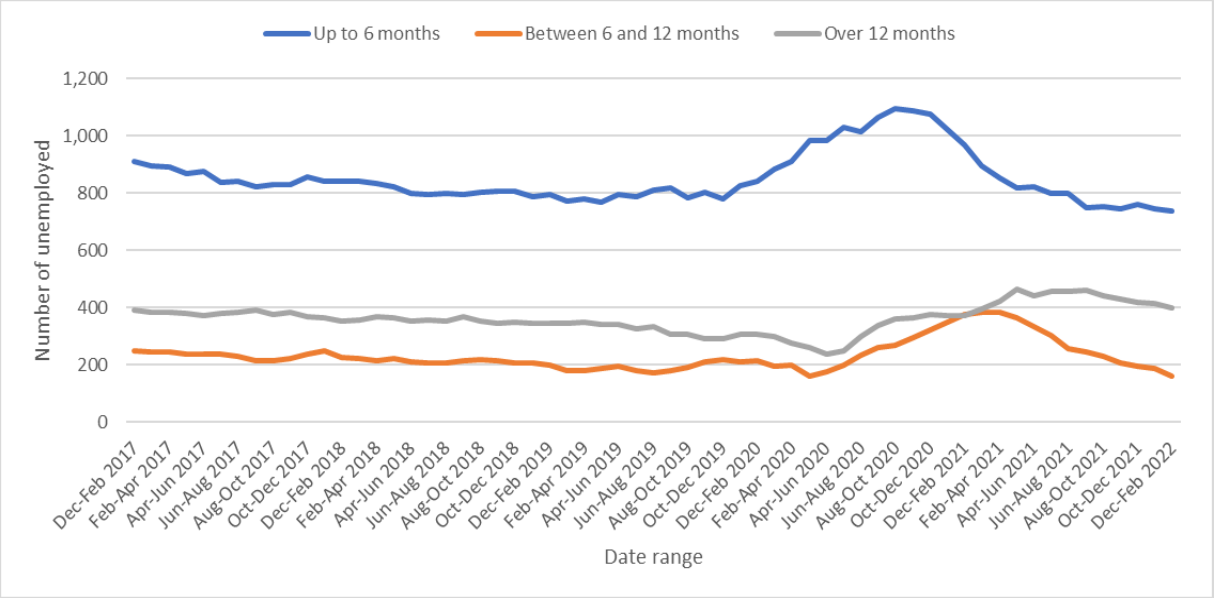

Figure 63: Unemployment by duration (United Kingdom: seasonally adjusted).
Source: ONS – Labour Force Survey

In 2021/22, 55.7% of service users engaged in treatment with BDAS were unemployed, many of whom were not seeking work. This is significantly higher than in previous years, and further investigation is required to understand the rationale for this increase as there has been a national decrease in unemployment since 2021/22. In 2020/21, 18.8% of service users were unemployed. However, 40% did not have an employment status recorded, which is likely to be much higher. This is 11.9% and 23.8%, respectively, in 2019/20.

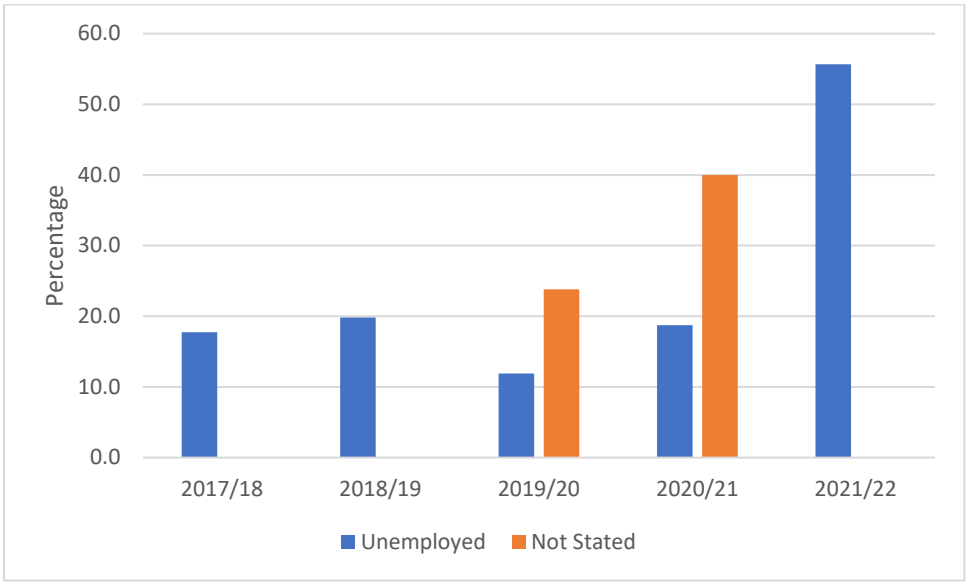

Figure 64: Percentage of clients unemployed at the start of their treatment journey (2017/18 to 2021/22). Source: NDTMS

8.4.5 Domestic Violence

The only data routinely collected by BDAS is how many service users received the Domestic Abuse Support Facilitation sub-intervention. In 2021/22 and 2020/21 this was 1.2% of service users accessing BDAS for alcohol only. It is difficult to know whether all service users who needed it had the sub-intervention or if all service users feel comfortable disclosing this information.

8.4.6 Co-occurring mental illness

In Bromley, the formal co-occurring mental health and substance misuse services, COMHAD, are provided by Oxleas Foundation Trust. However, many service users engaging with CGL have co-existing mental health issues.

In 2021/22, there were 243 referrals to Oxleas COMHAD service. The majority (n = 171) were liaison referrals, the remainder being community referrals. This is slightly higher than the number of referrals in 2020/21 (n = 230), where there were 90 community and 140 liaison referrals.

In 2021/22 the primary contact intervention delivered by COMHAD was alcohol misuse management.

In 2021/22, most referrals and contacts to COMHAD are male, White British, and either aged 25-34 or 55-64 years. There are low numbers of female referrals and contacts and few people aged 18-24 and 65+ years. This follows similar demographics to clients accessing BDAS. We must be cautious that the low number of people in treatment in younger and older age groups, and females, is a true reflection of need or whether we need to improve our engagement with these groups.

While COMHAD service by Oxleas supports many people with co-occurring mental health and substance misuse, many clients at BDAS have mental health issues. In

2021/22, 69.2% of clients entering alcohol treatment only in COMHAD reported a co-existing mental health issue, with a national average of 68.3%. In 2020/21, this was lower at 59.7% (national 66.9%). Following the start of the Covid-19 pandemic (at the end of 2019/20), there has been a significant increase locally and nationally in the COMHAD presentations when clients enter treatment for alcohol. Across the years, the percentage of COMHAD presentations in clients entering alcohol treatment has been similar locally and nationally.

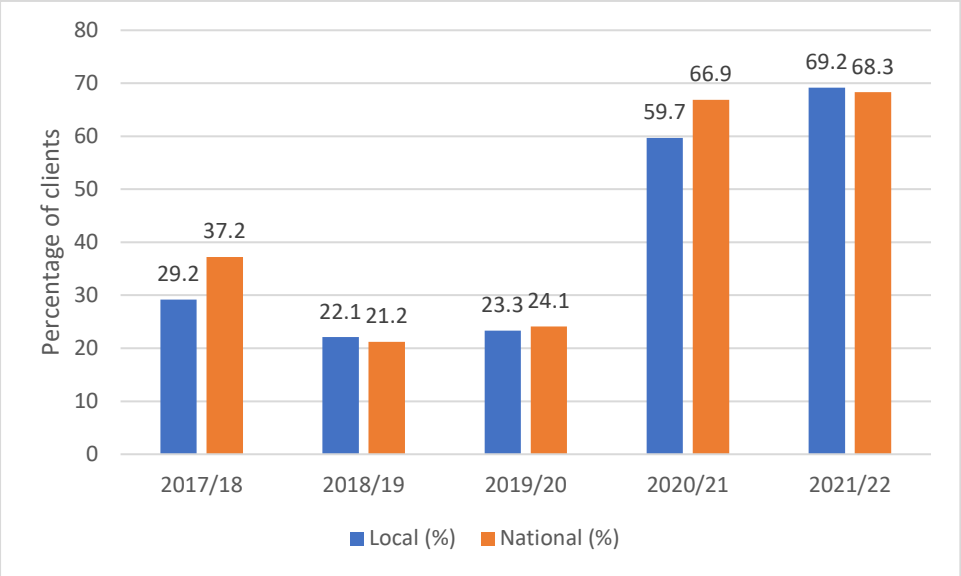

Figure 65: Percentage of COMHAD presentations for clients entering treatment for alcohol only (2017/18 to 2021/22). Source: NDTMS

Of all individuals in treatment where alcohol is listed as a problem substance, and they have co-occurring mental health issues, the majority of these service users were receiving treatment from their GP, at 60.5% in 2021/22 and 68.7% in 2020/21. This was higher than the national average in both years, at 58.3% and 58.8%, respectively. In 2021/22, 20.9% of service users with mental health issues received care from the Community Health Management Teams (CHMTs) or other mental health teams. In 2020/21, this was 17.5%. The national average was 19.2% and 19.5%, respectively. 28.3% of service users with a co-existing mental health issue were not engaged with any mental health services, including because they refused, in 2021/22. This is compared with a national average of 26.8%. In 2020/21, this was 21.5% (national 26.3%). An increasing percentage of people with a need is identified, but no treatment is received. Further investigation is required to identify why these individuals are not engaging in treatment.

8.4.7 The Recreational Users, Social or Binge drinking

There is no local information on recreational alcohol users, binge or social drinking, who then access BDAS for alcohol use. National data from the Health Survey for England (2018) highlighted that drinking over 14 units a week varied across age groups and was most common among men and women aged 55 to 64. In Bromley, 26.8% of adults (2015-18) drink over 14 units of alcohol a week. This is higher than the London (20.1%) and England (22.8%) average for the same period. Interestingly the percentage of binge drinking is below the London and England average.

BDAS and Bromley Changes plan to explore the support they can offer recreational drinkers in Bromley. Further investigation is needed to identify the percentage of recreational users/binge drinkers that go on access to BDAS.

8.5 Treatment Outcomes for BDAS

8.5.1 Successful Completions

Successful completion of treatment is defined locally as someone who has completed structured treatment.

The percentage of successful treatments has increased for both alcohol only and alcohol and non-opiate only from 2017/18 to 2020/21, with a peak of 68.2% of alcohol only and 58.4% of alcohol and non-opiate only service users successfully completing treatment. In 2021/22, the number of successful treatments dropped in both service user groups to levels similar to 2018/19. The percentage of successful treatments is lower for alcohol and non-opiate-only service users than for their alcohol-only counterparts.

Figure 66: Percentage of successful completions as a proportion of all in treatment (2017/18 to 2021/22). Source: NDTMS

Table 9 shows the proportion of all service users in treatment who successfully completed treatment in a set period who did not re-present within the next six months (i.e. 2021/22; period of completion is 01/10/2020 to 30/09/2021; haven't re-presented by 31/03/2021). As can be seen, the proportion of people who successfully completed treatment did not re-present in Bromley was more than the national average during the three years. There is little percentage change in the proportion of service users who successfully completed treatment in a set period who did not re-present within the next six months across Bromley and Nationally. Based on figure 66, there would be expected to be a drop locally in this percentage due to the decrease in people who successfully completed treatment.

Type of Drug	Year	Period of completion	Re-presented by	Bromley	National
Alcohol only	2021/22	01/10/2020 to 30/09/2021	31/03/2022	52.2%	36.6%
	2020/21	01/10/2019 to 30/09/2020	31/03/2021	53.9%	35.3%
	2019/20	01/10/2018 to 30/09/2019	31/03/2020	51.7%	37.9%

Table 9: Percentage of users in treatment who successfully completed treatment in a set period who did not re-present within the next 6 months (2019/20 to 2021/22). Source: NDTMS

8.5.2 Re-Presentations

Re-presentations are defined as individuals who successfully complete treatment in the first six months of the reporting period and then re-present within six months.

As can be seen from figure 67, the rate of re-presentation for alcohol-only service users has increased in recent years, with rate of re-presentation in 2020/21 and 2021/22 being 10% of service users. In 2017/18 and 2018/19, this was much lower at approximately 2% of people re-presenting. The percentage of re-presentations for alcohol and non-opiate-only service users decreased from 2017/18 to 2019/20. It then increased with the 2021/22 rate of re-presentations being similar to 2017/18 and higher than alcohol-only service user re-presentations.

Interestingly in 2019/20, no service users re-presented within six months for alcohol-only and alcohol and non-opiate-only service users.

