KENT PUBLIC HEALTH OBSERVATORY

Alcohol Needs Assessment

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Executive Summary

1. Current situation and context

A recent PHE review entitled 'Alcohol and Drug prevention, why invest?' estimates that the cost of alcohol misuse to society is around £21 billion. It was also estimated that there is a £3 social return for every £1 spent on alcohol treatment[1]. This is linked to the Dame Carol Black Review on Drug Services (and includes alcohol in its recommendations) which outline that there must be no further cuts to drug and alcohol services and improved join-up with NHS and social care services to amend the fragmentation of services (including in-patient medical detox). A recent peer to peer PHE peer review of Alcohol Clear partnerships in Kent in 2020 also recommended closer partnerships with NHS and social care and are reflected in the recommendations of this need's assessment. It is important to acknowledge the impact of covid19 pandemic on both the changes on alcohol consumption and access to care and treatment. This would be tackled through via this report.

1.1 Hospital admissions during Covid 19

Across the UK in 2020 (during the pandemic), rates of unplanned admissions to hospital for alcohol specific causes decreased by 3.2% compared to 2019 (before the pandemic). This is likely related to reduced admissions for mental and behavioral disorders due to alcohol use. Unplanned admissions for alcoholic liver disease were the only alcohol specific unplanned admissions to increase between 2019 and 2020. This increase was 13.5%, and from June 2020 onwards, there were significant and sustained increases in the rate of unplanned admissions for alcoholic liver disease. Nationally this indicates that it is heavy drinkers that are at increased risk of tipping into dependency.

1.2 Increased deaths in Liver Disease

In 2020, there was a 20.0% increase in total alcohol specific deaths compared to 2019 in England and 80% of all alcohol specific deaths are to liver disease. We also saw significantly higher death rates from May 2020 onwards (33.0% of deaths occurred in the most deprived group). Deaths from mental and behavioral disorders due to alcohol increased by 10.8% (compared to a 1.1% increase between 2018 and 2019), and deaths from alcohol poisoning increased by 15.4% (compared to a decrease of 4.5% between 2018 and 2019). Data from previous years show a rapid acceleration in deaths from alcoholic liver disease during the year of the pandemic, beyond that of the pre-existing upward trend.

[1] https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest

1.3 Impact of COVID on alcohol consumption

Concerns that changes in drinking habits and levels of alcohol consumption caused by the Covid-19 pandemic are causing increasing health issues. National figures show, of those whose drinking habits had changed, more women had increased their alcohol consumption than men. Alcohol consumption during the pandemic tended to increase with age up to the 55 to 63-year-old age band, after which it decreased (see table 1). There was no significant change in the number of alcohol specific deaths during 2020 compared to the period 2016 to 2019. In Kent, around **308,000 were drinking above the recommended levels of alcohol in July 2021.**

Table 1: Estimated number of adults in Kent drinking more, less or the same in September 2020 compared to pre-lockdown by age band

Change in alcohol consumption	18-34	35-54	55+
Increased	85,000	94,000	90,000
Decreased	84,000	102,000	117,000
No change	137,000	214,000	319,000

1.4 Heavy Drinkers at increased Risk and increasing risk during COVID

Although alcohol related cirrhosis can take a decade or more to develop, most deaths occur as a result of acute-on-chronic liver failure due to recent alcohol intake, which is strongly linked to heavy drinking. Liver mortality rates responds rapidly to changes in population level alcohol consumption and particularly to changes in drinking patterns of heavy drinkers, as we have seen during this pandemic. Liver mortality rates in England have increased 43% between 2001 and 2019, to the extent that liver disease is now the second leading disease-causing premature death among people of working age.

1.5 Opportunities for fragmented commissioning to align under Integrated Care System (ICS)

Commissioning the alcohol service pathways are fragmented. Public health in the council is responsible for treatment services. The ICS in Kent and Medway is responsible for hospital treatment and for liver disease treatment. The ICS and NHS England (NHSE) is responsible for primary care treatment of patients with alcohol related disease in the community, NHSE is responsible for commissioning prison substance misuse services. The police and community safety partnerships bare costs for violence and other alcohol related harms.

There are social care act responsibilities for vulnerable populations including rough sleepers (of whom 80% have alcohol related problems). In addition, the Ministry of Department for Levelling Up, Housing and Communities (formerly the Ministry of Housing, Communities & Local Government) commission some key health care services for vulnerable people provided by the district / borough councils in Kent. With a new K&M CCG, increased ownership of providers, sensitive and collaborative commissioning, and an increased focus on health disparities / inequalities – there are opportunities to improve these fragmentations on behalf of the people and families at risk of poorer outcomes.

1.6 Treatment Providers in Kent

There are three treatment service providers in Kent funded via the public health grant in KCC: CGL (West Kent, adult treatment service) Forward Trust (East Kent, adult treatment service) and We Are With You (Children and Young People, across Kent). There is a Substance Misuse Strategy for Kent (Forthcoming) and a co-occurring conditions joint working agreement in development (Appendix).

1.7 Links to other Needs Assessments

There are related needs assessments; mental health, sexual health, homelessness, domestic abuse, and a separate Drugs needs assessments and Drug, and Alcohol Treatment needs assessment.

2. Summary of alcohol prevalence in Kent

2.1 It is estimated that a quarter of people drink at levels above those recommended[2]. 12,689 adults in Medway and 70,000 adults in Kent are drinking at higher risk levels (double the recommended safe levels or above). An estimated 15% of the local residence are binge drinkers. One other trend for alcohol is that self-reported weekly consumption has declined significantly in the younger age groups since 2011, however has slightly increased for those aged 45 or older and is highest amongst 45- to 65-year-olds. There are 14,000 people (11.5 per 1,000, slightly lower than England at 13.5 per 1,000) estimated to need alcohol or alcohol and non-opiate treatment services in Kent. There are an estimated 1% dependent drinkers in Kent. There are about 2,300 people in recovery services in Kent which meets only 15% of the estimated need. The current deaths attributed to alcohol in Kent are 564 in 2019 and the areas of greatest deprivation in Kent are worse impacted. The average age of death of a person with alcohol related conditions is 54.3 years, in comparison with death from all causes of 77.6 years. The recent NICE and PHE guidance on the impact (both on the health

[2] The Chief Medical Officer (CMO) recommends drinking a maximum of 14 units a week, spread evenly over a few days with drink free days included in the week.

and social care system and individuals) of a co-occurring condition between alcohol and mental health highlights that this is still a barrier to care even though almost 50% of those seeking alcohol treatment have a mental health problem. This was highlighted recently in the Dame Carol Black Review on Drug Services.

2.2 Alcohol Mortality

Alcohol: Approximately 3% of all deaths are alcohol related. Alcohol-specific deaths e.g., alcohol poisoning, alcoholic liver disease or acute pancreatitis account for about one third of these. The other two thirds are *related* to alcohol misuse e.g., stroke, heart rhythm disorders, throat cancers as well as falls, accidents, or violence.

Kent was once well below the Southeast and National rate for deaths however now when compared alcohol related mortality benched marked against the Southeast and England, and the overall Kent mortality rate for alcohol death has risen (Figure A). Thanet, Swale, Folkstone and Hythe and Canterbury are all areas that see increased levels (Figure B)

Figure A: Alcohol-specific mortality in Kent, in comparison to Southeast and England

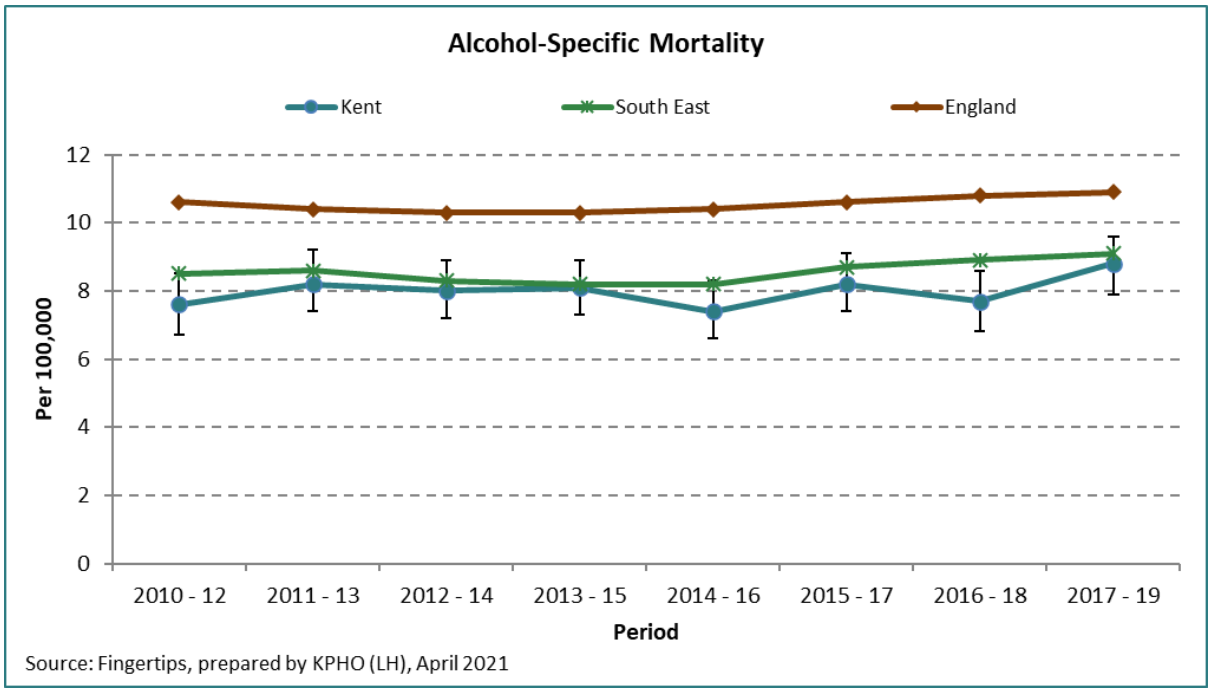


Figure A- This table demonstrates the number of alcohol specific mortalities in Kent. In comparison to the Southeast and the Rest of England from 2010 up to 2019. This is per populations of 100,000