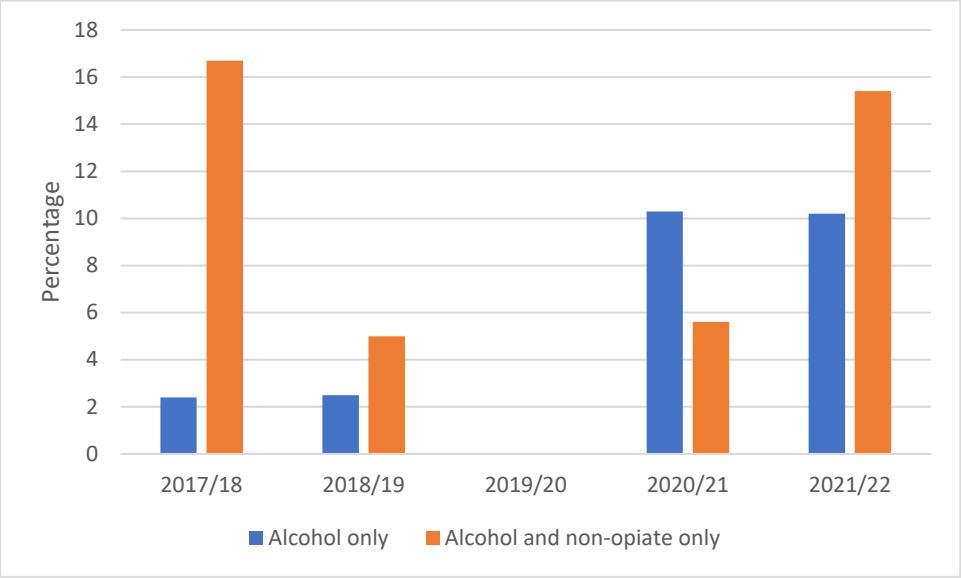

Figure 67: Percentage of users in treatment who successfully completed treatment in a set period who re-presented within the next 6 months (2017/18 to 2021/22). Source: NDTMS

8.5.3 Abstinence

Abstinence is not always the appropriate treatment method for all alcohol-only service users. Abstinence is only appropriate for alcohol-dependent service users

and is completed through a detox. A detox can either be supported by pharmacological interventions or can be psychosocial only.

The level of drug use is assessed and recorded at the 6-month mark post-starting treatment. The alcohol abstinence rate for 2021/22 was 8.6% (n=6/68), and for 2020/21, this was 16.7% (n=8/48).

8.5.4 Early Unplanned Exits

Unplanned exits are those who leave treatment before finishing a structured treatment programme. In Bromley, in 2020/21 and 2021/22, these are significantly lower than the national average for both alcohol and alcohol and non-opiates. In 2021/22 the unplanned exit rates are 6.1% (national 13.2%) 16.4% (national 17.2%) respectively. There is a slight increase in the percentage and number of unplanned exits in 2021/22, but data should be treated with caution due to low numbers (particularly for alcohol and non-opiate).

8.6 Service users in Bromley Changes

8.6.1 Total Numbers in Treatment

In 2021/22, NDTMS data highlighted 67 young people in treatment and 49 new presentations for all substances. 43% of young people in treatment at Bromley Changes have cited a problem with alcohol, the second biggest problem after cannabis.

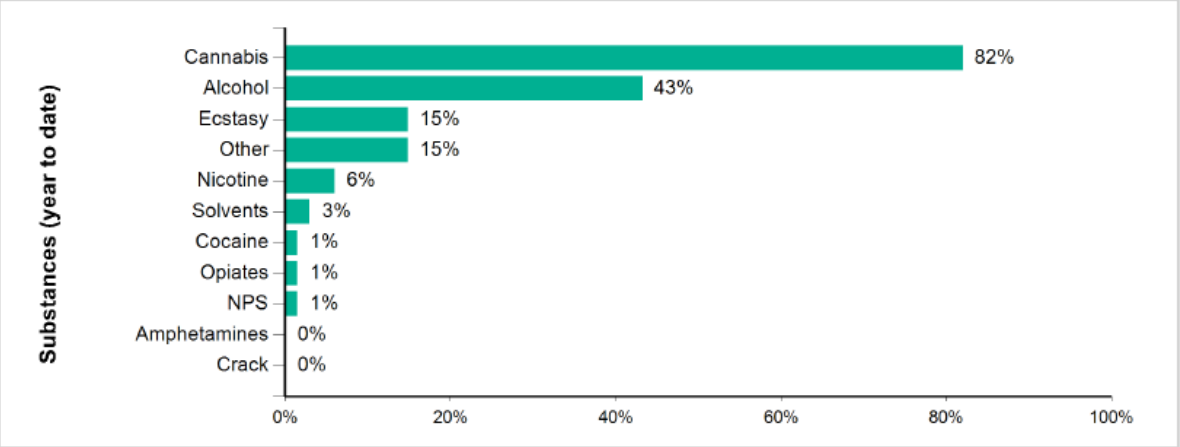

Figure 68: Percentage of each problem substance for all young people in treatment (2021/22). Source: NDTMS

As seen in figure 69, the number of people in treatment for alcohol fluctuates. In 2021/22, the annual number of young people in treatment for alcohol fluctuates from as high as 14 young people to as low as eight young people. Based on historical data, the average number of young people for the treatment of alcohol across a year is between 8-9 people.

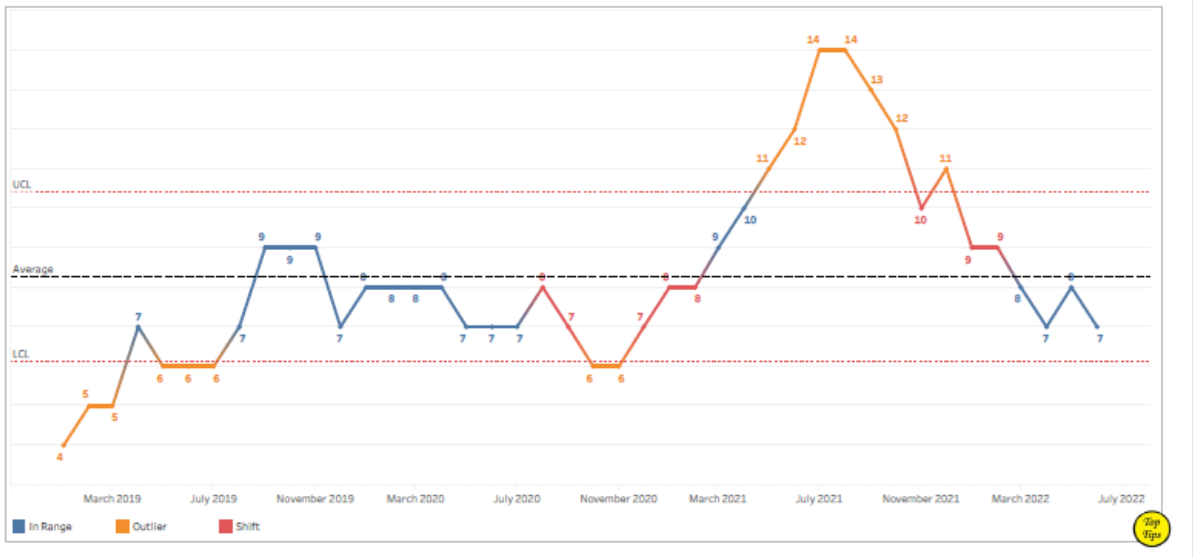

Figure 69: The number of young people in treatment for alcohol within the last 12 months period. Source: Bromley Changes

Between 1st January 2017 and the 9th August 2022, there were 315 young people in treatment with Bromley Changes across all cohorts. Between April 2017 and March 2022, there were 43 alcohol-only service users in treatment and 173 alcohol and non-opiate only young people in treatment (some young people could be accounted for across more than one financial year and/or quarter). Over the five years reported in figure 70, a significantly higher number of young people in treatment for alcohol and non-opiate only than alcohol-only. Of the five years, 2020/21 had the highest number of young people in treatment for alcohol only, whereas 2018/19 had the highest number of people in treatment for alcohol and non-opiate only.

Figure 70: The number of young people open to treatment with Bromley Changes for alcohol only and alcohol and non-opiate only service users (2017/18 to 2021/22). Source: Bromley Changes.

A snap-shot of Bromley Changes caseload (June 2022) shows 21 young people in treatment during this month. Most of these young people are in treatment for non-opiate purposes (10, 48%). In contrast, four young people are in treatment for alcohol only and seven young people are in treatment for non-opiate and alcohol only.

8.6.2 Service Users by Referral Source

The most common referral source into Bromley Changes is referral from either "health and mental health" or "youth justice" services. In 2021/22, 35% of referrals were from the youth justice system, and 31% were from health and mental health. The majority of the referrals from health services come from the hospital. Unlike adult services, there are very few referrals from "family, friends & self" in 2021/22; this made up 2% of the referrals. Conversations with Bromley Changes highlight that they receive many referrals from hospital services. Many of these referrals often involve first-time drug and/or alcohol users and therefore don't require and/or refuse engagement with the treatment service.

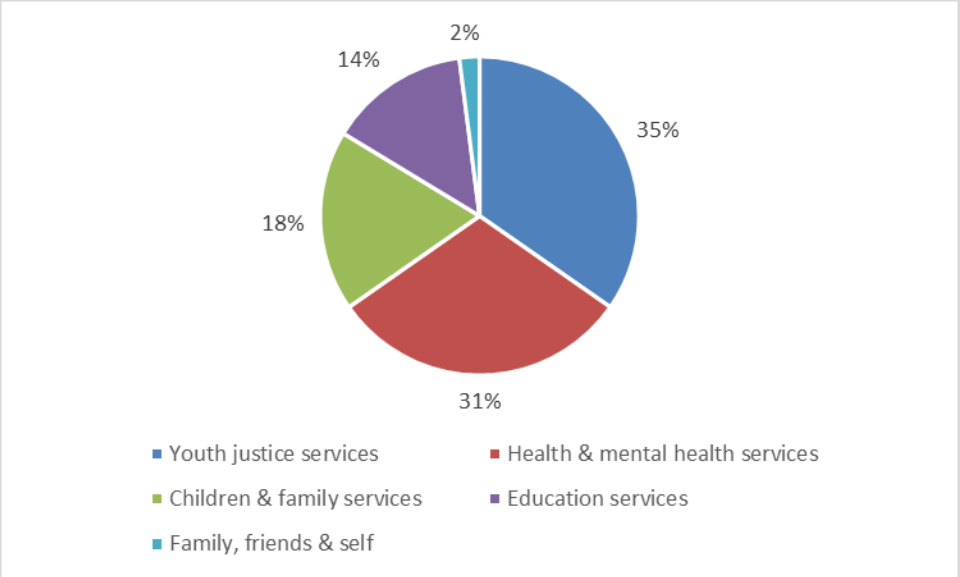

Figure 71: Referral pathway for young people in treatment for all cohorts (2021/22). Source: NDTMS.

Data from Bromley Changes over the 5 years 2017/18 to 2021/22highlights that the most common referrals for alcohol-only users into Bromley Changes are from hospitals and A&E, Youth Justice System and education services.

NDTMS Young People data (figure 72) highlights a decrease in the number of referrals from education services and family, friends & self across all cohorts. We must consider whether the low and decreasing numbers of referrals to Bromley changes from services including education, and family, friends and self, is a reflection of need or issues with access to services and/or referral pathways during covid.

Figure 72: Percentage of each pathway for young people in treatment for all cohorts (2018/19 to 2021/22). Source: NDTMS.

8.6.3 Service Users by Age and Gender

Most young people engaging in all treatment at Bromley Changes are male (figure 73). In 2021/22, 54% (n=36) of all client cohorts engaged in treatment at some stage during the year were male. A similar percentage of male clients was seen for 2020/21 (n=37, 57%). In all cohorts accessing treatment with Bromley Changes, there was a decrease in the percentage of female clients engaged in treatment from 2017/18 to 2019/20. Since 2019/20, there has been an increase in the percentage of female clients engaging in treatment (2019/20 = 37%, 2021/22 = 46%).

Interestingly data reported by Bromley Changes show that most young people in treatment for alcohol only are female. Between April 2017 – March 2022, 72.1% (n=31/43) were female.

Figure 73: Percentage of all cohorts in treatment by sex (2017/18 to 2021/22).
Source: NDTMS.

Regarding age, Bromley Changes offers treatment to individuals aged up to 18. In 2021/22, the most common ages for all cohorts in treatment with Bromley Changes are aged 15 to 17, with young people aged 17 being the highest proportion of young people in treatment. Similar figures have been seen for alcohol-only young people in treatment with Bromley Changes. Most young people at the start of treatment between April 2017 – March 2022 were aged 14-18. Although you can't directly compare all cohorts in treatment in 2021/22 (Figure 74), to those in treatment since 2017, there is a more significant proportion of younger people aged 14 in treatment for alcohol only.

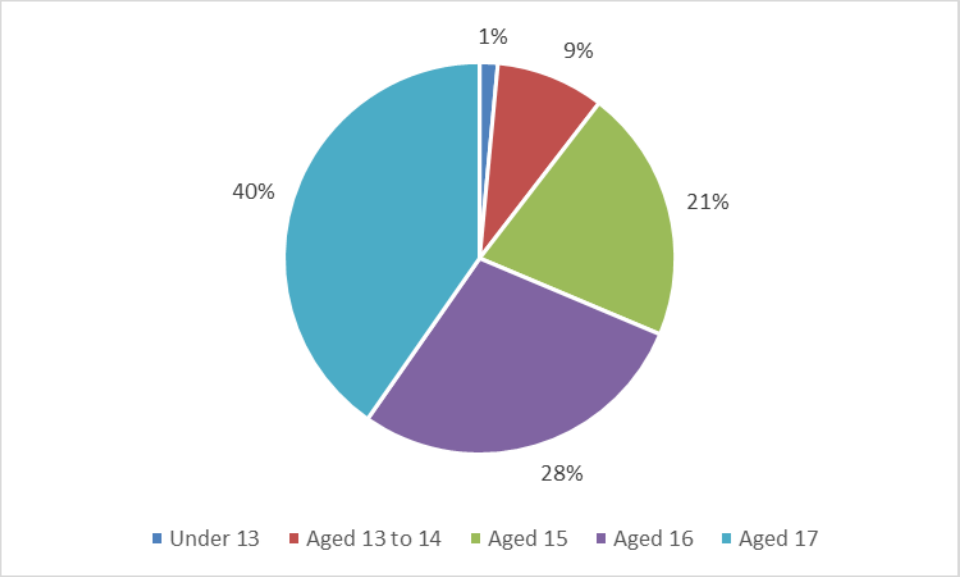

Figure 74: Proportion of all cohorts in treatment by age (2021/22). Source NDTMS

8.6.4 Service Users by Ethnicity

. Most young people in treatment with Bromley Changes between April 2017 – March 2022 for alcohol only were White British, followed by Other White. A similar ethnic trend is seen for all client cohorts in treatment with Bromley Changes over these years.

Due to the low numbers of alcohol-only service users who have been in treatment since 2017, it is difficult to compare this to the ethnicity breakdown in Bromley. Further investigation is required to identify if ethnic groups use alcohol in varying amounts and/or if there are issues with access to services.

8.6.5 Service User by Place of Residence

Similar to BDAS, Bromley Changes also collects information on residence of clients in structured treatment. All service users were Bromley residents except for one who still had links to the borough of Bromley. Postcode districts BR1 and BR5 had the highest number of residents in structured treatment over the 5 years 2017/18 to 2021/22. This includes Bromley Town and Cray Valley West respectively. Interestingy there were more clients in areas of low deprivation and a low number of clients in areas of deprivation including the North-West of Bromley (opposite to that seen in BDAS).

8.6.6 Service Users by Sexuality

The data by sexuality is largely incomplete for Bromley Changes, and the NDTMS does not report this. Bromley Changes reported for alcohol-only service users in treatment between April 2017 – March 2022, 7% were Gay/Lesbian, and 51% were heterosexual. The sexual orientation of many service users was unknown or not stated (42%). Further investigation is required to ensure that Bromley Changes support LGBQ+ individuals.

In 2021/22, 29% of young people in all cohorts mentioned having had unsafe sex at the treatment start. This is a significant increase from 2020/21 (14%) and 2019/20 (14%)— many people who are offered a sexually transmitted infection (STI) screening or Chlamydia screening refuse. In 2021/22, 71% of people refused a Chlamydia screen, and 69% refused an STI screen.

8.6.7 Service Users by Vulnerability

Figure 75 highlights the percentage of young people in all cohorts presenting with vulnerabilities. The most common vulnerabilities in all cohorts in treatment across the five years is domestic abuse, mental health, self-harm, and anti-social behaviour/criminal act. In 2021/22, 63% of young people required mental health treatment and 45% of young people presented with self-harm. Across the five years, there has been an increase in the number of presentations of mental health, domestic abuse and self-harm. In 2021/22, there was an increase in the number of young people presenting as a child in need. Further investigation is required to understand these increased vulnerabilities.

In 2019/20, there was a low number of presentations in all areas. This is also seen in the cumulative presentations, whereby 50% of individuals had no vulnerabilities.

Figure 75: Percentage of young people in all cohorts of treatment experiencing vulnerabilities (2017/18 to 2021/22). Source: NDTMS

Of those wider vulnerabilities, figure 76 shows the percentage of individuals in 2021/22 who have multiple vulnerabilities. In 2021/22, 4% of young people have six vulnerabilities. Historically there has been a higher percentage of young people in all cohorts without any vulnerabilities (2020/21 = 30%, 2019/20 = 50%, 2018/19 = 39%).

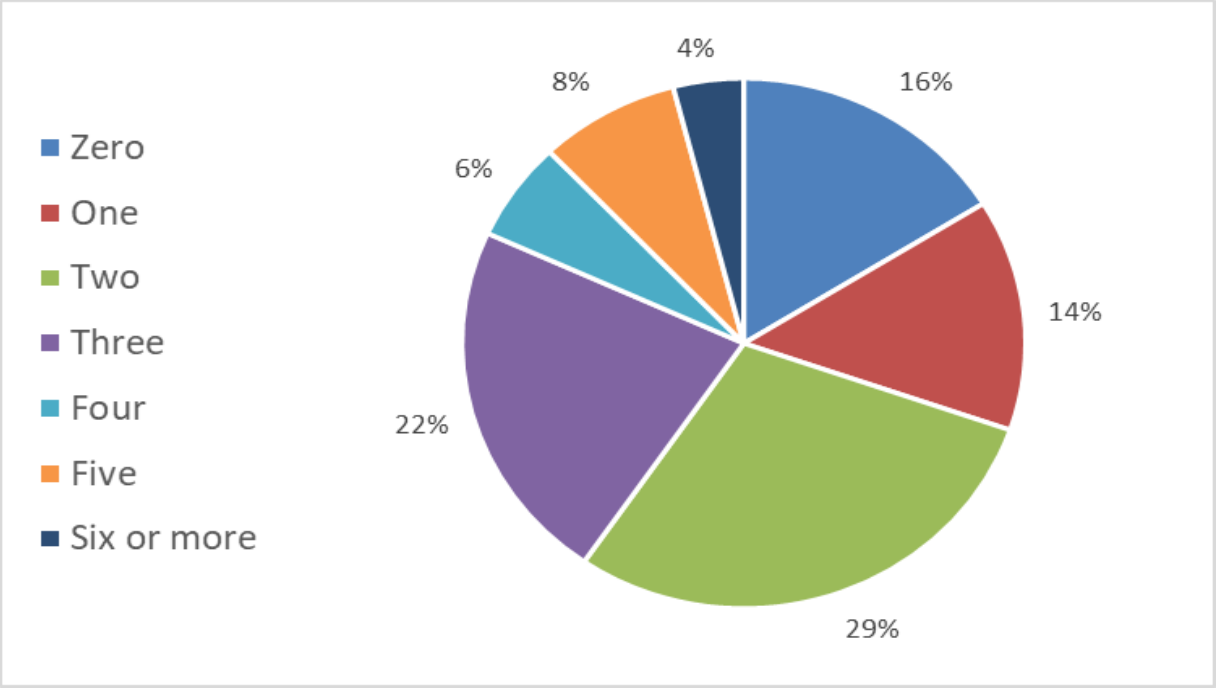

Figure 76: Percentage of young people in treatment (all cohorts) experiencing multiple wider vulnerabilities (2021/22). Source: NDTMS

In 2021/22, of those that require mental health treatment, 74% were already engaged. Many people declined to commence treatment, and many people didn't receive any treatment.

8.7 Treatment and outcomes for Bromley Changes

8.7.1 Interventions delivered

Bromley changes offer harm reduction, psychosocial and multi-agency interventions. In 2021/22, of all young people cohorts accessing treatment at Bromley Changes, 67% received harm reduction interventions, 0% received pharmacological, 79% received psychosocial interventions, and 28% received multi-agency working. All interventions were carried out in the community, and no interventions were provided in an inpatient or residential setting. In 2021/22, the primary psychological sub-interventions delivered included motivational, counselling and cognitive & behavioural interventions.

Bromley Changes have confirmed that 100% of clients accessing alcohol treatment will be offered both harm reduction and psychosocial interventions throughout their time in treatment as a minimum standard. Multi-agency interventions are only offered when necessary. Between April 2017 – March 2022, 12 out of the 43 alcohol-only service users engaged in multi-agency interventions (28%).

8.7.2 Outcomes

Unlike BDAS, structure interventions in Bromley Changes remain open-ended, with many people accessing services for up to 12 months. In 2021/22, the majority of young people were in treatment for 12-26 weeks (42%). There were also 19% in treatment for 27-52 weeks and 3% in treatment for over one year. Of those in treatment in 2021/22, 16% of all clients had previously been in structured treatment.

Between April 2017 – March 2022, there were 28 out of 38 planned exits (successful completions) for alcohol-only service users and 10 unplanned exits. Between 2019-2022, 0 service users re-presented within six months of their planned exit across all drug categories.

Key Points of the Chapter:

BDAS

- Throughout the last five years, there has been an increase in the number of new presentations at BDAS related to alcohol. In 2021/22 the total number of new presentations where one of the problem substances is alcohol was 262.
- In 2021/22, the most common problem substances cited where a client is also in treatment for alcohol use are Cannabis (n=53) and Cocaine (n=60).
- The most common referral source for BDAS is “Self, Family and Friends”. The percentage of referrals from “Self, Family and Friends” has increased following Covid-19 from 52% in 2018/19 to 84% of referrals in 2021/22. Whilst the percentage of referrals from “Self, Family and Friends” has increased, the percentage of “GP” referrals into BDAS has decreased since 2018/19.
- In 2021/22, the percentage of all clients who were engaged in treatment at some stage, 57.7%, were men (n=217). A similar percentage of male clients was seen for 2020/21 (n=215, 57.8%).
- In 2021/22, the 40-44 age group made up the highest proportion of service users engaged with BDAS at 18.9%. In 2020/21, it was the 45-49 age group (16.1%).
- In 2021/22, only 1.2% of individuals are engaged in BDAS and the CJS. This is significantly lower than the national percentage, which increased from 2019/20 (5.9%) to 2021/22 (6.5%).
- In 2021/22, 55.7% of service users engaged in treatment with BDAS were unemployed, many of whom were not seeking work.
- In 2021/22, 69.2% of clients entering alcohol treatment only reported a co-existing mental health issue, with a national average of 68.3%. In 2020/21, this was lower at 59.7% (national 66.9%).
- Of all individuals in treatment where alcohol is listed as a problem substance, and they have co-occurring mental health issues, the majority of these service users were receiving treatment from their GP, at 60.5% in 2021/22 and 68.7% in 2020/21.

- The percentage of successful treatments has increased for both alcohol only and alcohol and non-opiate only from 2017/18 to 2020/21, with a peak of 68.2% of alcohol only and 58.4% of alcohol and non-opiate only service users successfully completing treatment.
- The rate of re-presentation for alcohol-only service users has increased in recent years, with rate of re-presentation in 2020/21 and 2021/22 being 10% of service users.

Bromley Changes

- In 2021/22, 43% of young people in treatment at Bromley Changes have cited a problem with alcohol, the second biggest problem after cannabis.
- Between 1st January 2017 and the 9th August 2022, there were 315 young people in treatment with Bromley Changes across all cohorts.
- In 2021/22, 35% of referrals were from the youth justice system, and 31% were from health and mental health. The majority of the referrals from health services come from the hospital. Unlike adult services, there are very few referrals from “family, friends & self” in 2021/22; this made up 2% of the referrals.
- Most young people engaging in all treatment at Bromley Changes are male. In 2021/22, 54% (n=36) of all client cohorts engaged in treatment at some stage during the year were male. Data provided by Bromley Changes, highlight that most young people in treatment for alcohol only are female. Between April 2017 – March 2022, 72.1% (n=31/43) were female.
- In 2021/22, 63% of young people required mental health treatment and 45% of young people presented with self-harm. Across the five years, there has been an increase in the number of presentations of mental health, domestic abuse and self-harm.
- In 2021/22, there was an increase in the number of young people presenting as a child in need.
- In 2021/22, 70% of young people in all cohorts of treatment had more than one vulnerability.
- In 2021/22, of all young people cohorts accessing treatment at Bromley Changes, 67% received harm reduction interventions, 0% received

pharmacological, 79% received psychosocial interventions, and 28% received multi-agency working.

- Between April 2017 – March 2022, there were 28 out of 38 planned exits (successful completions) for alcohol-only services users and 10 unplanned exits. Between 2019- 2022, 0 service users re-presented within six months of their planned exit across all drug categories.