Figure B: Alcohol-related mortality in Kent by district

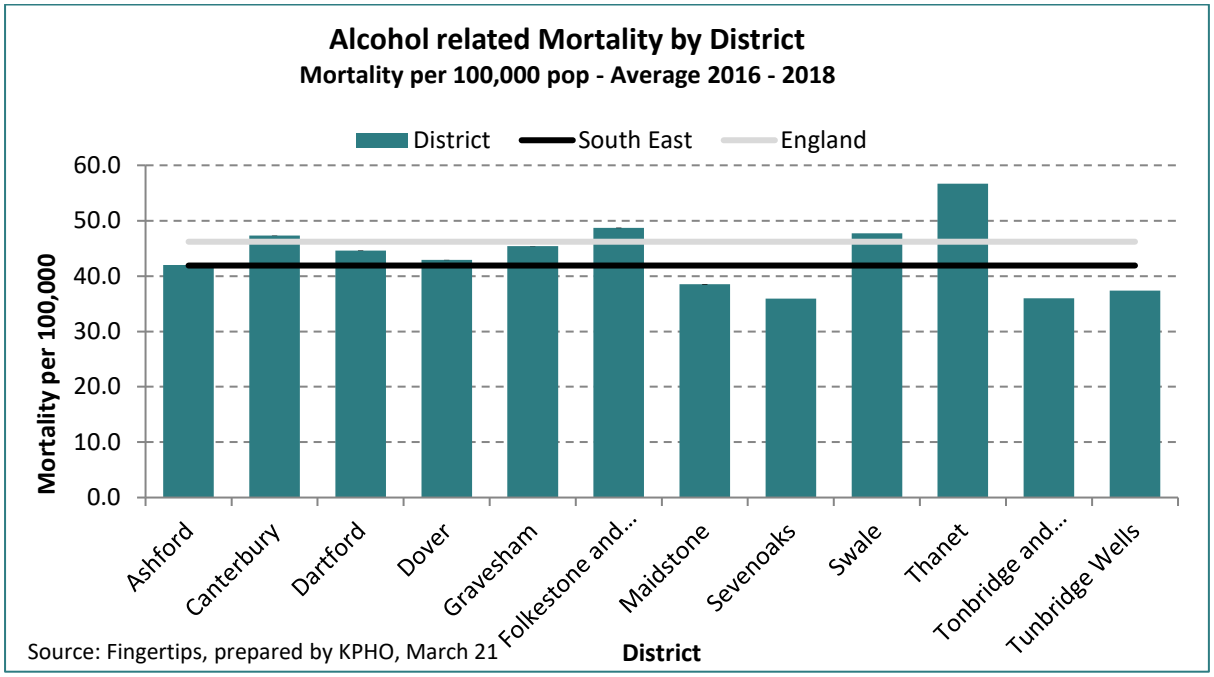


Figure B- This demonstrates the alcohol related mortality in Kent via district from 2016 through to 2018.

2.3 Substance Misuse Link to Homelessness

There are strong links to need for alcohol treatment services and those who are facing rough sleeping (linked to homelessness both locally and nationally). In Kent – 12% of new presenters (alcohol only) had a housing or urgent housing problem. Kent treatment services have a 1 – 2% higher need than the England average. A recent needs assessment on rough sleeping found there were on average 200-400 people in Kent who were rough sleeping. Data quality is poor. Of these people 80% have some combined alcohol and mental health problem.

2.4 Co-morbidity / Co-occurring Conditions

PHO's report on co-occurring conditions (dual diagnosis) report covers guidance and best practice for people facing mental health and a drug or alcohol problem (now termed co-occurring conditions). This report states that there should be no barrier to care for people who have both conditions and care should be provided in parallel and not sequentially. There should also be no stigma, prejudice or gatekeeping from staff who are presented with people who have high vulnerabilities and a substance misuse problem. A link to the guidance and the quality standards from the NICE are found here: https://www.nice.org.uk/guidance/qs188.

A local Kent study found an estimated **6,000 vulnerable adults across Kent and Medway** (0.49% of the adult population) with a co-occurring substance misuse and mental illness (from the Kent Integrated Dataset) and found a steep deprivation gradient. People with both mental health problems and a substance misuse problem face real barriers in access to care. The national PHE guidance states that there should be no reason for people with substance misuse disorder to be denied psychiatry and psychology services. The results from a national confidential enquiry shows that substance misusers are in the high-risk group for suicidal ideation and completing suicide and must have access to mental health support in a timely way as per any other group in need. A recent (2018) snapshot audit of Kent substance misuse services found that 25-35% of its service users had suicidal ideation.

2.5 Vulnerability and dependence

National estimation of brain damage for alcohol dependency (K.Wilson 2011 Alcohol Related Brain Damage in the 21st Century – a management conundrum https://doi.org/10.1192/bjp.bp.111.092569) shows that 35% of all alcohol dependent people will have brain damage at post-mortem. This places an additional unmet need via the Care Act responsibilities for Health and Social Care Services. Using national definitions of vulnerability and 'treatment resistant drinkers': there are an estimated **2000** people in Kent and Medway who have a) chronic long term alcohol dependency b) routinely do not engage in services c) have high repeat use of NHS urgent care and social care services (Alcohol Concern 2019).

3. Outcomes of Kent's Current Treatment services

3.1 Main treatment providers in Kent - Substance Misuse treatment provision in Kent is delivered by two providers: CGL (West) and Forward Trust (East). The Adult Community services offer drug and alcohol treatment to Kent residents aged 18 or over and support to family and friends who are concerned about someone's drug and/or alcohol use. One You Service – advice and low-level support on alcohol consumption.

Kent also commissions a Residential Recovery Service and a Young Person's Drug and Alcohol Service.

The Residential Recovery Service supports individuals who require support for Drug or Alcohol addiction but also have a housing related support need.

The Kent Young Person's Drug and Alcohol Service: The service provider is We Are With You, which works with predominantly 11–18-year-old, by offering them advice and support with substance misuse issues. They also work with 18 -24-year-old, who decide that their needs would be better suited to working with a Young Persons service rather than an adult's service.

3.2 Kent Treatment Services have slightly better outcomes then national average.

- Kent services are consistently higher performing for successful completions then the England average although like England (Figure C) – the successful completions rates are lower over time. This is occurring in a backdrop of increasing drug deaths and alcohol related deaths both locally and nationally.
- Successful completions of alcohol treatment have decreased at a higher rate than outcomes for opiates. However, given the excellent treatment outcomes in 2015/6 compared to outcomes now – there is some cause for concern across the system. (See recommendations of this needs assessment to address these).
- More details about the treatment services, please see **Treatment Services Needs** Assessment (link).

Figure C: Successful completion in substance misuse services, Kent, and England 2015/16 to 2017/18

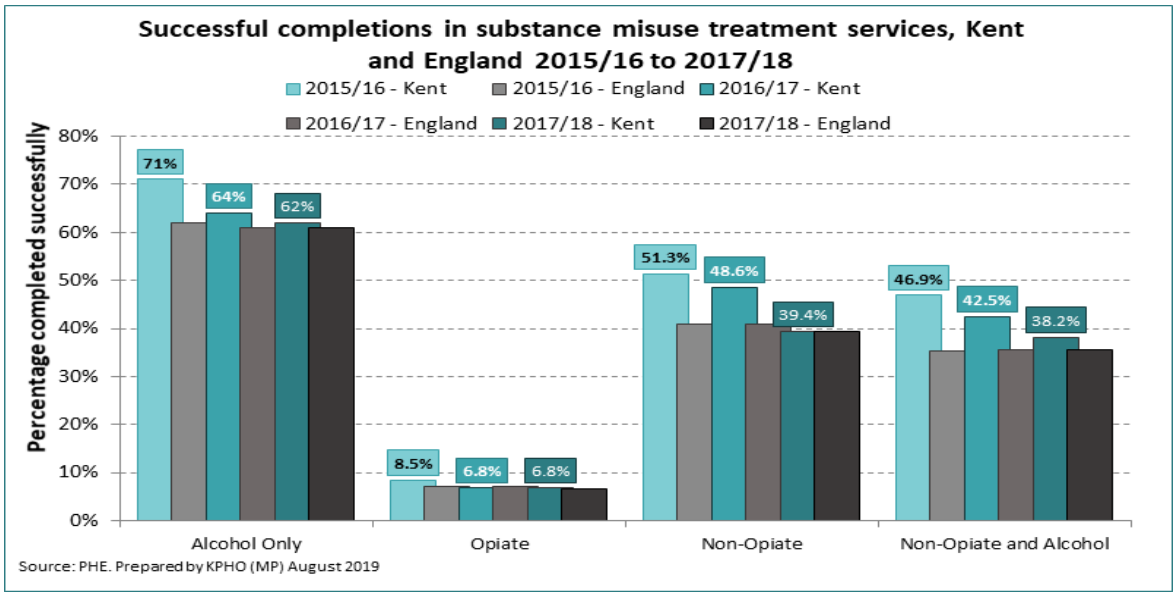


Figure C - This table demonstrations successful completions in substance misuse treatment services in Kent and England from 2015-2016 and again from 2017-2018 . This has been seperated via substance type.

4. Children, Young People and Families

4.1 Trauma Informed Outcomes and Care for Adverse Childhood Experiences

New research into the impact on childhood trauma and the consequences of this both neurologically and behaviourally (Adverse Childhood Experiences and Trauma Informed Practice) highlights the importance of the risk factor of exposure to a family with alcohol and drug addiction has on the development of a young child. It also highlights that having

four or more adverse childhood experiences (traumas) can increase risk of alcohol and drug dependency by 80%.[3]

4.2 Domestic Abuse/ Intimate Partner Violence

There are significant issues faced by women facing domestic abuse who also need substance misuse treatment. These issues mirror the issues described above in the section on co-occurring conditions and highlight the stigma and discrimination that is faced by people with addictions.

4.3 Foetal Alcohol Syndrome Disorders

There is increased awareness and research into the impact of maternal alcohol intake on the developing foetus and its impact on children. In Kent, the estimation of mother has consumed alcohol during pregnancy is about 6,500 in 2020.[4] However, according to Public Health Outcomes Framework / Child and Maternal Health Profile, about 4.1 % of mothers who drank at time of booking appointment in Southeast of England.[5] This estimate applied to Kent, which is about 650 cases, but this number might be an underestimation. New research highlights that symptoms impacting young people can mimic Asperger's trait and other learning difficulties. According to a UK study, the screening prevalence of FASD is in the range of 6% and 17%. This estimate applied to Kent, which is between 960 and 2,700 cases in 2020.[6]

[3] http://www.wales.nhs.uk/sitesplus/documents/888/Wales%20Public%20Health%20Conference%20MAB%20Draft%20%5BRe.pdf
[4] https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30021-9/fulltext
[5] https://fingertips.phe.org.uk/profile/child-health-profiles/data#page/1/gid/1938133222/pat/6/par/E12000001/ati/302/are/E06000047/cid/4/tbm/1
[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6344226/

The Recommendations from the Alcohol Needs Assessment

Recommendations for Prevention to Treatment pathways

- **For Public Health and All: Ensure there is good quality local awareness campaigns** reduce stigma and normalisation of harmful drinking. Target women of reproductive age.
- **For KCC Comms** spread coverage of the online tool 'Know your Score' further and in a variety of population groups including women of reproductive age and on men aged 40-59.
- **For ICS linked to Cancer Prevention and Population Health: Public Health: Prioritise and industrialise IBA awareness**
- **For Public Health and NHS/CCG: Targeted IBA** in areas **and** for populations at risk and populations where there is underrepresentation (i.e., the equalities protected characteristics)- conduct equity audit on IBA.
- For NHS Population Health CCG: Kent NHS prevention plan must have robust monitoring and evaluation and delivery of the CQUIN targets for alcohol and tobacco control.
- **For NHS CCG and Public Health:** A&E data needs to include additional codes that would distinguish different types of drinkers as mentioned in the needs assessment. This could be developed as part of the Population Health Management programme where there are incentivisation payments to providers to encourage them to use the codes. The codes can be used not just for analyses but for targeting IBA interventions as and when necessary. Supplementing this would be additional incentivisation to GPs to adopt similar kind of consistent coding in their data if not already implemented. This would improve needs assessment development considerably going forward, which currently rely upon weighted formulae and apportionment rules e.g. alcohol related admissions, which attempt to estimate the true burden of alcohol in the population, but this is not based on real time data.
- **For NHS CCG:** Given the strong association between Cancer and alcohol consumption, make links between cancer prevention and alcohol reduction in awareness campaigns and offer IBA in screening programmes. Understand the opportunities for secondary prevention in the Cancer pathway for liver and throat cancer.
- For KCC commissioners: Given risks associated from misuse of alcohol embed IBA into all public health programmes including stop smoking, wellbeing and sexual health. Ensure that IBA is part of all prevention programmes for CVD.
- For KCC commissioners and ICP/PCNs: For non-physically dependent drinkers, Improve the pathway for alcohol prevention using community support at One You Services and Live Well Services as well as routine IBA (Identification and Brief Advice) at primary care to help them cut down their alcohol intake. Pregnant women and

people with a history of depression/ anxiety and suicidal ideation must be prioritised.