9. Stakeholders and Partners

As well as the quantitative data presented in this needs assessment, qualitative data about the unmet need of alcohol in Bromley will further help us understand issues and provide a narrative to the data. This is in addition to the stakeholders engaged with in the Substance Misuse Needs Assessment (SMNA) – many of the themes raised there were also relevant for alcohol use. In addition, the CGL Service User Forum was engaged with during the SMNA, and many of the topics covered included alcohol. Therefore, the data from the SMNA should also be considered.

In doing this, many stakeholders across the borough were interviewed. These were:

Support Organisations:

- Alcoholics Anonymous (AA)

N.B Extensive engagement with support organisations occurred in the SMNA

Local Authority Departments:

- Adult Social Care (ASC)
- Children's Social Care (CSC)
- Housing

Organisations dealing with other needs/issues:

- Maternity Services (MS)
- Mental Health Services (MHS)
- Social Prescribing Team (SP)
- Police Service (PS)
- Youth Justice Service (YJS)
- Health Visitors (HV)
- School Nurses (SN) including Named Nurse for Children Looked After and Lead for Youth Justice
- Clarion Housing (CH)

Substance Misuse Intervention Providers:

- Bromley Changes (BC)

- Primary Care (PC)
- Emergency Care (EC)
- Alcohol Liaison Team at the PRUH (ALT)

The following organisations were also reached out to, but unfortunately no meeting was arranged: Ambulance Service, Job Centre, and Public Protection (Trading Standards).

A standardised survey was used to ask questions to all the stakeholders (see Appendix), as well as providing the opportunity for them to share anything else they felt would be helpful. The surveys were carried out by three members of the needs assessment team. A summary of the discussions with the organisations follows.

It should also be noted that many of these organisations see individuals who are in "crisis" – that is people with more extreme needs. Therefore, those who are not engaged with services or those with developing alcohol-related needs may not be captured by this analysis.

9.1 Demographic and Vulnerable Groups

Many of the services provided care for the entire adult population, including Alcoholics Anonymous, Police Service, Social Prescribing Team, Primary Care, Emergency Care, and the Alcohol Liaison Team at the PRUH. This means alcohol use is seen as a problem across genders, deprivation/affluence, ethnicities, and age, to name a few. However, Primary Care reported that they rarely, if ever, see any young people with alcohol issues. They are not sure why this is, but they often only see the impacts on children when the parent or guardian is drinking.

Some of these organisations also reported they deal with more specific groups, for example:

- Emergency Care tended to deal with people with complex needs who attend health services frequently and those with other social stressors such as drugs and housing issues.
- Men and middle-aged people appeared to be the most common adult groups engaged with these organisations. Alcoholics Anonymous reported that most of their clients were male and middle-aged, but they were seeing more people in their 20s joining. The Alcohol Liaison Team at the PRUH reported they

cared for three times as many men as women, mostly aged ‘40-50-years-old and white. Clarion Housing also report a higher use of alcohol in their male clients, with 33-55-years old forming the majority. Housing, specifically the Rough Sleeping Team, also reported higher alcohol use in men and those 30-50-year-olds.

- Most groups reported that the main ethnic group was White British, but this is likely a reflection of Bromley as this is the main ethnic group.
- Regarding location, the Police Service and Housing report that Bromley Town Centre is where they deal with most of their clients.
- Finally, Mental Health Services also reported veterans and those who are retired have significant alcohol use issues and are often not covered by services.

There were organisations providing for very specific groups too. Adult Social Care is one, who tend to look after an older population with associated health issues, such as neurological impairment or dementia. Maternity Services also only deal with pregnant women. They report that they tend to be younger, with all women completing a survey at booking about their alcohol use. Clearly Bromley Changes, Children’s Social Care, School Nurses, and Youth Justice Service specifically work with children and young people. It was clear from most of these organisations that, like in the services mentioned above, that males make up most of the workload, with the majority being in the older age group (age 15+). Youth Justice Service specifically noted that many individuals on their workload are mixed-race or black, and some come from high-income households.

Many reported similar vulnerable groups in adults who used alcohol including:

- Mental illness (mentioned by almost all organisations)
- Victim of or witnessing abuse – exploitation, financial, physical, sexual, domestic
- Self-neglect
- Isolation
- Social issues, such as housing
- Riskier behaviours, including sexual and substance misuse
- Crime

- Learning difficulties
- Unemployed

In young people, some of these vulnerable groups were similar, but there were also some more distinct groups:

- Mental illness (mentioned by almost all organisations)
- Victim of or witnessing abuse –physical, sexual, grooming, exploitation, neglect
- Riskier behaviours, including sexual and substance misuse
- Crime
- Gang affiliation
- Safeguarding issues (on Child Protection plan, or Looked After Child)
- Learning difficulties

It is worth nothing that it was also reported by Children's Social Care (specifically the Care and Care Leavers team) that there is a transitional issue – that is young people transferring from children's services to adult's services. They reported that they have people up to the age of 23-years-old on their books as they struggle to transfer their care to another provider that can provide the same service they can, which the individual requires.

9.2 Alcohol-Related Harms and Impacts

The harms and impacts of heavy alcohol consumption were also discussed with the organisations. Clearly, there are many physical health impacts which were covered by most organisations. These harms included alcohol-related liver disease, brain injuries, accidents, gastrointestinal bleeding, anaemia, and mental illness caused by alcohol. There is also the significant risk of unaided alcohol withdrawal including seizures, as reported by the Alcohol Liaison Team at the PRUH. Housing reported concerns that people who use alcohol often find it harder to access health services, making these issues worse. These heath issues are almost exclusively seen in adults as these harms take many years to develop. The exception to this is accidents due to alcohol consumption, as reported by Youth Justice Service. However, there is one physical health harm to babies – Maternity Services reported the issue of foetal

alcohol syndrome (FAS) in babies born to mothers who drink heavily, however no measurement of this burden was given.

Social isolation is a common impact of alcohol consumption, particularly from family and close friends. This includes marriage breakdown, losing contact with or custody of children, and loss of wider social and support networks. This was reported extensively, particularly by Emergency Care, Alcoholics Anonymous, School Nurses (when considering the parents of children, they see), Youth Justice Service, Health Visitors, Clarion Housing, and Social Prescribing Team. Health Visitors and Social Prescribing Team reported that they often see family and social breakdown in individuals from affluent backgrounds or communities. Mental Health Services felt that families can often cope with individuals who have mental illness and help support their loved ones through it. But they felt this was not the case with alcohol and that addiction as a mental illness is poorly understood across the board.

There were other impacts noted by the organisations, such as:

- Going to prison or getting into trouble with the police
- Financial difficulties or bankruptcy
- Becoming unemployed
- Losing housing, or becoming homeless
- Domestic abuse and violence (the alcohol user being either/both the perpetrator and/or the victim)
- Neglect, including hoarding
- Children going into care, or being put onto Child Protection Plans
- Mental ill health because of alcohol itself, or because of the impact of alcohol on other aspects of their life
- Learned behaviour by younger members of the household.

However, the consensus was that alcohol impacts all areas of life. To illustrate this, Mental Health Services said that alcohol “breaks people”. Alcoholics Anonymous work with clients on the “12-step programme”, which aims for the individual to rebuild all aspects of their lives including the incentive to engage with health services.

Clarion Housing were concerned, however, that many people do not disclose if they have an issue with alcohol in fear of losing housing or other services. Therefore, they

noted that many of the alcohol-related harms and impacts may not be seen or attributed to alcohol.

With respect to young people, School Nurses felt that most young people with alcohol issues had adverse experiences previously, such as drug use by their parents. In addition, if their service hears about alcohol issues in children, it is often tied up with other substance use such as cannabis. Children's Social Care agreed with this. However, they both note they often only see complex cases. Youth Justice Service also reported that they see familial alcohol and substance misuse, where there is consumption of alcohol as a family unit, including young people.

Adult Social Care reported that young people often have other significant risk factors if they are drinking risky quantities of alcohol, such as personality disorders, frequent A&E attendance, and self-harm. School Nurses and Youth Justice Service added safeguarding issues, family/social issues, and mental health issues more generally to this list. Youth Justice Service also reported trauma as being a significant factor in the consumption of alcohol. School Nurses also reported other risky behaviours with alcohol use, such as sexual risk-taking resulting in sexually transmitted diseases and unplanned pregnancies.

Bromley Changes discussed the impact of alcohol use on school attendance and school exclusion, which is often temporary but disruptive to their education. Children's Social Care also noted the loss of support network when young people leave education, having a detrimental impact on those who are transitioning to adult age. Youth Justice Service and the Police Service agreed that they see education being disrupted due to alcohol consumption, but both also explained that young people under the influence of alcohol also get into trouble with the police, often through shoplifting or drunk driving. Bromley Changes also discussed child sexual exploitation (CSE) as sometimes being associated with alcohol. Often, Bromley Changes see young people who are in crisis. The Alcohol Liaison Team at the PRUH also reported that adult alcohol use puts a strain on child development.

Overall, Mental Health Services reported that they felt alcohol has been ingrained as a white British coping mechanism for all sorts of trauma and negative life experiences. Considering the White population of Bromley, this is something to be considered.

A final interesting observation came from the Social Prescribing Team. They reported that many of the clients they see are now abstinent. However, this means they are more socially isolated as they do not want to return to social networks they were previously in which may trigger a relapse. So, while it is universally agreed that reducing alcohol intake is good, the consequent isolation must be considered.

9.3 Use of Bromley Drugs and Alcohol Service (BDAS) and Other Services

Many stakeholders and services work closely with BDAS, and expressed how invaluable the BDAS services are, particularly when working with complex cases. Professionals will offer to refer their service users to BDAS if it is felt to be appropriate, but for BDAS to work with them, the individuals must consent and willingly engage. In Emergency Care the service users frequently engage with BDAS, often they are unable to access other services as they are alcohol users and don't meet the criteria, so BDAS is a good option for them. Maternity Services will offer to refer all women who have reported to have an issue with alcohol use in pregnancy, but women still must consent to this. Alcoholics Anonymous described how sometimes their members come to the organisation via BDAS or vice versa, but the service does not always work for everyone. Primary Care refers many individuals to BDAS and many people who engage have reported to have incredibly positive, life changing results, but others just won't engage or don't feel the service is appropriate for them.

The key issue with engagement was that it relies on the individual to consent and want to voluntarily engage with BDAS. Adult Social Care highlighted that the Services are often constrained by the person engaging with them, the ones who most need it most, they can't engage with as they have not consented to it. Many will completely refuse; some individuals will only engage when in crisis or use BDAS inappropriately as a means of support. The Alcohol Liaison Team at the PRUH mentioned that often individuals will consent in A&E, but then subsequently don't engage once discharged from hospital. In these situations, BDAS will feedback to the Alcohol Liaison Team at the PRUH if the patient does not respond. Children's Social Care also highlighted the need to persistently try to engage with these individuals and not to discharge them if they don't answer the phone.

Some who are referred by stakeholders such as Primary Care feel that the BDAS service is not suited to them. The geographic location was highlighted as an issue by Primary Care and Social Prescribing Team, many are not able to travel that far, for others the opening times don't fit with their work schedules. Housing reported that they often refer to BDAS, but few engage due to being in temporary accommodation where they can be moved from Bromley at short notice. They try to keep those vulnerable individuals or those who are rough sleeping within the Borough, but they sometimes have to be relocated due to housing capacity. In these situations, Housing tries to work together with BDAS to ensure they are linked up with other services when they move.

In order to ensure those complex cases engage properly with BDAS, the Clarion Housing team described how they will ring and speak to BDAS after they have made a referral to see how they can best engage with this individual in a way that will suit them. Making every contact count is important when working with BDAS. Once someone in their service is working with BDAS they will link up, attending meetings etc, to engage BDAS on what is going on.

The stigma surrounding alcohol use was recognised by several stakeholders as being a barrier for engagement with some individuals who don't want to be seen to be going to the place where the drug or alcohol addicts go. Others feel that they don't have an issue with alcohol and BDAS is only for those with serious issues.

The Social Prescribing Team described how often people perceive their issue to be a mental health issue, not an issue with alcohol, so they don't feel that BDAS will solve their problems, but unfortunately, many mental health services will not accept them unless they are abstinent. Primary Care described a barrier to accessing BDAS, is that they will not work with someone under the influence of alcohol on the day. This can be challenging for professionals to deal with but also will prohibit those who cannot control their drinking from accessing services. The Social Prescribing Team noted that for some who have recurrent issues with alcohol use, they are afraid of being referred again to BDAS as they feel it did not work the first time and are worried about relapsing again. Mental Health Services reported that some of their service users are reluctant to engage with BDAS, but as most clients are in the Co-

Occurring Mental Health, Alcohol and Drugs Service, they usually have engaged with BDAS in some way.

School Nurses reported that the majority of the referrals they make to Bromley Changes are for children or young people with substance misuse issues as it is rare to see children/ young people with alcohol related issues in Bromley. They described how often the young people they see will not want to engage with Bromley Changes as they believe they are just socially drinking and don't see their alcohol use as problematic. The young people under their care with serious addiction issues, often have so many other professionals and organisations working with them that the young person feels it is an added stress to engage with Bromley Changes as well.

Alcohol use among parents in the household is a more common feature encountered by Health Visitors but they described that often parents they see don't want to be referred as they don't see that they have a problem. Some will try to hide it as they see it as stigmatising, while others feel that being referred to an alcohol service could be a threat to their family, that if referred to BDAS then Children's Services might remove their children. School Nurses described that in households where a parent is drinking, the Bromley Changes hidden harm worker is very useful, to work with the children around the effects of parental alcohol use on them.

Bromley Changes reported that they have good relationships with a number of services, but feel that often professionals are not referring cases to them, or they receive inappropriate referrals. For example, they described how they often get referrals for young people who are first time users and not continuous users, these young people don't often want to engage as this isn't the correct service for them.

Other services or organisations used by service users for their alcohol needs include:

- NHS: A&E, Secondary Care
- GP services/Primary Care
- Alcohol Liaison Team
- Psychology and Mental Health Services – either NHS or Private psychologist/therapist
- Bromley Well

- CAMHS for children/young people
- Social Prescribing
- Housing and Homeless team
- Private Inpatient facilities/Rehabs
- Community centres
- Alcoholics Anonymous
- Al Anon
- Adfam
- Young minds
- Talk to Frank
- Turning Point – Croydon
- Chris Hill – Beat My Addiction
- Living Well Foodbank
- Anerley Town Hall
- Cocaine Anonymous

9.4 Methods to Increase BDAS Engagement

In order to improve BDAS engagement, stakeholders had several suggestions, to look at ways to improve the referral process and the service delivery. Alcohol Liaison Team at the PRUH and Primary Care emphasised that the BDAS model may not work for all patients and suggested that increased flexibility in terms of access, such as offering walk in appointments could reduce barriers, making it easier for people to engage. Mental Health Services also emphasised the importance of the location and times of the service if you want people to engage. A variety of opening times and locations are needed to accommodate people who are working, ensuring that the location is accessible yet private, so people feel comfortable going there; Ideally if the resources allowed, offering a service with longer opening times, 7 days a week so that service users are able to access BDAS services out of hours or on weekends, which are often the most critical times for people with addictions.

Adult Social Care and Youth Justice Service proposed having a drop-in centre specifically for young people, that they can access independently, with staff that understand the specific needs of young people. The centre could provide other

services, and include a GP, nurse, sexual health advisor, social worker and psychologist so when young people attend they can access all the support in the same place, in a “one-stop-shop approach”. A suggestion was made by Health Visitors for a drop in specifically for parents where they can access support that is catered to them, advice about how to maintain a healthy relationship with alcohol and to receive help before it becomes a negative problem. The Health Visitors also suggested this could include support services for the partner of drinkers.

To combat the stigma which is a barrier to many individuals to accessing alcohol services, Primary Care and Mental Health Services suggested that BDAS could run satellite services within Primary Care, thereby normalising alcohol support services and reducing the stigma surrounding them. Primary Care ran a successful pilot providing alcohol support out of a GP practice, details of which are in Stakeholder initiatives, Section 9.6.

Children’s Social Care reflected that BDAS is a very adult focused service, so they find that often younger adults do not want to attend. Young people need services that are aimed at them and tailored to their needs. There is a need for BDAS to become more youth friendly and for a transition service, possibly with the use of a liaison worker to support young people in the transition from Bromley Changes to BDAS. Housing highlighted that when a young person is housed with much older people with drinking needs, there is a risk this will impact them negatively and they could also spiral into alcohol use.

To better engage with individuals involved in criminal activity, the Police Service suggested that for any alcohol-related crimes, the Criminal Behaviour Order (CBO) should include their alcohol addiction and mandatory engagement with the alcohol service as part of the post-conviction order. They felt that this would help people engage and discourage reoffending as they will be obligated to engage with alcohol services as a condition of the order, which would hopefully in turn encourage positive behaviours. The Police Service highlighted a need for their service to work more closely with BDAS to ensure a clear pathway of referral following repeat offending, recognising the vicious cycle of offending driven by addiction. An example of this could include involving BDAS in Anti-social Behaviour (ASB) meetings, to discuss complex cases.

Many stakeholders expressed the need for outreach workers or complex needs workers to become a part of the BDAS service. These outreach workers would support people with day-to-day issues they are facing outside of alcohol such as employment, housing, mental health issues, debt recovery, accessing benefits etc. These external issues are likely to be having a huge impact on the service users lives and could even be driving their alcohol use. Adult Social Care suggested these outreach workers could go out to community centres, shelters, women centres to engage with people there and Youth Justice Service and School Nurses proposed they go to particular areas where children and young people are hanging out, and increased substance misuse is happening. Housing suggested that BDAS outreach workers could link up with homeless outreach workers, working in partnership to provide support and advice to those on the street, or carrying out home visits for those who are unable to attend the BDAS centre.

The Alcohol Liaison Team at the PRUH and Adult Social Care described how useful case workers would be, particularly for complex cases. The Alcohol Liaison Team at the PRUH highlighted how this would potentially help address the gap in engagement between hospital and community services; as they described how often individuals will consent to engage while in A&E but then they are discharged and are overwhelmed at home, so they subsequently disengage, falling through the cracks. Children's Social Care also emphasised the need for outreach workers to have a flexible approach as individuals often have a very chaotic lifestyle, so a more persistent approach is needed to engage them, rather than discharging if they don't respond to one phone call. Primary Care also highlighted the need for a clear dashboard on dropouts.

Partnership working with other organisations, was highlighted as an area for improvement. Bromley Changes expressed how a closer working arrangement with other agencies such as Education and Housing is needed to ensure that drug/alcohol use is being reported by other services. For example, a Bromley Changes representative could attend housing meetings or work closer with housing officers on complex cases. Bromley Changes and the Youth Justice Service emphasised how their partnership and close working together could increase engagement of young people, for example they have a youth resilience worker who attends the health care panel. Alcoholics Anonymous also highlighted that there is a

need for improved working together across services and voluntary support organisations.

Housing and Clarion Housing suggested better communication and collaborative working is needed, especially with individuals with unstable living situations and chaotic lifestyles. Other London Boroughs have a process whereby homeless individuals can be referred to detox beds in the NHS but housing are unaware if this is available in Bromley. Inpatient treatment like this may be better for certain alcohol-dependent homeless individuals due to chaotic lifestyle, and in many situations they may require detox before their housing issues can be resolved. BDAS would be responsible for facilitating placement in these detox beds.

The complexities around mental health and alcohol use were discussed frequently by stakeholders. Emergency Care and Primary Care suggested that a closer, strategic partnership with Mental Health Services was needed so that individuals with a dual diagnosis could receive support for both their alcohol addiction and their mental health simultaneously. Better pathways to support people to access mental health services for those with dual presentation are also needed to reduce the barriers and delays to getting treatment and support. Adult Social Care and Children's Social Care also re-emphasised the need for a combined approach with Mental Health Services, describing how as things stand Mental Health Services don't step in until the alcohol problem is resolved. Youth Justice Services also described how the same issue was a barrier for young people in being referred to or accessing CAMHS. BDAS needs to be closely working alongside MHS in order for it to work. MHS services described how they tend to go out to service users in order to engage them while alcohol services such as BDAS tend to expect the service user to come to them. They suggested that the co-location of services to one facility so that individuals can access MHS and BDAS at the same time in the same location would be likely to improve engagement.

Several stakeholders highlighted the fact that there is a need to raise wider awareness of BDAS services. A few stakeholders mentioned that BDAS and BC had provided updates to the staff in their organisation, but suggested that more frequent and regular training, updates, educational support for staff would be beneficial. It would also help improve the referral process and help with unrealistic expectations of

what BDAS can do. There were suggestions that BDAS could increase its presence on social media platforms, and normalise the service by posting information in GP surgeries, Childrens centres etc.

Alcoholics Anonymous also reiterated the need for further education, highlighting that health care professionals do not appear to understand alcoholism or addiction more generally. There was the perception that they are aware of the issue, and want to do what they can to help, but there often isn't time or resource, or the in-depth understanding of the complexity of addiction.

MS requested easier access to BDAS information to give women accessing their service, for example they suggested that information about BDAS could be added to the KCH Maternity app, or information cards that midwives could give out to women in clinic. School Nurses highlighted the need for better education for children and young people, alcohol use and the dangers of misuse, possibly to be included in the National Curriculum. School Nurses also reflected that there is a need for a better understanding of the full extent of alcohol use in young people locally, statistics on the level of alcohol use and related factors so that they can dig deeper into the causes, and services could then be adapted to better meet the needs.

9.5 Stakeholder Work and Relationship with BDAS

All stakeholders reported a strong and positive working relationship with BDAS and Bromley Changes. There were no negative comments overall about the working relationship with the service. For example, Emergency Care reports good relationships with case workers and managers, and works particularly closely with the complex needs worker. They report that BDAS always contributes well to multiagency decisions, shares expert opinions, and ensures clients are safeguarded. Adult Social Care described BDAS as "invaluable", particularly in complex cases. The Alcohol Liaison Team at the PRUH report that BDAS will feedback to them if a client they have referred does not want to engage, so they are aware if the client represents. Primary Care report that when they do get in touch with BDAS, the advice is always helpful. Clarion Housing reported it was very easy to get in touch with BDAS and discuss clients with case workers.

Stakeholders reported attending team meetings with BDAS which they find a useful forum to get their expertise and make plans for patients, including Emergency Care, School Nurses, Health Visitors, Children's Social Care, Clarion Housing and Housing.

Children's Social Care also specifically noted the good quality training that BDAS provides. However, the Social Prescribing Team stated that they would like some more training, particularly around the timing of referral and the confidence to motivate individuals. At present, they don't feel confident to explore potential drug use.

Health Visitors report they would have little contact with BDAS as they would often liaise with Children's Social Services about complex cases which would require BDAS input. Social care often makes the referrals and communicates with BDAS, or Health Visitors would do this in collaboration with social care. However, they encourage people to self-refer, which is also the approach made by Primary Care.

However, there was the acknowledgement that BDAS struggles to fulfil all the functions organisations would like to see it fulfil. There was acknowledgement that BDAS needs more resourcing to do this by Emergency Care. Emergency Care also acknowledge that there may be an unrealistic perception by external agencies of what BDAS can achieve or should achieve. Therefore, they suggest that other agencies need to be trained on their remit.

One other issue raised by Primary Care is that they very rarely get any correspondence from BDAS about their patients, and they would like to see a more systematic communication channel, such as through clinic letters. However, Housing report that there is a constant flow of communication with them. They are currently working with BDAS to ensure they understand cases better and communicate with case workers, so they are working with the same people.

Mental Health Services reported that they are keen on working much more closely with BDAS and Bromley Changes. They report that there has been the realisation across all levels of care that the co-location and provision of mental health services and alcohol/drug treatment services is needed. Mental Health Services acknowledge that there is a "chicken or the egg" issue with mental health and alcohol addiction, and that they must find a way to provide mental health care to those who need it with

addiction. There is the acknowledgement that the present set-up, where an individual must be abstinent before they can access mental health services, is not sustainable. However, there are multiple issues with why this might be – the financial arrangements for the commissioning of mental health and alcohol services, the confidence of mental health staff to work with those who use substances, and those who have an addiction may be more complex, requiring more resourcing, resulting in a subconscious decision to not accept the referral. They acknowledge that BDAS would be more willing to come to Mental Health Services to see a patient, but this is not reciprocal. Therefore, they are keen to make changes in this respect and have a closer relationship with BDAS. Emergency Care echoed that they would like to see a greater strategic partnership with Mental Health Services to ensure those with a dual diagnosis receive support for their addiction and mental health needs simultaneously and without delay.

9.6 Stakeholder Initiatives

The Alcohol Liaison Team at the PRUH shared with us their Alcohol Assertive Outreach Treatment (AAOT) programme. Based on a significant evidence base, AAOT is a model of care developed for people with severe mental health problems who have significant functional impairment including multiple and complex problems. It is a vehicle for delivering effective treatments. It aims to maintain regular, frequent contact to monitor a patient's condition to provide effective treatment and rehab, keeping them out of hospital and on top of their case.