- For NHS and Social Care: Industrialise Making Every Contact Count for all people in the NHS and frontline services to help people become confident in having difficult conversations regarding substance misuse and cutting down.
- For all services: align and co-ordinate social prescribing, recovery, and social support so that those recovering from addictions have access to all community resources.
- Public Health & All partners: Each partner agency to have clearly defined links and action for the Kent and Medway Drug and Alcohol Strategy

Recommendations for Alcohol Supply and Enforcement & Crime

Licensing:

- For Kent Public Health & Districts: Map the number of off licences and licensed premises in Kent districts against areas of deprivation and risk factors for harm.
- For Kent Public Health & Districts: Work with districts to challenge licence applications in areas with risk for potential harms using 'cumulative impact'.
- For Kent Public Health and Trading Standards: Understand and audit the issues and barriers for Kent districts for Late Night Levies and work in areas of greatest alcohol risks in a place-based approach.
- Kent Public Health and District Vulnerable People Teams: Work with retailers and treatment services in areas of greatest risk in Kent districts to tackle the availability and sale of cheap white cider to vulnerable groups.
- For Kent PH: Revisit the impacts of the Local Alcohol Areas (LAA) to see if lessons can be brought back to the Kent Substance Misuse Alliance regarding sales of high strength alcohol to vulnerable groups.
- For Kent PH: Understand the impact via additional scoping - of 'on-line' and 24-hour internet alcohol supply.
- **For Trading Standards**: work with off licences in areas of economic deprivation to tackle the sales of high strength alcohol to dependent drinkers.

Leadership

- For Kent PH and All Partners: To Use the Alcohol Clear assessment findings to monitor continuous improvement of the partnership's goals in relationship to current needs for enforcement and impact on demand and legislation.
- For ALL: Create a strong action and outcome-based plan to tackle alcohol related harms in Kent, strengthening links between crime, alcohol, violence, and treatment services. Embed Alcohol prevention into criminal justice pathways.

- For children and families and Health and Social care: to ensure that the Care Act responsibilities for carers and families are taken into account and further harm prevented.
- **ALL Crime Partnerships: strengthen the Crime Strategic Assessment:** create a clear 3-year Action Plan to tackle illegal trading, disrupt supply, tackle anti-social behaviour and access to services, violence, and sexual assault.
- **Industrialise IBA (Identification and Brief Advice) across criminal justice settings**

Trauma Informed Practice Training

- For Police and Crime System: Identify and **support families** at risk of disruption and harm from alcohol misuse with better trained staff. This includes ensuring there is a 'trauma informed' programme to tackle the lasting consequences of **Adverse Childhood Experiences**.
- **For KCC and Partners in Domestic violence** and abuse strategies: include links between family-based approaches to conflict linked with substance misuse treatment services.
- **For Prisons: ensure that there are exit care plans for those** on custodial sentences to improve access, help and support for those with addictions.
- **For Police and Crime Partnerships: Increase reach of drink driving risks via local media and evidence based young people's prevention initiatives.**

Workforce

- **For Employers:** Employers to understand the risks and consequences of work stress and use of alcohol as a 'relief' and also to enable employees to destigmatise the need to get help. Improve communication and support.
- **For Employers of statutory and Voluntary Services:** Improve joint training for links between alcohol and mental illness.

For Commissioners & Providers of Treatment Services: Treatment and Recovery Pathway

- **For Treatment Services: Improve the quality treatment and recovery services:** targeted at vulnerable dependent drinkers: Instigate audits into intake and throughout of high complex and vulnerable people.
- For ALL KCC/ NHS commissioners and ALL providers: A longer period in treatment for complex patients should be prioritised and models of care improved regarding access to detox and rehabilitation for the most vulnerable.

- For Kent and Medway substance misuse treatment services: improve clarity of their outcomes data, investigate and audit relapse rates and outreach to vulnerable and complex groups via a series of equity audits shared with commissioners.
- For Kent Public Health: Prioritise deep dive needs assessment for inpatient detox and rehab
- **For Mental Health and NHS Health Services:** tackle the co-morbidities associated with alcohol use disorders including high quality mental health services. Ensure pathways to treatment are open and use the joint working protocol.
- **For Treatment Services and Mental Health Services and NHS services: Use and Strengthen current Joint Working Protocol.**
- **For NHS and Public Health**: Create Alcohol support teams linked to Emergency Departments can help with ensuring people are linked to continuing community care and recovery support.
- **For Public Health & Commissioners:** Instigate Modelling and Audit to understand shared costs so that better outcomes in treatment can be made for vulnerable patients who disproportionately use multiple health services.
- **For Providers:** Create shared and multidisciplinary treatment plans that are co-operative that plan care for the vulnerable client/patient e.g., alcohol relapse medication**.**
- **For Public Health and Commissioning:** Embed equity audit – as treatment outcomes vary according to deprivation and district.
- **For KCC & NHS commissioners**: Explore linking up recovery services across whole system – not solely for substance misuse – **Improve entry and access to recovery services for service users.**
- **For KCC commissioners:** Clarify the pathway for alcohol misuse at different levels of need. Ensure the treatment gap for highly complex and dependent drinkers is addressed (via provision of outreach and IBA and links to acute hospitals).
- **For KCC Commissioners** ensure that mildly dependent drinkers can access alternative treatment options in open access behaviour change services e.g. One You (as no need for medical assessment).
- **For NHS mental health system**: Ensure that mental health system has sufficient access and non-discriminatory practice in including substance misuse disorder patients and where necessary joint treatment plans. **KCC / KMPT to audit.**
- **KCC commissioners and Providers:** Target outreach and proactive care for most vulnerable population in the most deprived areas (and wards) in Kent. Prioritise Thanet.
- **For Treatment Providers:** Increase proportion of people engaged with treatment providers and target people in more deprived communities.
- **For Treatment Providers and CCG:** An aging cohort of alcohol dependent clients will mean services will need to work closely with NHS and health care providers including social care and mental health for shared care plans**.**

- **For Social Care:** Improve access to referral for adult safeguarding reviews from substance misuse and take seriously the Serious Incidents and suicidality linked to increasing drug and alcohol sudden deaths in Kent.

1 Introduction to Alcohol Public Health Needs Assessment in Kent

There are immediate and long-term consequences of alcohol misuse, as well as of societal and demographic factors on alcohol consumption and alcohol-related harms which result in chronic diseases and conditions and early death.

This report examines the current level of adults' (18+) alcohol misuse in Kent using the latest data available and provides an update on the Alcohol: Adult Needs Assessment 2014/15.

The ways to address alcohol misuse and related harms are complex and involve a combination of social policy, awareness raising of harms and well-functioning prevention, treatment, and recovery pathway.

Alcohol misuse also has impacts that go beyond disease and illness. It impacts on the lives of those who become addicted to alcohol and their families and loved ones, often those impacts can be felt for generations. The scope of this Alcohol Needs Assessment is primarily on the impacts on health and illness. There will be further assessments which focus on children and families including adverse childhood experiences and the links to crime and disorder.

This needs assessment covers epidemiological and demographic description of the scale of need and demand in Kent. 'Need' is defined as 'can benefit from an intervention' and 'demand' is defined as 'service use'. It will cover the adult population aged 18+ in Kent but occasionally overlap into issues impacting children and young people. A separate needs assessment will cover children and young people in full.

This needs assessment will also cover the changes in need and demand post COVID19 pandemic. The assessment covers the following pathways of care: prevention and recovery, hospital to prevention, supply, and targeted vulnerable groups.

This needs assessment uses secondary data sources and does not cover user needs or user participation. This is a gap and one that should be bridged in follow up assessments.

Separate needs assessments are available for:

- Drug Needs Assessment
- Homelessness / Rough Sleeping Needs Assessment
- Children and Young People Drug & Alcohol Needs Assessment (0-25 years old)
- Mental Health Needs Assessment
- Domestic Abuse

1.1 Background

1.1.1 Priorities from the 2014/15 Health Needs Assessment on Alcohol related harm.

The previous alcohol needs assessment (2014/15) identified several key areas for improvement: touch on the old needs and new information: These are still live issues.

- More identification and earlier referral is required from primary care and hospital
- Services should take into account the geographical spread of vulnerable and high-risk populations; an effort to reach under-represented groups and district populations in treatment is required.
- There is a real risk of individuals becoming increasingly marginalised as an inadvertent result of housing legislation and welfare reform. Housing and employment strategies should be mindful of accommodation needs of those with alcohol misuse issues.
- Commissioners should include Identification and Brief Advice (IBA) as a core workforce competency and practice from provider services as far as possible. This would reflect the wide-ranging demographic impacts of alcohol misuse.
- There should be a stronger focus on identifying areas of alcohol license density especially in vulnerable communities and sub-populations. This should extend to tackling irresponsible marketing and promotional activities.

1.1.2 Kent Substance Misuse Strategies.

There have been comprehensive partnership wide strategies covering prevention, Treatment and Recovery and Supply in Kent that have mirrored National strategies and guidance. The strategy is currently in development. A draft strategy is available upon request. A link to the previous strategy can be found here (https://www.kent.gov.uk/__data/assets/pdf_file/0010/79219/Kent-Drug-and-Alcohol-strategy.pdf).

1.2. Use and Misuse of Alcohol, in UK and Kent

Alcohol (ethanol) is a psychoactive substance that can cause physical and psychological dependence, damage to physical and mental health, and in its most serious and advanced stage, neglect, anorexia, and death.

In 2016, the Lancet published a report stating that that alcohol is the seventh leading risk factor for both deaths and disease burden (as measured in Disability-Adjusted Life Years (DALYs)) and among those aged 15-49 alcohol use was the leading global health risk factor.[7]

[7] *https://www.thelancet.com/article/S0140-6736(18)31310-2/fulltext*

Alcohol has potential to do great harm, not only by causing serious ill health but also through domestic violence, neglect, crime, and disorder.

Although most people (70%) drink within recommended healthy levels, it is estimated that a quarter of people drink at levels above those recommended[8]. Around 70,000 adults in Kent are drinking at higher risk levels (double the recommended safe levels or above). An estimated 19% are binge drinkers.

A recent PHE review entitled *'Alcohol and Drug prevention, why invest?'* estimates that the cost of alcohol misuse to society is around £21 billion. It was also estimated that there is a £3 social return for every £1 spent on alcohol treatment.[9]

1.3 Methodology for this Needs assessment

A variety of data sources are used for this assessment, including hospital episode data, ONS and Kent treatment service data. The data sources will be cited. Where possible, analysis will be split by West Kent (covering the NHS geography of West Kent CCG and Dartford Gravesham and Swanley CCGs and the treatment provider CGL) and East Kent (covering the East Kent NHS: areas in Swale, Ashford, Canterbury & Coastal, South Kent Coast and Thanet CCGs whose treatment provider is the Forward Trust). Where possible data will also describe Kent as a whole, NHS Integrated Care Partnership (ICPs) or district level presentations. Further iterations of this data and analysis will be tailored to new NHS configurations, e.g., Integrated Care Partnership (ICP) and Primary Care Networks (PCNs) over time.

[8] *The Chief Medical Officer (CMO) recommends drinking a maximum of 14 units a week, spread evenly over a few days with drink free days included in the week.*

[9] https://www.gov.uk/government/publications/alcohol-and-drug-prevention-treatment-and-recovery-why-invest/alcohol-and-drug-prevention-treatment-and-recovery-why-invest

Summary of Chapter 2

Alcohol has become cheaper and more easily available. Using the 'cumulative impact' approach to challenging some Licencing decisions may be a way that local areas can mitigate the impact of density of off-licences in areas of deprivation. The rise of 24 access to alcohol and online trading may have impact on underage consumption and post Covid increase in consumption in adults. Compared to the England average Kent's Treatment Services are cost effective. Alcohol misuse leads to an estimated cost of over £70 million to Kent including over £5 million to the Kent's primary care and hospital system. There are good partnerships in place between treatment services, commissioners and the crime and safety partnerships. Drink driving rates are high and the high rates in Gravesham need to be understood better by local partnerships.

2 Alcohol policy: legislation, strategy, and economic review

This section contains information on the latest key policy developments relates to alcohol misuse. These are reviewed within three key areas:

- Legislation
- Alcohol strategies
- Economic review

2.1 Alcohol Availability and Licencing Legislation.

Alcohol is a legal substance and is widely available. It is accepted that a key control of alcohol misuse is tackling levels of consumption. The most important factor that influences consumption is availability. The issue of availability and affordability are aspects of government legislation and policy. An important element of alcohol policy that is under local control is licensing, (which governs who can sell alcohol and how it can be sold) and there are many conflicting considerations involved in licensing legislation, such as protecting employment and business interests within night-time economies (NTE) and revenue.

The Licensing Act 2003 (HO, 2003) contains the principle that any costs associated from alcohol harm would be borne by businesses and not taxpayers. Yet alcohol prices are not set nationally. This means that local authorities and Health Care systems bear the costs of high levels of alcohol sales relative to price due to the significant burden on Health and Social Care and police services that alcohol misuse creates.

The Institute of Alcohol Studies in its response to the Home Office consultation on locally set licence fees, urged an exploration of mechanisms to allow local authorities to set their own fees such as a 'risk-based' fee structure (IAS, 2014). This is where fees would be aligned allowing them to recoup their costs associated with licensing activities, e.g., the costs of

street cleaning, policing, Health and Social Care. Recovering associated costs would also provide funding for licensing enforcement which is currently unfunded.

Across England, there has been a steady increase over recent years in the number of licences granted to sell alcohol, both personal and on premises (Home Office, 2013), (figure 1).

Figure 1: Premises with 24-hour alcohol licences by premises type, England, and Wales, 31 March 2018[10]

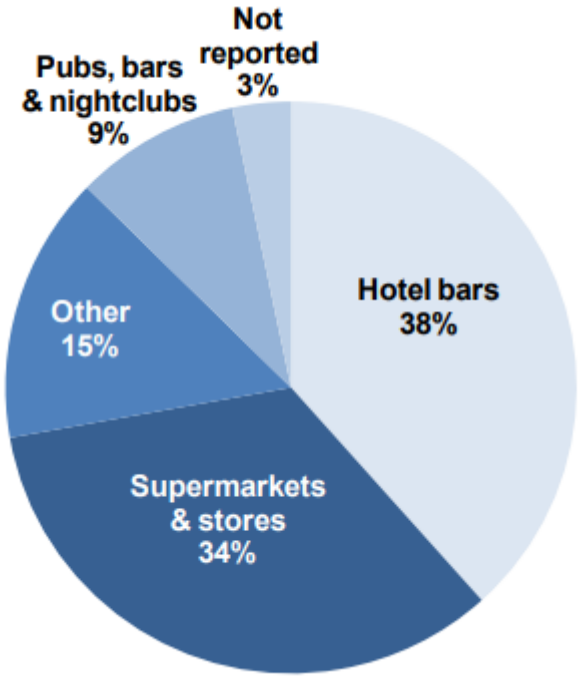


Figure 1 - This chart indicates the premises within England and Wales as of the 31st of March 2018 that have a 24-hour alcohol premises licence.

In 2009- 2010 the density of licensed premises in England and Wales were at their highest for over 100 years. (Table 1)

Table 1 Density of licensed premises, England & Wales, 2012, (per 100,000 population)[11]

Type of premises	Outlet density per 100,000 of population
On-premises licence	213

[10] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/750830/alcohol-late-night-refreshment-licensing-2018-hosb2318.pdf

[11] Office for National Statistics, 'Alcohol, Entertainment and Late-Night Refreshment Licensing, April 2009 – March 2010', Population Estimates Unit.

Off-licence	92
Clubs	29 (A decrease from 49 in 1971)

The availability and density of licensed premises can have significant public health impacts in relation to crime and disorder, health problems and risky behaviours towards vulnerable groups. These particularly impact places with 'night-time economies' i.e., bars and nightclubs. Data for licencing density in Kent is held at district level with the issuing local authority. Identifying areas of licensing density is a useful Public Health tool to assist authorities to challenge the granting of licences in vulnerable areas, e.g., areas of high health risks or where vulnerable children reside.

2.1.1 Licensing premises

All licence applications must comply with four licensing objectives, namely: the prevention of crime and disorder, public safety, the prevention of public nuisance and the protection of children from harm.

Licence applications can only be refused on the grounds that granting them would be detrimental to one or more of those licensing objectives.

The only recourse that authorities have to control the density of outlets is to identify areas of *'cumulative impact'* usually within town centres. This is the term given to assessing the broader impacts of alcohol harms in a community including health impacts. However, each licensing application must be assessed individually and although the numbers of these have increased substantially, there is some dispute as to how effective these are.

2.1.2 Night-time economies (NTE)

Studies have shown that alcohol fuelled anti-social behaviour and violence in NTE is related to the concentration of licensed premises. Serious violence in the NTE is proportional to the number of people present and the overall capacity of licensed premises in the street *(Curtis et al., 2011).*

2.1.3 Affordability and Minimum Unit Pricing

In the last ten years, (2005-2015) although the average unit price of alcohol has increased by 36%, alcohol has become 2% more affordable relative to disposable income over the same period, since 2005 *(NHS Digital, 2016).*[12]

The suggestion to introduce a minimum unit price on alcohol as part of national legislation was abandoned by the UK Government in 2013. In response some local authorities have introduced it on a voluntary basis with business owners, e.g., Newcastle.

In 2012, Scotland passed an Act to introduce minimum unit pricing, but it is still not in effect after it was challenged in the European Court after protestations by major wine producing countries in Europe (Scottish Parliament, 2012). The Court ruled it did impinge upon free trade and suggested higher taxation is used instead, however left it to the Scottish Courts to decide. It is anticipated that it will now go to the Supreme Court in England. Wales has since proposed introducing minimum unit pricing.

2.1.4 Drinking age and trading hours

Alcohol laws restrict the sale of alcohol to those younger than 18 years of age. There are some restrictions in place in licensed premises on supervised consumption in the presence of adults.

The controversial Licensing Act 2003 (HO, 2012) enabled the potential for 24-hour alcohol trading; advocates envisioned a 'Mediterranean-style café culture whilst others cautioned that longer drinking hours would lead to more associated alcohol harms, not fewer. To counter the potential harms, the Police Reform and Social Responsibility Act (PRSRA) (HO, 2011) provided and expanded the power of licensing authorities to impose Early Morning Restriction Orders (EMROs) and Late-Night Levies (LNLs) on alcohol vendors within the local vicinity, as part of the UK Government's alcohol strategy. To date, the uptake of using these measures has lagged behind expectations.

Online trading has increased, particularly during the COVID19 pandemic. A systematic international study in 2021[13] showed variation in the regulation of these online and 24-hour sales in the UK. In most, regulations do not meet the same standard as bricks-and-mortar establishments and may be insufficient to prevent youth access.

[12] Includes purchases at supermarkets, off licences etc. Excludes purchases in pubs, bars, restaurants etc. 2. Current Prices 3. Across all households.

[13] https://www.sciencedirect.com/science/article/abs/pii/S0168851021001901

2.1.5 New marketing tactics and impact on responsible drinking

It is illegal to sell alcohol to people who are already intoxicated. This is important as heavy episodic drinking (binge) drinking emerged as a serious concern.

Conditions are now in place to counteract 'binge drinking' such as 'buy one get one free' sales of alcohol products, drinking games and promotions.

It is not known what the impacts of new developments in selling alcohol are such as the emergence of novel marketing tactics by alcohol manufacturers, such as 'alcohol shots' for sale in retail outlets and the proliferation of online alcohol home delivery services and online sales.

2.1.6 Marketing and Advertising

An estimated £800 million is spent each year on advertising alcohol in the UK; globally it is estimated to be around $1trillion. It is one of the most significant and quickly moving consumer goods marketed. Marketing of alcohol is expanded from the traditional adverts and billboards to new online social media, sponsorship and point of sale promotions. The impact upon young people and children should not be underestimated (WHO, 2011). Research has shown that early exposure to such materials leads to earlier and more frequent consumption (WHO, 2009).

In the UK advertising is controlled by various co-regulations; these controls have been criticised for failing to protect young people and children from alcohol marketing exposure and there have been calls for more restrictions similar to those in place in France, for example.

2.1.7 Reducing strength of drinks

In recent years many areas have attempted to encourage outlets to participate in voluntary bans on the provision of high-strength drinks following a UK Government initiative 'Reducing the strength' (LGA, 2016). As there is no obligation, these have been met with varying success as it is conditional upon sufficient numbers of business owners being willing to participate and for them to be willing to put harm reduction strategies ahead of profit-margins. Where it has worked, there has been a positive effect, e.g., Suffolk (LGA, 2016).

Attempts in Kent have not been successful. In 2014, the Home Office launched the pilot of Local Alcohol Areas (LAAAs) to address the issues associated with antisocial effects of irresponsible drinking in the night-time economy; outputs are awaited (HO, 2014).