This was implemented at King's College Hospital (KCH), which is in the same trust as the local hospital, PRUH. They focused on alcohol-related frequent hospital attenders, who are those who had 3 or more alcohol-related admissions per year with multiple unmet health and social care needs. They will also rarely access community addiction services. This cohort of patients represents 9% of people with alcohol dependence, but 59% of admissions and 1.4 million bed days per year, costing £848 million nationally. In Lambeth and Southwark, a £5 million cost was estimated.

By implementing this service, the number of alcohol-related admissions at KCH rapidly reduced, as can be seen in Figure 77 below. As this was implemented in KCH, the implementation of AAOT at the PRUH should be considered.

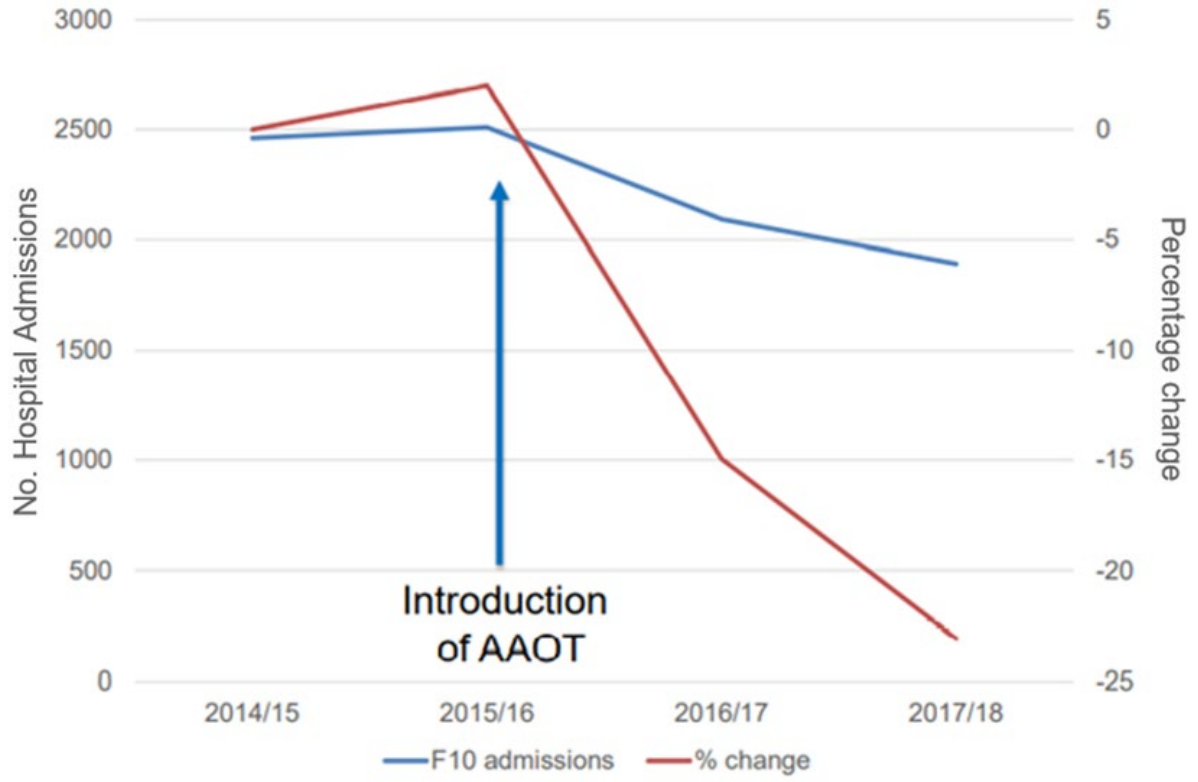

Figure 77: Number and percentage change of hospital admissions after the implementation of AAOT at KCH in 2015/16 Source: ALT.

Another initiative was run by Primary Care in order to try and engage individuals struggling with alcohol use and combat the stigma surrounding alcohol services. Three GP practices ran a pilot where those individuals who were drinking at harmful levels were able to come to the GP practice to see an alcohol specialist nurse, rather than go to BDAS. They found that this method worked much better for those who felt uncomfortable going to BDAS, and they were able to engage and get help at the GP Practice instead. For others whose drinking was more severe or pharmacological treatment was needed, they were able to link into BDAS from Primary Care in this way. The drawback was that Primary Care did not have the resources or space to continue this service.

An evaluation of the pilot took place. It found there was a 75% engagement rate, with patient satisfaction surveys revealing clients much preferred to be seen in the GP setting than at BDAS. During this time, BDAS delivered brief intervention training to

20 members of staff across the three GP practices. However, there were instances where a client should have been referred to BDAS and were not, indicating that training may need to be more thorough. The report concludes that more surgeries across Bromley should implement the programme. It was recommended that clusters are developed across Bromley where GP's can refer to the nearest surgery for clients to be assessed and seen for brief interventions. The planning of new services will require referrals systems and processes to be developed before the service is initiated. This will also require CGL to deliver training across surgeries before new services are initiated to embed learning from the pilot.

Key Points of the Chapter:

- Several support organisations and external agencies were interviewed to identify the vulnerable populations they serve, if they misuse alcohol, where they get support, and why they may not access Bromley Drugs and Alcohol Service (BDAS)
- Organisations cater for many vulnerable groups, including the homeless, unemployed, those in absolute poverty, victims of domestic violence, offenders, young people, learning difficulties or mental health issues.
- Many of these vulnerable individuals do not engage with BDAS
- In terms of Alcohol-Related Harms and Impacts, it was highlighted that alcohol impacts all areas of life, having physical health impacts, but also significant social, psychological and economic impacts
- Many stakeholders and services work closely with BDAS, and expressed how invaluable the BDAS services are, particularly when working with complex cases, but often there were challenges with engaging people.
- Many reasons for lack of engagement with BDAS were given by the organisations:
    - Accessibility, location and opening times
    - Other needs are a priority (e.g. housing, income)
    - Stigmatisation
    - Gaps in the referral between organisations or in communication
    - Barriers to accessing services such as dual mental health diagnosis
    - A lack of knowledge about the service in the first place
- Several methods of ways to increase engagement were suggested:
    - Increased flexibility in terms of access, geographic location, timings of clinics to reduce barriers
    - Drop in clinics
    - Improved partnership and communication with other organisations – particularly mental health services and primary care
    - Provision of youth friendly services and transition to adult services
    - Outreach – to reach communities not served by any organisation, including the homeless population, young people etc

    - Complex needs worker to support with issues outside of alcohol, eg. housing, employment, benefits etc.
    - Raise wider awareness of BDAS services through education and training.
- All stakeholders reported a strong and positive working relationship with BDAS and Bromley Changes. But recognition that partnership working and communication could be improved.
- Stakeholder Initiatives described: Alcohol Assertive Outreach Treatment (AAOT) programme and Primary Care Pilot

10. Unmet Needs and Recommendations

In Chapter 8, the demographic characteristics of young people and adult service users in BDAS for alcohol treatment, their treatment modality, and treatment outcomes were explored. Some of these individuals will have completed treatment successfully and have their needs met. However, there will be those engaged with the service who will still have an addiction or use substances, particularly vulnerable individuals or those who go on to be admitted to hospital or die due to alcohol-related issues (Chapter 7).

There will also be individuals who consume alcohol heavily and are not engaged with services, as identified in Chapter 5 and Chapter 6. Many will be vulnerable and in minority groups who do not access BDAS for several reasons, as explored with local stakeholders in Chapter 9 (as well as Chapter 11 in the Substance Misuse Needs Assessment - SMNA). In addition, it was important to engage with these stakeholders/partners as for all individuals with an alcohol treatment need, engaged with services or not, their needs are complex that cannot be solved by alcohol services alone.

This needs assessment primarily aims to identify unmet needs to be addressed. However, many of the recommendations are similar to those identified in the SMNA. Where there is significant crossover of a recommendation, this is clearly outlined. These recommendations should be integrated into the service specification, or considered when commissioning, depending on the recommendation.

In total, there are 21 recommendations.

Like the SMNA, there are many unknowns about alcohol consumption, particularly locally. The national data is populated from surveys such as the Health Survey for England and other surveys, particularly for young people. These are based on sampling frames, and so are representative (however, reporting alcohol use in a survey is problematic particularly regarding the accuracy of alcohol consumption). However, locally, only AUDIT-C/AUDIT data for adults, and School Health Education Unit survey results for young people is available – both with significant limitations as discussed.

In addition, there are many vulnerable groups discussed including those with no fixed abode, unemployed, victims of violence or abuse, co-occurring mental illness, offenders, amongst many more. However, we do not know the full extent of alcohol use in these groups.

Recommendation 1:

Crossover with SMNA Recommendation 3

To understand alcohol use across the borough and considering the potentially large number of particularly vulnerable residents who need alcohol services, a specifically commissioned data collection exercise may be necessary, using a sample of the population. This should attempt to understand the magnitude of alcohol use (including binge, recreational, and addictive use) in both the general and vulnerable population, demography including gender, age, home location, and employment, and reasons why they may not engage with formal alcohol services. This exercise would be important to identify any emerging or unknown unmet needs, particularly in the recovery from Covid-19.

Primary care screening of alcohol consumption is supposed to take place within a year of a patient joining the practice, as well as in other set circumstances such as NHS Health Checks or where the consultation is specifically about alcohol, as examples. However, there are clearly significant gaps in this occurring, with 48% of people joining a GP practice in Bromley in 2021/22 not having an AUDIT-C or FAST screening (and they didn't decline it). This will better help GPs identify those with alcohol needs and make appropriate referrals.

In addition, as also identified in the SMNA, GPs reported that they receive very little information from BDAS about patients who are under their care, including what treatment they are receiving, their progress, or any referrals to other services, such as Tier 4.

This is a patient safety issue as, firstly, GPs are unaware of what interventions their patient are receiving, having an impact on their ability to safely consult and prescribe as necessary. Secondly, if GPs are not recording what *they* are doing, this

information won't be seen by their colleagues in future consultations, or for BDAS to review on referral from GPs.

Whilst communication issues were identified with primary care through the stakeholder engagement, these principles are also important for other services, such as statutory services and other healthcare settings. Information should be shared between agencies which complies with data protection and information governance regulations to aid recovery.

Recommendation 2:

Crossover with SMNA Recommendation 4

As part of the service specification, there needs to be a requirement for BDAS to share information with other services, including primary care, about the service user's treatment journey.

Additionally, BDAS and LBB need to work with primary care colleagues to ensure they are collecting alcohol consumption data using validated tools, including when patients join the practice, in commissioned health checks, and in consultations that are primarily focused on alcohol.

Related to the above, there needs to be an agreement with BDAS about the data they collect. For example, whilst there is no national requirement for data on sexuality and disability to be collected, as examples, there should be a local agreement that this is routinely collected. At present, there are significant gaps in the data for these demographics as well as ethnicity, but to a lesser extent. This data will help LBB and the service provider understand the needs being met in this group, and work to improve this if needed.

Recommendation 3:

Crossover with SMNA Recommendation 26

Ensure the service specification is explicit that adequate data collection is a condition of providing the service to accurately monitor trends and needs.

As identified in the SMNA, there is no formalised substance misuse and/or alcohol specific partnership strategies or groups, as seen in other local authorities. These partnerships are helpful in bringing together all the stakeholders that could contribute to an individual's treatment and recovery pathway, including but not limited to frontline services where many individuals with addictions will present, including primary care and A&E, statutory services such as the Job Centre, housing, and social services, probation services, and of course the service providers themselves. This will provide partners with buy-in as they will have helped set the priorities and contributed to resourcing

Recommendation 4:

Crossover with SMNA Recommendation 1

A formalised partnership strategy and group should be established to provide strategic oversight on the provision of holistic care and support to service users in alcohol services, as well as identifying emerging needs so strategies can be put in place to meet this need.

It is exceptionally clear from the stakeholder engagement, as well as the data available on vulnerabilities of clients engaged with BDAS, that people often have exceptional and complex needs if they have an addiction to alcohol. It is clearly not possible for BDAS to be able to tackle these needs alone. For successful recovery, many of these needs must be addressed in parallel or in a finely tuned sequence which will be different depending on the client. It will therefore require not only the strategic collaboration as advised in *Recommendation 4,* but also "on-the-ground" partnerships, with each stakeholder taking responsibility for their own area of expertise but in a joined-up manner.

Recommendation 5:

Crossover with SMNA Recommendation 15

Formalised Memorandum of Understandings (MoUs) or partnership agreements should be set up with providers of basic needs and support services, particularly within employment and housing for adults, but also mental health services,

education services, debt assistance, and social services. This should be a part of the clients' treatment plan, and a shared understanding and responsibility with other services. This agreement should also ensure training is provided to increase awareness of services and the needs of clients with substance dependency.