2.1.8 Recommendations for Kent Substance Misuse Alliance

- Map the number of off licence and licensed premises in Kent districts against areas of deprivation and risk factors for harm.
- Work with districts to challenge licence applications in areas with risk for potential harms using 'cumulative impact'.
- Understand the issues and barriers for Kent districts for Late Night Levies and work in areas of greatest alcohol risks in a place-based approach.
- Work with retailers and treatment services in areas of greatest risk in Kent districts to tackle the availability and sale of cheap white cider to vulnerable groups.
- Revisit the impacts of the Local Alcohol Areas (LAA) to see if lessons can be brought back to the Kent Substance Misuse Alliance regarding sales of high strength alcohol to vulnerable groups.
- Understand the impact via additional scoping - of 'on-line' and 24-hour internet alcohol supply.

2.2 UK Government alcohol Policy and Strategy

The UK Governments' Alcohol Strategy (HO, 2012) set out the intentions of Central Government to reduce harms associated with binge drinking, alcohol-related violence and reducing the numbers of people drinking at harmful and hazardous levels.

It introduced

- national measures to reduce the availability of cheap alcohol
- closer controls on alcohol marketing especially in relation to young people.
- alcohol screening became part of the NHS Health checks programme
- and alcohol awareness as part of the Change4Life social marketing programme.

A number of initiatives described in the strategy are being implemented in Kent.

From April 2012, amendments to the statutory guidance on the Alcohol Licensing Act 2003 (ibid) saw licensing authorities and local health bodies formally became 'responsible authorities' under the Act, ensuring that they are automatically notified of an application or review and can also instigate a review of a license.

2.2.1 Welsh strategy: Linking Tobacco to Alcohol

Wales unified its alcohol, drug and tobacco strategies and has seen a 30% fall in drug-related deaths and decreases in the three main alcohol categories of drinking above guideline limits, binge drinking and heavy drinking (Welsh Government, 2013).

2.2.2 Responsibility Deal: Work with Industry

In 2011, the UK Government launched the Public Health Responsibility Deal which aimed to herald a new voluntary partnership with commercial organisations, public bodies, academics, and non-government organisations to promote public health goals.

An evaluation report published in 2015, has been highly critical of its effectiveness. It was particularly critical of the failure to introduce evidence-based policy and minimum unit pricing.

2.2.3 The Prevention Green Paper, published on July 22, 2019

The Green Paper *'Advancing our health: prevention in the 2020s'*[14] offers the next opportunity to further galvanize a shift of focus from cure to prevention.

The Prevention Green Paper looks to stop ill-health happening in the first place, rather than prioritizing treatment after the fact. This Green Paper signifies a shift from considering how long people live as being important, to an even more important measure being how long people live in good health. it promises that the Government, "both local and national, working with the health and care system, [will] put prevention at the centre of all our decision-making." It aims to reduce the incidence of illnesses such as cancer, diabetes, and heart disease. Measures are outlined which will help to achieve this – a tobacco levy, an extension of the sugar tax, advice on sleep hygiene.

There are two new commitments outlined in relation to alcohol:

•The promise to "work with industry to deliver a significant increase in the availability of alcohol-free and low-alcohol products by 2025"

•To "review the evidence to consider increasing the alcohol-free descriptor threshold from 0.05% abv up to 0.5% abv in line with some other countries in Europe" in order to "support further innovation in the sector and encourage people to move towards alcohol-free products".

2.2.4 National Drug Strategies 2010 "Reducing Demand, Restricting Supply, Building Recovery and Supporting People to Live a Drug Free Life[15]", 2012, and 2017.

[14] https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document

[15] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf

Although called the 'Drug Strategy' this includes alcohol in its promotion of recovery and treatment services.

It focused on building resilience to ensure people did not become dependent / addicted to alcohol. It focused on restricting and controlling supply of alcohol to vulnerable groups and ensuring treatment services were using the best high-quality methods and treatments to aid recovery of those in need.

2.2.5 The National Alcohol Strategy 2012[16]

This seeks to reduce drinking to excess. It intends to reduce alcohol-fueled violent crime, binge drinking, alcohol-related deaths, and underage drinking; both Kent and Medway have localised the national strategy (Kent Drug and Alcohol Strategy 2017-22[17]; Medway Health and Wellbeing Plan).

This was updated in the 2017 UK Drug Strategy.[18] The updated strategy included priorities in tackling:

- Gang related crime linked to drug and alcohol
- Understanding the needs of the aging addict
- Tackling the harms related to families impacted by addiction
- Tackling mental illness of the person who has the substance misuse problem
- Using 'modern' crime prevention methods to best tackle alcohol related crime

2.2.6 The Health and Social Care Act 2012[19] & The Care Act 2014

Working with other organizations, local authorities are responsible for improving health; this includes alcohol related harms.

[16] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/224075/alcohol-strategy.pdf

[17] https://democracy.kent.gov.uk/documents/s77730/B7%20-%20Appendix%203%20-%20Kent%20Alcohol%20and%20Drug%20Strategy%20Final.pdf

[18] https://www.gov.uk/government/publications/drug-strategy-2017

[19] https://www.legislation.gov.uk/ukpga/2012/7/contents/enacted

2.2.7 The New Modern Crime Prevention Strategy 2016[20] and the Policing and Crime Act 2017[21]

These give certain powers to tackle 'drivers' of crime such as alcohol and give specific actions including:

- Late Night Levy improvements applying to defined areas, rather than whole Licensing Authority areas.
- Cumulative Impact Policy improvements, with more statutory powers to control alcohol sales.
- Consult on Licensing interventions for groups of premises in certain locations, in a group review intervention power (GRIP) which may require improved security or other area license conditions.
- Civilian (police) staff powers of entry to enter and inspect licensed premises; and
- Sobriety tagging as a Court Order and improved GPS based electronic monitoring.

2.2.8 Other Key Kent Plans and Strategies impact on Alcohol related misuse and harm

- **Sustainability and Transformation Plan 2017[22]**

Alcohol prevention is covered within the Kent and Medway STP Prevention Plan. Joined up care for dependent drinkers is also a key part of both Local Care and Mental Health in Kent's STP. This will also include a plethora of guidance and policy that impacts on domestic violence, homicide reviews, homelessness and suicide prevention and trauma informed care that are impacted by alcohol misuse.

- **Safer in Kent Plan 2017-2021[23]**

Tackling Substance misuse and mental health are some of the key priorities of the Police Crime Commissioner (PCC) in Kent.

- **Serious Violence Strategy 2018[24]**

This document cites alcohol as a driver of homicide, knife crime and domestic violence and calls for evidence-based interventions targeting alcohol related violence and domestic abuse.

[20] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/509831/6.1770_Modern_Crime_Prevention_Strategy_final_WEB_version.pdf

[21] http://www.legislation.gov.uk/ukpga/2017/3/contents/enacted

[22] http://kentandmedway.nhs.uk/wp-content/uploads/2017/03/20161021-Kent-and-Medway-STP-draft-as-submitted-ii.pdf

[23] https://www.kent-pcc.gov.uk/getmedia/74246ee9-38f0-4d1e-9b27-d8a9075bd708/Safer-in-Kent-2018_final.pdf

24 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/698009/serious-violence-strategy.pdf

Recommendations:

- Work across Children and Families and Health and Social Care to ensure that the Care Act responsibilities for carers and families are taken into account and further harm prevented.

2.3 Economic review and Social and Economic Costs of Alcohol related harm. (including Crime see 2.4.4)

2.3.1 Burden of Alcohol related harms: and a new approach to tackling the public's health

In 2016, Public Health England published an evidence view on the cost effectiveness of Alcohol control policies. There is a growing body of evidence demonstrating the extent of the burden of alcohol upon public services. Alcohol is associated with a wide range of social and health harms and treating drunk and abusive individuals engenders frustration and personal safety fears for front-line staff.

- Investment in interventions to reduce alcohol harms can produce a high return; for every 100 alcohol-dependent people treated at a cost of £40,000, savings of £60,000 can be made. This equates to preventing 18 Emergency Department visits or 22 hospital admissions (PHE, 2016).
- The Governments Alcohol Strategy (2012) estimated that the total cost to society in England at £21 billion per year; £3.5 billion to the NHS, alcohol-related crime was estimated at £11 billion and lost productivity at £7.3 billion (2010/11 costs).
- Of the costs to the National Health Service (NHS), the four largest disease conditions associated with alcohol harms are heart disease, stroke, liver, and cancer. Accident and Emergency attendances (about 70% are related to alcohol at weekends) and hospital admissions have more than doubled over the last 15 years to approximately a million episodes (PHE, 2014).

2.3.2 Estimated Costs of alcohol harm in Kent

In Kent, the costs to the NHS alone have been estimated between £71.2 million (£59 per adult; Alcohol Concern, 2015) and £108 million (Kent Public Health, 2014). Detailed costs by Alcohol Concern are outlined in table 2.

Table 2 Estimated costs to the NHS in Kent (Alcohol Concern, 2015)

£7.1m **Outpatient visits** **£16.6m** **Cost of AE visits** **£47.4m** **Inpatient admissions**
Admissions
£10.5m **Wholly alcohol attributable** **£36.8m** **Partly alcohol attributable**
Admissions by age group
£1.5m ***16–24-year-olds*** ***£12.9m*** ***25–54-year-olds*** ***£21.9m*** ***55–74-year-olds*** ***£11m*** ***75+ year olds***
Admissions by Gender
£31.8m **Male admissions** **£15.5m** **Female admissions**

2.3.3 Costs to NHS Emergency Departments

In 2009/10, the Government estimated that there were more than 7.1 million alcohol – related emergency department (ED) attendances which cost the NHS £696 million

(HOCHC,2012). Estimates for alcohol-attributable ED admissions range from 2% to 40% rising to 70% at peak times (ibid).

Common alcohol-related conditions treated at Emergency Departments include:

- road traffic accidents
- assaults (96%)
- domestic violence (87%)
- fractured limbs
- head injuries
- psychiatric problems
- overdose, seizures, and unconsciousness
- self-harm (90%).

Emergency Departments also admit to hospital a significant number of those who are suffering from the long-term health effects of sustained heavy drinking, such as

- chronic liver disease
- pancreatitis
- gastrointestinal bleeding
- cardiac arrhythmia
- cancer.

Government figures estimate that in 2009/10 there were 1.4 million alcohol-related ambulance/paramedic journeys, which accounted for 35% of all emergency journeys costing £449m in ambulance services (ibid).

2.3.4 NHS Prescribing costs

The total Net Ingredient Cost (NIC) for items prescribed for alcohol dependence in 2015 was **£3.93 million**. This is 15% higher than in 2014 when the total NIC was £3.42 million and more than double the level ten years ago (NHS BSA, 2015). No data is available for Kent.

2.3.5 Costs to Society

A study by the National Social Marketing Centre is recognised to be the best attempt to date of assessing the impact of alcohol upon society as it includes data for both private and external costs *(Lister et al, 2008).*

It estimates that the total social cost of alcohol to England in 2006-07 was

£55.1 billion.

This comprises:

• Family Value Costs: **£22.6 billion** costs to individuals and households, including crime and violence, private health and care costs, informal care costs for families, lost income due to unemployment, spending on alcohol consumption above guideline levels (on the basis that "From a family perspective the economic impact of such purchasing can be devastating") [ibid].

• Human Value Costs: **£21.9 billion** the pain and grief associated with illness disability and death

• Public Health Costs **£3.2 billion**

• Statutory Care Costs : **£5.0 billion** such as social care, criminal justice, and fire services

• Productivity Costs: **£7.3 billion** of costs to employers due to lost productivity, absenteeism, and accidents

2.4 Economic costs of consumption and alcohol-related harm

The Government's Alcohol Strategy (2012) estimated that the total cost to society in England at £21 billion per year; £3.5 billion to the NHS, alcohol related crime was estimated at £11 billion and lost productivity at £7.3 billion (2010/11 costs). Other estimates have costs ranging between from £20 billion to £55 billion in England inclusive of a variety of non-medical costs (ibid).

Alcohol misuse has implications for the health and behaviour of employees with lost productivity - estimated to be about £7.3 billion per year by the Commons health select committee in 2012[25].

Of the costs to the National Health Service (NHS) the four largest disease conditions associated with alcohol harms are:

- heart disease,
- stroke,
- liver disease, and
- cancer.

Accident and Emergency attendances (about 70% are related to alcohol at weekends) and hospital admissions, have more than doubled over the last 15 years to approximately a million episodes[26].

2.4.1 Impact of delay to alcohol treatment

Not getting alcohol treatment incurs costs to 'society' as well as the human costs, via a range of issues such as economic losses, costs to social care, costs to health services and

[25] https://publications.parliament.uk/pa/cm201213/cmselect/cmhealth/132/132we01.htm
[26] Public Health England, 2014

personal and emotional costs. This section describes the problem of the Treatment Gap of 85%. This means that although there are services in place, they are only accessed by 15% of the population of dependent drinkers. (see section on Demography and Prevalence). This is not an issue unique to Kent. However, it shows that there is a population that is unable to get care and support and that can incur a social and economic cost to Kent. Table 3 shows the estimated costs that accrue from not getting treatment and recovery from alcohol addiction.

Table 3: Kent Estimated costs of dependent drinkers not in treatment

Service Area	Kent Estimate
Primary Care	£3,198,470
Emergency Department	£459,571
Hospital	£2,956,072
Ambulance	£1,880,062
Mental health	£960,958
Police	£28,387,679
Probation	£6,334,441
Anti-social behaviour	£7,977,703
Adults	£6,914,394
Child and Family	£15,280,079
Housing and homelessness Services	£995,680
Fire Service – callouts	£66,629
Fire Service – false alarms	£48,329
Total	£76,420,965

Source: Commissioning Pack - NDTMS

The current commissioning budget for substance misuse in Kent (Alcohol and Drugs) is about £10 million and the costs of not getting treatment are estimated to be over £76 million.

2.4.2 Treatment Costs per head in Kent

The treatment budget, on average is £7.55 per head. Kent is ranked 146th/ 153 in England for spend per head– so very cost-effective and value for money. Alcohol and Drug treatment amounts to 14% of the total Kent Public Health budget, compared with 19% of budget is average in the UK (given we are average). This must be seen in conjunction of increasing drug and alcohol deaths and increases in both need and demand for services.

See: costs to mental health

Recommendation: Ensure that the Health and Social Care system are working collaboratively to ensure that there are multiple opportunities for dependent drinkers to seek help and support for recovery (including adequate mental health support).

Recommendation: Resist further reductions to the substance misuse budget and find ways to make efficient use of system costs.

2.4.3 Estimated Costs to Emergency departments

The Commons Health Select Committee found that in 2009/10 that there were more than 7.1 million alcohol – related emergency department (ED) attendances which cost the NHS **£696 million**. Estimates for alcohol-attributable ED admissions range from 2% to 40% rising to 70% at peak times. Research suggests that the proportion of total consultant time dedicated to intoxicated patients is around 25%.

Recommendations: Alcohol support teams linked to Emergency Departments can help with ensuring people are linked to continuing community care and recovery support.

2.4.4 Crime, criminal justice, and societal costs

Alcohol has been shown to have a strong link to violent crime and domestic abuse and can lead to both immediate healthcare costs of wounds and injuries, and long-term costs affecting mental health.

It is estimated 40% of violent crimes and 30% of domestic violent incidents are committed where the perpetrator is under the influence of alcohol[27] as perceived by the victims. Of all violent crime, 47% resulted in an injury, 15% needed medical attention and 1% needed admitted patient care. (National data)

Figure 2: Recorded crime in Kent between 2007 and 2018

[27] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/natureofcrimetablesviolence

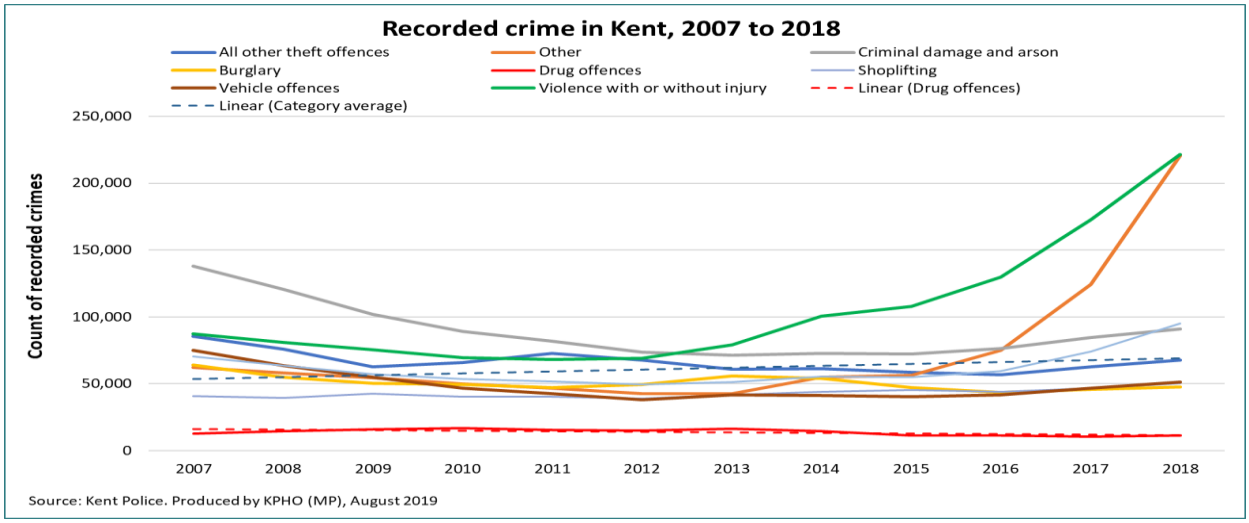


Figure 2- This table shows the recorded crime in Kent from 2007 through to 2018. It is varied by the different types of crime reported.

Source: Kent Police

In Kent, 17% of referrals into treatment services were made through the Criminal Justice System (CJS), higher than the 14% reported nationally in the Kent Police Force Area (KPFA). Of those (17% above), 50% were referred in through the prison service, and 24% through alcohol treatment or drug rehabilitation requirements (Table 14)

Recommendation: Continue to improve the data referrals for alcohol – to give indication – at least. Allowing to strengthen partnerships and helps get more continuity of care – with prisons etc

Overall, there is a good picture of partnership between treatment services and criminal justice services as there are better than national rates of referrals to treatment and requirements to treatment (ATR) from low level offenders. However, as table 4 shows there are areas for improvement e.g., referrals from arrest and probation.

Table 4: Referral source for Criminal Justice System referred treatment clients

Criminal Justice System Referrals to Treatment	Kent PFA	England
Arrest referral / CJIT	6%	15%
CRC	10%	3%
Probation	6%	13%
DRR	9%	6%
ATR	15%	6%
Other	4%	12%

Of the clients in treatment in 2017/18, The estimated number of people committing crimes are shown in Table 15. Shoplifting is the largest category, followed by violence against the person and domestic burglary. Only driving offences are higher in the alcohol category then the drug category.

Table 5: Estimated number of crimes committed before treatment entry, Kent clients

Offence Type	Estimated number of crimes committed before treatment entry: Drug clients	Alcohol clients
Shoplifting	141,294	4,992
Theft of a vehicle	1,904	14
Theft from a vehicle	5,713	23
Domestic burglary	1,143	72
Non-domestic burglary	7,236	40
Robbery	2,285	26
Fraud	3,047	14
Criminal damage and arson	130	33
Violence against the person	336	118
Sexual offences	52	28
Begging	17,900	1
Drink/ drug driving	28	40
Other theft	14,472	76
Drug offences	81,120	12
Prostitution	3,487	0
Breach offences	340	48
Public order	50	17
Other	213	36
Total	**280,749**	**5,590**

Figure 5- This table shows the number of crimes committed before and after entry of treatments for drug and alcohol misuse clients.

Source: NDTMS data

2.4.5 Reducing Re-offending

Alcohol clients have shown the larger reduction in re-offending rates upon starting treatment than drug clients, however those drug clients that do reduce offending rates have a much higher impact on average and higher return on investment.

Table 6: Estimated social and economic costs of treatment, Kent clients in 2017/18

Estimated % change after starting treatment	Drug clients	-28%
	Alcohol clients	-53%
Estimated crimes prevented per year after starting treatment	Drug clients	78,230
	Alcohol clients	2,956

	Drug clients		Alcohol clients	
Average crime-related cost	Before starting treatment	After starting treatment	Before starting treatment	After starting treatment
Social costs	£ 3,403	£ 2,454	£ 604	£ 285
Economic costs	£ 28,337	£ 20,441	£ 1,744	£ 822
Social and economic costs	£ 31,739	£ 22,895	£ 2,349	£ 1,107

Gross benefits	**Drug clients**	**Alcohol clients**	**Total**
Social benefits	£ 2,909,791	£ 980,697	£ 3,890,488
Economic benefits	£ 24,232,524	£ 2,831,052	£ 27,063,575
Social and economic benefits	£ 27,142,315	£ 3,811,749	£ 30,954,063

Figure 6 - This table shows the decrease of percentage and cost of crime that has been prevent one year after treatment.

Source: NDTMS data

2.4.6 Drugs vs Alcohol Costs

We cannot separate the costs to drugs and alcohol from our treatment services data however we can show that Alcohol only clients are more likely to have successful treatment, have lower crime rates prior to treatment and more likely than drug clients to not reoffend once treatment has started, making it cost-effective. In terms of cost effectiveness regarding alcohol treatment Table 7 shows that on crime reduction costs alone, alcohol treatment almost pays for itself.

Drug clients have considerably higher crime rates and are more likely to reoffend after treatment has started, however for those that engage well with treatment the crime and societal economic benefits are unequivocal.

Estimated savings for social and economic costs of Alcohol Treatment in Kent in 2017/8 are in approximately **£3.8 million pounds**.