In the stakeholder engagement, it was clear there was a lack of understanding of what BDAS can offer both adults and young people. On occasion, there was an over-expectation of what they could provide, with organisations unsure of what they are actually able to offer. This may have an impact on referrals to the service. This is reflected in the poor referral rates from some services. In the adult services, most referrals come from the individual themselves or their family/friends. Very few come from other services, who we know these individuals engage with through our stakeholder engagement, such as housing, social services, and hospital (as examples). In young people services, there has been a drop off of referrals from educational services since the Covid-19 pandemic, and the quality of referrals from hospital has been a point of concern.

The stigma surrounding alcohol use was recognised by several stakeholders as being a barrier for engagement with some individuals who don’t want to be seen to be going to the place where the drug or alcohol addicts go.

To tackle both, a programme of training would be beneficial.

Recommendation 6:

Crossover with SMNA Recommendation 17

As part of these MoUs or partnerships, BDAS, with the expertise they have on alcohol and substance misuse, should have a programme of education for organisations to raise awareness of the local drug and alcohol services and increase understanding of the issues these individuals face. This would help improve the referral process to BDAS and Bromley Changes and reduce stigma. This should be delivered to statutory services including, but not limited to, housing, social services, children and young people services, and employment services.

As part of *Recommendations 5 and 6*, many of the organisations necessary for these partnerships will be within local authority, such as social services and housing. As commissioners, LBB should also have a role in ensuring all appropriate Local Authority departments are engaged and committed to addiction recovery.

Recommendation 7:

Crossover with SMNA Recommendation 18

LBB Public Health should also work with other borough departments, such as health visitors, school nursing, and social services, to ensure partnership work is engrained into everything we do, from commissioning to delivering services. This includes wider harm reduction methods, such as the use of leisure centres and recreational facilities for those in treatment and recovery.

Whilst young people are included in all recommendations, it is worth exploring partnerships required specifically for young people. A lot of the stakeholder conversations revealed that there is the perception there is poor understanding of alcohol use in young people and the impact this might have on their lives. This includes formal services, such as education, Children's Services, Health Visitors, School Nurses, but also voluntary and charitable organisations.

Recommendation 8:

Crossover with SMNA Recommendation 14

Increased partnership with organisations who work with children. This would include statutory services, but also youth groups, charities, and after school/activity groups, in order to help them identify a child in need of support, and where appropriate provide brief interventions and signposting.

Like in substance misuse, the co-occurrence of mental ill health and alcohol is well documented. The experience in Bromley is no different. The burden is so great that this needs specific and urgent attention. In adult services, 69.2% of alcohol users engaged with BDAS in 2020/21 had a mental health issue. Many were not receiving

treatment. In the young people service, 63% required Mental Health support whilst in services.

In addition, the condition causing the most alcohol-related morbidity in Bromley is mental or behavioural disturbance due to alcohol. Whilst this is not the most common cause of mortality, it is clearly resource intensive and distressing for the individual and their loved ones. This burden could be reduced with appropriate mental health support.

Most service users need to be abstinent for a sustained period before being able to access mental health support, leaving them in a never-ending cycle of mental ill health and addiction/relapse. There was recognition through our stakeholder analysis that more needs to be done to foster joint working and relationships between mental health and addiction services, with a significant change in the referral process and referral acceptance policy needed. National guidance states that the provision of mental health and substance misuse services should follow the "*no wrong door"* principle

Recommendation 9:

Crossover with SMNA Recommendation 8

There must be a stronger partnership with mental health services, implementing the "*no wrong door"* policy. Many clients need the assistance of both in parallel to recover from addiction. Evidence from the literature, as evidenced in the SMNA, suggests many methods of achieving this, including specialist dual-diagnosis clinics, training of staff, psychoeducational groups, and blended models of care. Better pathways to support people to access mental health services are also needed to reduce the barriers and delays to getting treatment and support.

There is a recognised impact on the children in the household where the parents drink. One third of those in treatment at BDAS for alcohol only in 2021/22 reported they were a parent. Of those, 18% of those who had a child at home were a child in need, a significant increase from the previous year. Yet the Children in Need census collected by local authorities showed a higher percentage of children in need in Bromley had a parent that misused alcohol. This likely indicates that there are more

children in need, in alcohol-using households in Bromley than those engaged with services. There was a concern from stakeholders that often parents will not disclose their alcohol use for fear of being seen as an unfit parent and having their children removed.

The effects of alcohol consumption on children in the household is important as it is frequently an issue in safeguarding cases. Data from 2019 showed that a higher proportion of children drank alcohol if their mother or father drunk more alcohol, not to mention the physical, psychological and intellectual impact this can have on the child. Stakeholders recognised the need for more specialist work with these families.

Recommendation 10:

Crossover with SMNA Recommendation 12

Further work with social services and other agencies is urgently required to identify parents who are dependent on alcohol, to identify children in the household at risk of using alcohol themselves, and to tackle the wider vulnerabilities young people using the service face, to ensure they get the support they need.

Recommendation 11:

Specific support services are needed for parents who drink, for example drop-in clinics with flexible times and support groups where they can meet other parents. This is to improve their own health and wellbeing, but also that of their children.

Many of the stakeholders work with individuals with an alcohol-related unmet need. These individuals trust the organisations they attend, including mutual aid groups, youth centres, and charities, and do not want to engage with BDAS. Like the SMNA, in order to engage with these individuals with an unmet need, BDAS needs to reach out to these groups and meet individuals in their trusted spaces in the community.

To do this, many of the stakeholders we engaged with felt that there needs to be more formalised outreach work to ensure those with an unmet need are encouraged to engage with BDAS, and then ensure they continue to engage. These should be formalised arrangements between BDAS and the community organisations.

Recommendation 12:

Crossover with SMNA Recommendation 11

A formalised outreach programme should be resumed with outreach organisations, such as mutual aid groups, youth centres, voluntary organisations, and charities, in order to engage individuals with an unmet need. They must ensure these relationships are reciprocal, capitalising on the expertise of the organisation and the trust clients put into them.

Stakeholders expressed the need for Complex Needs Workers to become a part of the regular BDAS service, as many service users are battling other issues apart from alcohol. These workers would work with BDAS service users who have the most complex needs by supporting people with day-to-day issues that they are struggling with, such as employment, housing, debt recovery, or accessing benefits. These issues are likely to be having a huge impact on their lives and could even be driving their alcohol use.

Recommendation 13:

Crossover with SMNA Recommendation 19

Appoint Complex Needs Officer(s) to work with individuals in BDAS with complex additional issues by liaising with other organisations with the appropriate expertise to help resolve these issues. These officers would provide advice, help make referrals, signpost, and support them in the process.

The data from this needs assessment demonstrates clear demographic trends. Men tend to drink more heavily and regularly, as identified by national data. They also make up most of the alcohol-specific morbidity and mortality in Bromley. In addition, the quantity and regularity of drinking increases with age. Binge drinking is now seen in older people as much as it is seen in younger people. Admissions and deaths specifically due to alcohol have the highest proportion in the 55-64-year-old group,

which reflects the long-time frame required to develop alcohol-specific health issues. Whilst the highest proportion of those in alcohol services are men and 40-49-years-old, and so is meeting the need of reducing alcohol-specific morbidity and mortality, more needs to be done to ensure at risk groups have their needs met.

Recommendation 14:

In the context of higher morbidity and mortality and in the absence of data specific of alcohol use in Bromley (for people not engaged with BDAS), we should ensure that the appropriate outreach is occurring in younger age groups, particularly in men, to ensure treatment needs are met, and prevention strategies are implemented to avoid the increasing morbidity and mortality seen in middle-aged groups. This could be through the form of identification in acute services, such as A&E, or in other services these groups engage with, such as outreach organisations.

There are data from OHID which indicates that the proportion of non-drinkers in Bromley is lower than England and London, but the proportion of heavier drinkers (>14 units) is higher. This may mean that, overall, Bromley residents drink higher quantities of alcohol, but more work will need to be done to make a definitive conclusion.

Overall, Bromley is an affluent borough in the 9th Index of Multiple Deprivation decile, meaning it is amongst the 20% least deprived boroughs in England. However, as in all areas, there are pockets of deprivation. The data in this needs assessment indicates that the alcohol-specific morbidity in these areas is higher than in more affluent areas. There was too little data to analyse this fully for mortality.

Therefore, there is a complex relationship between deprivation, alcohol consumption, and alcohol-specific harm which needs to be understood.

Recommendation 15:

In addition to the demographics outlined in *Recommendation 3,* there needs to be focus on prevention and treatment in the most deprived areas of Bromley to

prevent the alcohol-specific morbidity and mortality which disproportionately affects these areas. However, in doing this, prevention and treatment in the less deprived areas should not be ignored particularly as the borough-wide alcohol consumption appears to be higher than national and regional averages. Understanding alcohol consumption and morbidity/mortality is key to tackling this and will be helped by carrying out *Recommendation 1.*

In 2017/18, 6% of service users in adult services were known to the Criminal Justice System (CJS). By 2021/22, this was 1.2%. However, the rate has remained stable on a national level. Therefore, it is important to understand whether this a reduced need (i.e., genuine reduction in people with alcohol treatment need also engaged with the CJS) or an emerging unmet need (i.e., those with an alcohol treatment need and engaged with the CJS are not being captured as well as they used to). Understanding this will require partnership work with the CJS, particularly probation, but as this is a potential unmet need should be prioritised. The Police Service highlighted in the stakeholder survey that there is a need for closer working together with BDAS to ensure a clear pathway of referral following repeat offending, recognising the vicious cycle of offending driven by addiction.

In addition, to better engage with individuals involved in alcohol-related criminal activity in BDAS, the Police Service suggested that Criminal Behaviour Orders (CBO) should include their alcohol addiction and mandatory engagement with the alcohol service as part of the post-conviction order. The Police Service felt that this would help people engage and discourage reoffending as they will be obligated to engage with alcohol services as a condition of the order, which would hopefully in turn encourage positive behaviours. In addition, the government are looking to reduce alcohol-fuelled crime and have aimed to cut reoffenders by placing alcohol bans and sobriety tags on offenders released from prisons.

Recommendation 16:

In collaboration with partners, such as probation, it is important to ensure those engaged with the CJS and have an alcohol treatment need are captured and

engaged by BDAS to meet this need. A better understanding of whether this is an unmet or recently reduced need is required and could be understood better by carrying out *Recommendation 1.*

Recommendation 17:
In collaboration with the police, explore the feasibility of developing a CBO pilot to include alcohol addiction and mandatory engagement with the alcohol service as part of the post-conviction orders.

Nationally, unemployment has reduced since 2013 (with a brief increase during the Covid-19 pandemic). However, the unemployment rate of service users engaged with BDAS increased from 18.8% in 2020/21 to 55.7% in 2021/22 – the opposite trend. It is important to understand whether this is a new need, a delayed response to the pandemic, or more accurate data entry. If this is an emerging need, much closer work with appropriate stakeholders such as the Job Centre will be needed to support appropriate employment or volunteering opportunities that work with recovery.

Recommendation 18:

In collaboration with partners, such as the Job Centre, it is important to support those in recovery back to work, as appropriate, ensuring that work is not a barrier to successful recovery. A better understanding of whether this is an emerging need is required and could be understood better by carrying out *Recommendation 1*.

The geographic location of the BDAS service was highlighted as an issue by some stakeholders, with them reporting that many are not able to travel that far as they don’t have a car or cannot access public transport. Location is key for engagement -

it must be accessible yet private enough, so people feel comfortable going there. This is further supported by morbidity and mortality being greatest in the North-West and East of Bromley, which are furthest from the alcohol service.

In addition, rates of hospital admissions (morbidity) are higher in areas of increased deprivation (North-West, North, and East of Bromley). There is a clear correlation between deprivation and morbidity. These areas of high rates of hospital admissions are in the extremities of Bromley and furthest from alcohol services. There is no clear correlation between deprivation and mortality, however, there is high mortality in areas and/or around areas of deprivation. The number of clients engaged with BDAS for alcohol-only is also highest from areas of deprivation (North-West and North of Bromley).

It is encouraging that the areas with the highest morbidity and mortality are also the places where the most people engage with BDAS. However, the fact there is more morbidity and mortality indicate there are likely many more individuals in these areas and beyond that require alcohol services.

Recommendation 19:

Crossover with SMNA Recommendation 20

There is a clear need for alcohol services to be located where the morbidity and mortality is greatest. This should be in the form of BDAS services being physically located there, or in stronger outreach work. This could also be in the form of a “hub and spoke” model, with satellite services being located across the borough that are linked to a centrally located service.

To improve BDAS engagement, stakeholders suggested that increased flexibility in terms of access, such as offering walk in appointments could reduce barriers, making it easier for people to engage. A variety of opening times are needed to accommodate people who are working, ideally if the resources allowed, offering a service with longer opening times, 7 days a week, so that service users can access BDAS services out of hours or on weekends, which can be the most critical times for people with addictions.