Recommendation: Partnership and sharing costs

- **Link the system together to understand shared costs so that better outcomes in treatment can be made for vulnerable patients who disproportionately use multiple health services.**
- **Create shared and multidisciplinary treatment plans that are co-operative that plan care for the vulnerable client/patient e.g., alcohol relapse medication.**

Table 7: Crimes and costs in drug and alcohol treatment services in Kent

Crimes and Costs in Kent	Drug treatment	Alcohol treatment
Clients 2017/18	3,055	1,515
Estimated crimes per client before treatment	91.9	3.7
Service spend 2017/18	£5,074,000	£2,633,000
Service spend / number of clients	£1,661	£1,738
Estimated crime reduction after starting treatment	-28%	-53%
Average reduction in social and economic costs per pt. after starting treatment	£8,844	£1,242

Source: NDTMS data

2.4.7 Alcohol-related violent offences

The local authorities of Dartford, Dover, Folkestone & Hythe, Gravesham, Swale and Thanet experienced more violent injuries per head of population than the Kent average in 2018/19. All Kent districts, except for Sevenoaks, had a higher rate of violent offences than the England average. Thanet district is the clear outlier (Figure 3).

Figure 3: Violent offences per 1,000 population

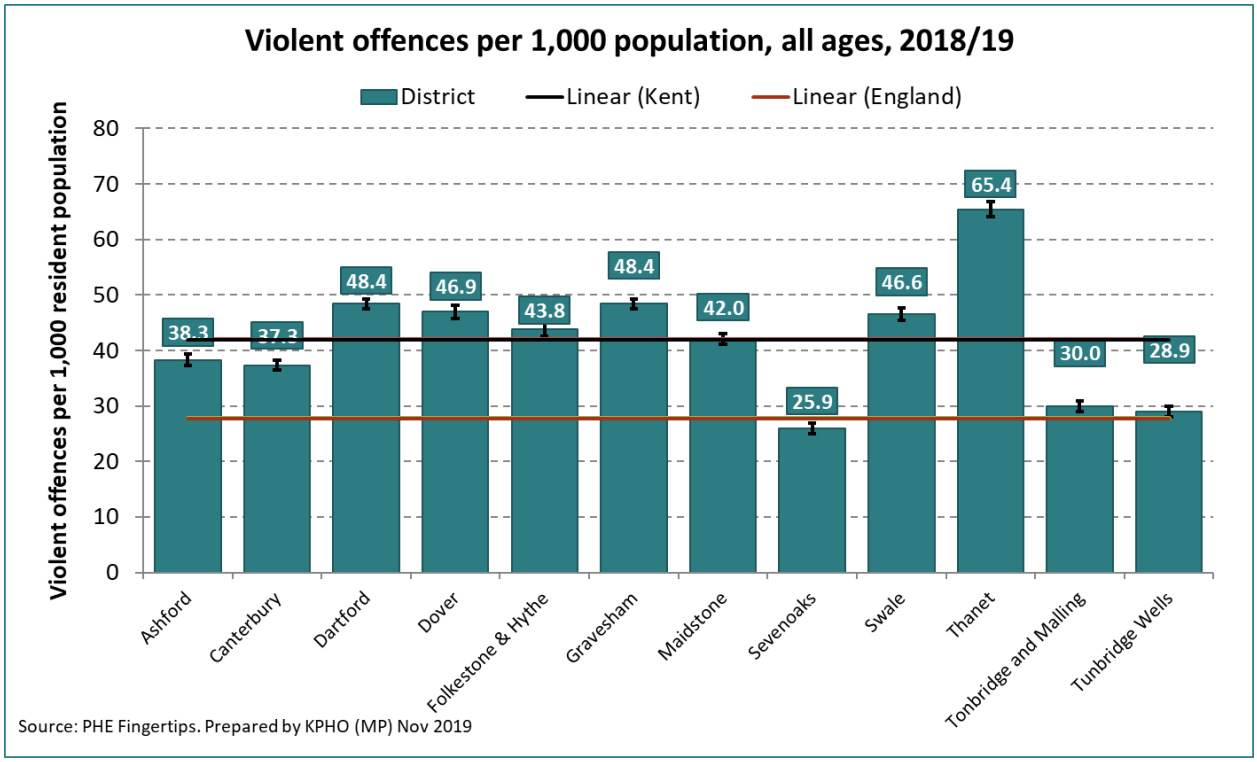


Figure 3- This chart shows the violent offences through Kent via each district in Kent per populations of 1000 from people of all ages in 2018 to 2019.

The extent to how much alcohol misuse contributes to crime is debated, however from the data – it is clearly linked. Alcohol reduces frontal lobe capacity to regulate and control impulsivity.

Public Health England (PHE) [28], has concluded that police recorded crime data should include an alcohol marker. Prior to the PHE update on police data the best estimates were collected from police recorded data from arrests (NEW ADAM and Greater Manchester Police) and violent crime with alcohol as perceived by the victims of violence within the Crime Survey for England and Wales (CSFEW).

There are pros and cons for both approaches [29]. The self-reported CSFEW presents a higher rate, but is a subjective view of the victim, however the police recorded data may present a low figure due to testing methods and delays after the incident. Therefore, the contribution of alcohol to crime rates may be anywhere between 35% and 60%.

[28] https://fingertips.phe.org.uk/documents/Alcohol-related%20crime%20indicators;%20methodological%20review.pdf
[29] https://fingertips.phe.org.uk/documents/Alcohol-related%20crime%20indicators;%20methodological%20review.pdf

Table 8: Alcohol Related Crime Victim Self Report vs Police Crime Data

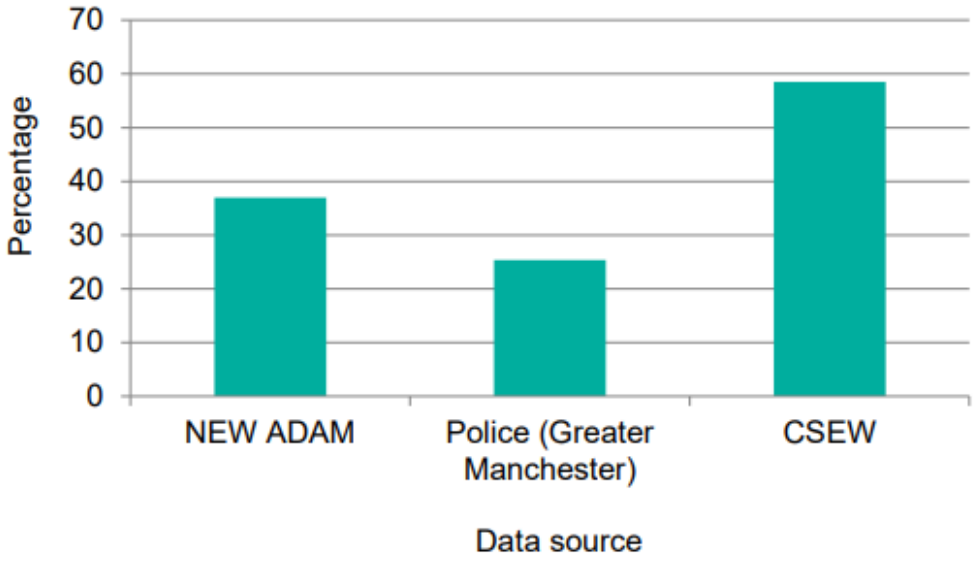


Figure 8 - This chart shows the data between the police crime data and the alcohol related crime victim self-report between CSEW, Police Greater Manchester and NEW ADAM

Source: LAPE alcohol-related crime indicators review

Table 9: Alcohol related violent crime estimated for Kent

Alcohol related violent crime estimates for Kent	Proportion of violent crime due to alcohol	Rate of alcohol offences per 1,000 population, 2018/19	Violent Crime count	Alcohol related violent crimes
Low estimate:	25.4%	10.65	65,157	16,550
High estimate:	39.0%	16.35	65,157	25,411

Source: CSFEW 2018/19

Using these two estimates applied to Kent crime rates, there are between a predicted 16,550 and 25,411 violent crimes in Kent where alcohol is involved, accounting for between 25% and 39%.

Recommendation: The links between violent crime and alcohol are great enough to warrant close working between criminal justice, police, and treatment services. It would be advisable to include preventative services in this partnership as well as treatment services, for example, IBA and health coaching for people in the criminal justice system via KCHFT (Kent Community Health Foundation Trust).

2.4.8 Perceptions of Alcohol Related Crime

The CSFEW[3031] also contains more detail on alcohol and drug related violence as perceived by the victims. The type of violence, time of day, day of week, location and whether the perpetrator was known to the victim all have variable rates of alcohol involvement. The tables below summarise some of these. Perceived alcohol involvement is more likely with wounding incidents; around pub/s clubs; where there are more than 1 perpetrator; with male perpetrators who are strangers; and in the evenings and at weekends.

Table 10: Proportion of types of violence where alcohol is perceived factor

% of offender(s) perceived to be under influence of alcohol	All violence	Violence with injury	Wounding	Assault with minor injury	Violence without injury	Domestic	Acquaintance	Stranger
Yes	39	44	52	39	36	31	35	49
No	52	49	41	55	55	66	59	37

Source: CSFEW 2018/19

Table 11: Location of violent between alcohol-related and non-alcohol related incidents

Number of violent offences	Around the home	Around work	Street	Pub or club	Other location	Public space locations
Alcohol-related	36	42	39	91	33	67
Not alcohol-related	53	54	41	6	54	23

Source: CSFEW: focus on violent crime 2016

Both tables 10 and 11 show that there are links between alcohol and violence and violence using a weapon.

Recommendation: Continue to work with Kent Crime Community Safety in assessing population health risks from alcohol misuse in knife crime and domestic abuse.

30 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/datasets/natureofcrimetablesviolence

31 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/compendium/focusonviolentcrimeandsexualoffences/previousReleases

Table 12: Offender characteristics in relation to alcohol-related activity

Offender characteristics	% Alcohol-related
Number of offenders	
One	44
Two	50
Three	50
Four or more	58
Sex - Male(s)	48
Sex - Female(s)	39
Aged under 16	7
Aged 16 to 24	50
Aged 25 to 39	51
Aged 40 or older	40
Relationship to victim	
Stranger	62
Acquaintance	41
Known well	35

Source: CSFEW: focus on violent crime 2016

The age of offenders who commit alcohol related crimes are spread fairly evenly across all ages over 16. There are 35% of crimes where the offender is well known to the victim (Table 11). Alcohol related crimes are more likely to be committed at night and at weekends (Table 12).

Table 13: Time of offence between alcohol-related activity and non-alcohol related activity

Time of offence	During the week	At the weekend	Morning / Afternoon	Evening / Night
Alcohol-related	30	67	17	68
Not alcohol-related	59	26	71	25

Source: CSFEW: focus on violent crime 2016

2.4.9 Drink Driving

The trends in the rates of alcohol related driving arrests is decreasing overall in Kent (Table 13 and 14). There were a total of 2,266 arrests due to driving offences involving alcohol in Kent in 2017. However, there are a mixed pattern of offences including being drunk and disorderly. There are a number of districts in Kent where the rates of road traffic accidents related to alcohol is higher than the national average (Figure 6) with Gravesham, Canterbury and Thanet having the highest rates in Kent.

Recommendation: Crime partnerships and public health (KCHFT) health promotion to work together to create greater awareness campaigns to reduce alcohol-related road traffic accidents.