Recommendation 20:

There is a need for increased flexibility and accessibility of the BDAS service offered in terms of longer opening hours, providing a 7 day/week service, with a mixture of appointment-based clinics and drop-in clinics to accommodate for people's needs and increase their likelihood of staying engaged with the services.

There are several issues identified in this needs assessment which may justify a joint young person and adult's alcohol and substance misuse service, also identified in the SMNA.

Firstly, young people often disengage when they leave children's services and/or fall through the gaps as the adult focused services do not properly address their needs. Therefore, there is a recognised need for support of young people as they transition from young people to adult services. Some young people services state they have individuals on their books who are older than 18, as they fear that once they transfer their care to adult services, they will be lost in the system or will disengage.

Secondly, several stakeholders highlighted the need for more services, that are aimed specifically at young people and tailored to their needs. There was the perception that perhaps the services provided to young people do not have the equivalent depth or appreciation as the adult's service.

Thirdly, as clearly stated in *Recommendation 9,* there is a huge mental health burden in those with an alcohol treatment need. Having the co-occurring mental illness service more integrated into the mainstream adult's service would therefore go some way to meeting this need and recognising those who may need both alcohol and mental health support. This may require more partnership or integration of mental health services into BDAS.

Recommendation 21:

Crossover with SMNA Recommendation 25

Due to the perceived lack of parity between young person and adult services, the transitional issues from young people to adult services, and the significant double

mental health and alcohol treatment burden, in the next commissioning round, the three separate BDAS services (adult services, young person services, and COMHAD) should be procured as one whole, integrated, and streamlined service.

11. Discussion

In 2021, the UK Government published a new drug strategy *From Harm to hope: a 10-year drugs plan* to cut crime and save lives by tackling the drug problem and providing a high-quality treatment and recovery system for those suffering from addiction, including alcohol. [10] To achieve this, the Department of Health and Social care (DHSC) is providing £85.7 million in additional grants to improve drug and alcohol services. [11] However, there has not been a new alcohol-specific policy in the UK since 2013.

Unfortunately, in recent years, local authority funding has been cut and so the quality of alcohol misuse services has also suffered an impact. A loss of specialist services and workforce has meant there is increasing unmet need in the community, with an increasing number of hospital admissions and death. In 2019/2020 there were an estimated 280,000 admissions to hospital where the primary reason for admission was attributable to alcohol [5]. This impact has also been seen locally where there has been increased morbidity.

This needs assessment has systematically assessed unmet needs in the borough by collecting and evaluating both quantitative and qualitative data. This data has assessed needs in those engaged with substance misuse service for alcohol, and those who are not.

The needs assessment has uncovered many unmet needs, or perhaps more appropriately “unknown unmet needs”, particularly in vulnerable populations. The evaluation of these unmet needs has resulted in 21 recommendations for commissioners to consider when commissioning alcohol misuse services in the coming years. Several recommendations are similar to those made in the substance misuse needs assessment and have been highlighted when there is overlap. Many of these recommendations are for the service provider themselves to initiate but should be included in the service specification so they are contractual. Others are more focused on how the service should be commissioned, such as the development of a partnership strategy or group and the integration of services. There is a theme across several recommendations that there are gaps in key data and

knowledge and so there is a need to urgently identify any emerging or unknown unmet needs, particularly in the recovery from Covid-19.

Following the passage of the 2022 Health and Care Act, Integrated Care Systems (ICSs) were introduced to bring together NHS organisations, local authorities and other organisations to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas. After several decades during which the emphasis has been on organisational autonomy, and a divide between commissioners and providers, the newly formed ICSs instead depend on collaboration and focus on places and local populations as the driving forces for improvement. The needs assessment has acknowledged the difficulties in partnership work and presented evidence on ways to improve partnership work. Hopefully, with the collaboration introduced by the ICSs and the new government drug strategy which encourages such ways of working, partnership working will become easier in years to come.

Clearly, all this not only relies on commissioning a high-quality service, but also on the funding available to local authorities to do this. The funding pledged in the UK Government strategy to achieve these pledges will therefore be important to realise this ambition. However, much of its strategy is still focused on a criminal justice focused system as has been the policy for the last decade, so there must be caution by the government to not repeat the mistakes of the past and allow alcohol-related mortality to rise even further. An alcohol-specific policy is urgently needed to provide the backing to address the needs and recommendations laid out in this needs assessment.

References

[1] NHS Digital, “Health Survey for England, 2019: Adult' health-related behavours data tables,” 20 December 2022. [Online]. Available: https://files.digital.nhs.uk/2E/B925DF/HSE19-Adult-health-behaviours-tab.xlsx. [Accessed 20 June 2022].

[2] Public Health England, “Monitoring alcohol consumption and harm during the COVID-19 pandemic,” 2021. [Online]. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1002627/Alcohol_and_COVID_report.pdf. [Accessed 4 August 2022].

[3] Public Health England, “Health Profile for England 2021,” 2022. [Online]. Available: https://fingertips.phe.org.uk/static-reports/health-profile-for-england/hpfe_report.html#summary-7---leading-causes-of-death. [Accessed 4 August 2022].

[4] NHS Digital, “Statistics on Alcohol, England 2021,” 27 January 2022. [Online]. Available: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-alcohol/2021. [Accessed 4 August 2022].

[5] Office for National Statistics, “Quarterly alcohol-specific deaths in England and Wales: 2001 to 2019 registrations and Quarter 1 (Jan to Mar) to Quarter 4 (Oct to Dec) 2020 provisional registrations,” 6 May 2021. [Online]. Available: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/quarterlyalcoholspecificdeathsinenglandandwales/2001to2019registrationsandquarter1jantomartoquarter4octtodec2020provisionalregistrations. [Accessed 4 August 2022].

[6] Public Health England, “The range and magnitude of alcohol’s harm to others,” June 2019. [Online]. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806935/Alcohols_harms_to_others-1.pdf. [Accessed 4 August 2022].

[7] Public Health England, “Working Years of Life Lost due to Alcohol,” December 2016. [Online]. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/574053/alcohol_public_health_burden_statistics.pdf. [Accessed 4 August 2022].

[8] Public Health England, “Adult substance misuse treatment statistics 2019 to 2020: report,” 26 November 2020. [Online]. Available: https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2019-to-2020/adult-substance-misuse-treatment-statistics-2019-to-2020-report. [Accessed 4 August 2022].

[9] Public Health England, “Safeguarding and promoting the welfare of children affected by parental alcohol and drug use: a guide for local authorities,” 4 December 2018. [Online]. Available: https://www.gov.uk/government/publications/safeguarding-children-affected-by-parental-alcohol-and-drug-use/safeguarding-and-promoting-the-welfare-of-children-affected-by-parental-alcohol-and-drug-use-a-guide-for-local-authorities. [Accessed 4 August 2022].

[10] HM Government, “From harm to hope,” December 2021. [Online]. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1079147/From_harm_to_hope_PDF.pdf. [Accessed 4 August 2022].

[11] Office for Health Improvement and Disparities, “Additional drug and alcohol treatment funding allocations: 2022 to 2023,” 13 April 2022. [Online]. Available: https://www.gov.uk/government/publications/extra-funding-for-drug-and-alcohol-treatment-2022-to-2023/additional-drug-and-alcohol-treatment-funding-allocations-2022-to-2023. [Accessed 4 August 2022].

[12] HM Treasury, “Build Back Better,” March 2021. [Online]. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/968403/PfG_Final_Web_Accessible_Version.pdf. [Accessed 4 August 2022].

[13] NHS, “Standard General Medical Services (GMS) Contract,” January 2022. [Online]. Available: https://www.england.nhs.uk/wp-content/uploads/2022/01/B1210_i_Standard-General-Medical-Services-Contract-06012022.pdf. [Accessed 3 August 2022].

[14] NHS Digital, “Smoking, Drinking and Drug Use among Young People in England 2018 [NS],” 20 August 2019. [Online]. Available: https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2018#top. [Accessed 28 June 202].

[15] NHS Digital, “Smoking, drinking and drug use among young people Part 5 tables - drinking prevalence,” 20 August 2019. [Online]. Available: https://files.digital.nhs.uk/DD/B85A57/sdd-2018-tab5.xlsx. [Accessed 28 June 2022].

[16] World Health Organisation, “International Classification of Diseases 10,” World Health Organisation, n.d. [Online]. Available: https://icd.who.int/browse10/2019/en. [Accessed 24 September 2021].

[17] NHS Digital, “Alcohol-specific deaths in the UK: registered in 2020,” Office for National Statistics, 7 December 2021. [Online]. Available: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/bulletins/alcoholrelateddeathsintheunitedkingdom/registeredin2020. [Accessed 10 August 2022].

[18] Greater London Authority, “Ethnic group projections (2016-based housing-led),” November 2017. [Online]. Available: https://data.london.gov.uk/download/ethnic-group-population-projections/a9598ef0-808c-4f96-9eac-8bb314bd92cd/Ethnic%20group%20projections%20%282016-based%20central%20trend%29.xlsx. [Accessed 1 November 2021].

[19] Institute of Alcohol Studies, “LGBTQ+ People and Alcohol,” 2021.

[20] Office for National Statistics, “Sexual orientation, UK,” 25 May 2022. [Online]. Available: https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/datasets/sexualidentityuk. [Accessed August 2022].

[21] HM Government, “Drug Strategy 2017,” HM Government, London, 2017.

[22] Office for National Statistics, “Characteristics of children in need,” 28 October 2021. [Online]. Available: https://content.explore-education-statistics.service.gov.uk/api/releases/dc190008-a8f7-41a4-faa6-08d973655eae/files. [Accessed 1 November 2021].

[23] Public Health England, “Alcohol dependence prevalence in England,” March 2021. [Online]. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/969030/Estimates_of_alcohol_dependent_adults_2018-19.ods. [Accessed 21 June 2022].

[24] Office for National Statistics, “Adult drinking habits in Great Britain 2017,” 1 May 2018. [Online]. Available: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/bulletins/opinionsandlifestylesurveyadultdrinkinghabitsingreatbritain/2017#:~:text=4.,the%20population%20of%20Great%20Britain.. [Accessed 27 June 2022].

[25] UK Government, “Alcohol use disorders identification test,” n.d.. [Online]. Available: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/

attachment_data/file/684826/Alcohol_use_disorders_identification_test_for_consumption__AUDIT_C_.pdf. [Accessed 27 June 2022].

[26] NHS Digital, “Health Survey for England,” n.d.. [Online]. Available: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england. [Accessed 27 June 2022].

[27] University College London, “Health Survey for England (HSE),” n.d.. [Online]. Available: https://www.ucl.ac.uk/epidemiology-health-care/research/epidemiology-and-public-health/research/health-and-social-surveys-research-group/studies-0. [Accessed 27 June 2022].

[28] NatCen Social Research, “Health Survey for England,” n.d.. [Online]. Available: https://natcen.ac.uk/our-research/research/health-survey-for-england/. [Accessed 27 June 2022].

[29] NHS Digital, “Health Survey for England 2019 [NS],” 15 December 2020. [Online]. Available: https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2019. [Accessed 20 June 2022].

[30] NHS Digital, “Health Survey for England 2019 Adults’ health-related behaviours Report,” 20 December 2022. [Online]. Available: file:///C:/Users/Haywoj01/OneDrive%20-%20Bromley/Documents/Alcohol%20and%20Substance%20Misuse/Alcohol%20Needs%20Assessment/Data%20Set/Adult%20National%20Drinking%20Behavour.pdf. [Accessed 20 June 2022].

[31] NHS Digital, “Health Survey for England, 2019: Children's health-related behaviours data tables,” 15 December 2020. [Online]. Available: https://files.digital.nhs.uk/E5/EF7550/HSE19-Child-health-behaviours-tab.xlsx. [Accessed 27 June 2022].

[32] Office for Health Improvement and Disparities, “Local Alcohol Profiles for England,” n.d.. [Online]. Available: https://fingertips.phe.org.uk/profile/local-alcohol-profiles/data#page/3/gid/1938133118/pat/6/par/E12000007/ati/202/are/E09000006/iid/92778/age/168/sex/4/cat/-1/ctp/-1/yrr/4/cid/4/tbm/1/page-options/car-do-0. [Accessed 27 June 2022].

[33] Public Health England, “Parents with problem alcohol and drug use: Data for England and Bromley, 2019 to 2020,” 2020. [Online]. Available: https://www.ndtms.net/resources/public/Parental%20substance%20misuse/London/LN_Bromley_2019-20_Parental_substance_misuse_data_pack.html. [Accessed 15 November 2021].

[34] Advisory Council on the Misuse of Drugs, “Drug-related harms in homeless populations and how they can be reduced,” 19 June 2019. [Online]. Available:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810284/Drug-related_harms_in_homeless_populations.pdf. [Accessed 8 November 2021].