Table 14: Alcohol-related arrests in Kent, 2015-17

Alcohol related arrests in Kent, 2015-17	2015 Arrests	2016 Arrests	% Change from 2015	2017 Arrests	% Change from 2016
DRIVING WHILST UNFIT (DRINK)	369	371	0.5%	408	10.0%
DRUNK AND DISORDERLY	847	792	-6.5%	683	-13.8%
DRUNK IN CHARGE OF MOTOR VEHICLE	64	77	20.3%	89	15.6%
EXCESS BREATH ALCOHOL	1,106	1,080	-2.4%	1,049	-2.9%
OTHER ALCOHOL RELATED	77	41	-46.8%	37	-9.8%
Total	**2,463**	**2,361**	**-4.1%**	**2,266**	**-4.0%**

Table 14: Road Traffic arrests due to Alcohol between 2015 and 17

Reason for Arrest	2015	2016	2017
DRIVING WHILST UNFIT (DRINK)	369	371	408
DRUNK AND DISORDERLY	847	792	683
DRUNK IN CHARGE OF MOTOR VEHICLE	64	77	89
EXCESS BREATH ALCOHOL	1,106	1,080	1,049
OTHER ALCOHOL RELATED	77	41	37
Total	**2,463**	**2,361**	**2,266**

Figure 4 Alcohol related road traffic accidents, 2014-16

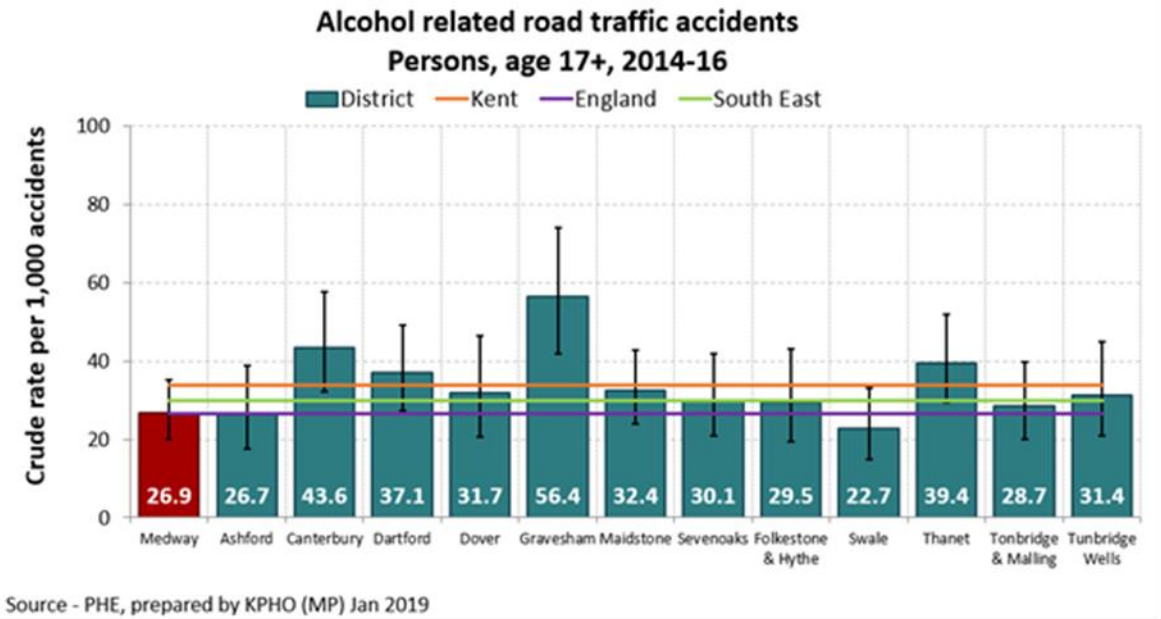


Figure 4 -This table shows the number of Alcohol related road traffic accidents for persons ages 17 years and older between 2014 and 2016. Separated between each district in Kent.

Figure 5: Alcohol related road traffic accidents, where at least one driver failed a breath test, 2013-15

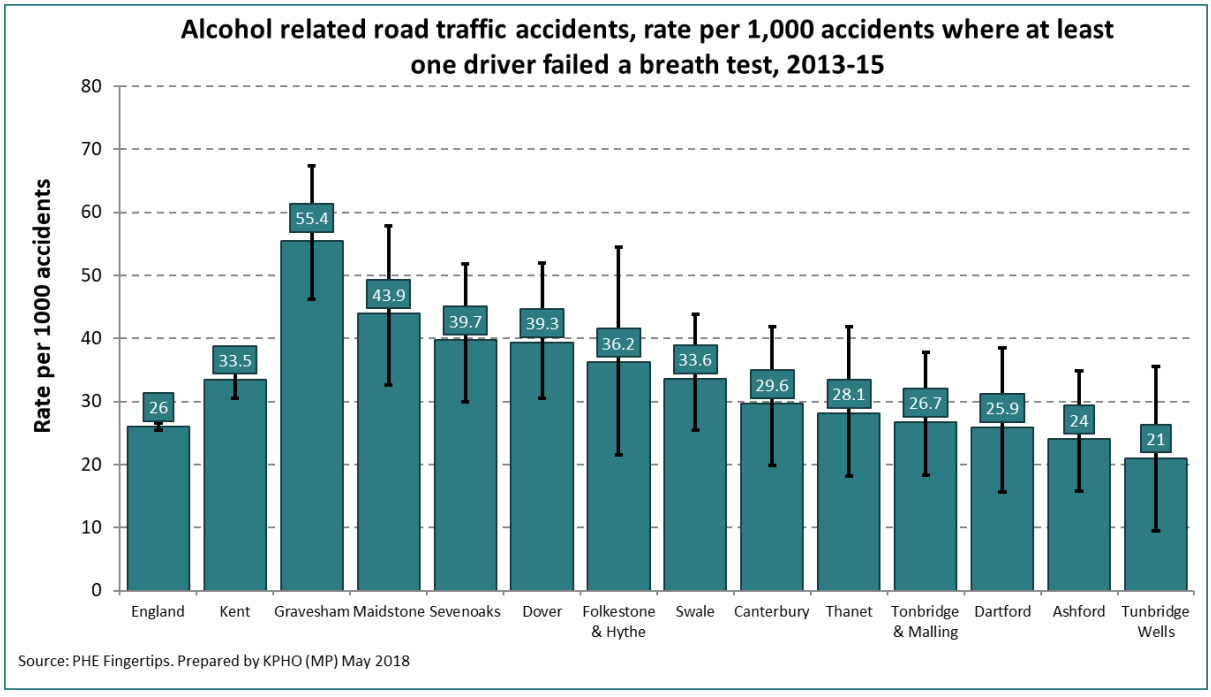


Figure 5 - This table shows the number of alcohol related road traffic accidents where per 1,000 where at least one of those drivers failed a breath test between 2013 and 2015.

From the data in Fig 5 there is an outlier in Gravesham for drink- driving. This would be useful to present to local partnerships to understand why this is the case.

Summary of Chapter 3

In Kent, there are an estimated 300,000 people who are drinking to physically dangerous levels. Roughly 55,000 people who are at higher risk of developing an alcohol dependency and about 15% of the Kent population regularly binge drink. There are an estimated 12,000-14,000 people who are dependent drinkers and will need treatment services to quit safely and of these 2,000 will be highly vulnerable and complex people and need a range of services to work together to support them.

During the 2020 COVID19 pandemic there were some changes to consumption. National figures show, of those whose drinking habits had changed, more women had increased their alcohol consumption than men. Alcohol consumption during the pandemic tended to increase with age up to the 55 to 63-year-old age band, after which it decreased. There was no significant change in the number of alcohol specific deaths during 2020 compared to the period 2016 to 2019. In Kent, around 308,000 were drinking above the recommended levels of alcohol in July 2021.

There are variations across Kent districts for alcohol dependence treatment and these often map to deprivation, however given the complex and multiple needs faced by people needing treatment ease of access and early help is needed. The overall age of people needing support is 40-65 and this cohort also become frail due to premature aging resulting in a host of physical problems and co-morbidies. There is a 23-year life expectancy reduction in patients with alcohol-related conditions. Services need to work together to tackle the physical and mental aspects of addiction and recovery noting many of the service users will have undiagnosed brain damage due to late presentation.

3 Demography and epidemiology of alcohol use in Kent

This section will cover the nature and extent of alcohol use and misuse in Kent—how many people drink alcohol, estimates of the levels of misuse and dependency, and estimates of who is in need of service. This section will also cover changes in consumption due to COVID19 pandemic, using YouGov data. It is important to state that alcohol is a legal substance and that the vast majority of Kent residents drink within 'responsible' limits (roughly 75% of the population) – however this needs assessment assesses the risks and harms given changes in levels of consumption among certain groups.

3.1 Alcohol Misuse

The broad definition of 'alcohol misuse' is drinking over the government recommended levels and also if alcohol impacts negatively on a person's day to day activities and relationships.

Current estimates applied to Kent show 21% of Kent's adult population are drinking above 14 alcohol units a week. Thirty-five units a week is considered a **dangerous drinking level**. This is 14 pints of Beer (average 4% beer) a week, or 14 glasses of wine (13%) a week (about 2 bottles of wine).

There are four broad categories of Alcohol Misuse (Table 15)

- **Harmful drinking** (over 14, up to 35 [female] /50 [male] units a week)
- **Hazardous drinking** (over 14, up to 35 [female] /50 [male] units with no 'free' days or 'binge' drinking)
- **Higher risk drinking** (over 35 [female] /50 [male] units a week)
- **Binge drinkers** (Drinking over 6 [female] / 8 [male] units in one sitting)

3.2 How Alcohol Causes Harm

The previous section gives the context to alcohol misuse as a Public Health issue in the UK, showing its complexity and association with a range of issues such as:

- Crime and justice system, and community safety
- Psychological issues and mental health
- Links to other dependencies, e.g., drug problems
- Relationship and family problems
- Lifestyle and physical health
- Children and safeguarding/adult vulnerability

There are three main reasons for this:

a) The use of alcohol to alleviate multiple stressors can have compound impacts (e.g., violence and mental illness) in deprived communities due to a lack of protective factors and coping strategies. This can also link to adverse childhood events and trauma which can make regulating addictive behaviours difficult for some people.
b) The action of alcohol as a toxic agent can combine with poor self-care, poorer nutrition, and poorer quality (cheaper) products to produce greater health problems (liver disease).
c) The differential cost and availability of treatments and therapies and the barriers to getting help can be different across social gradients.

3.2.1 Alcohol consumption above recommended levels (during COVID)

PHE analysis of YouGov survey data shows the proportion of respondents who reported drinking over the recommended 14 units of alcohol per week at different times during the pandemic (see figure 8). This suggests that over 1 in 5 adults were drinking over the recommended levels before lockdown. This increased to 1 in 4 during the first national lockdown, after which the proportion reduced slightly over time. However, by December 2020 the percentage of respondents consuming over 14 units per week peaked at 27%. This

fell to 23% during the third national lockdown, but by July 2021 it had increased again to roughly 1 in 4 adults. When these proportions are applied to 2020 Kent resident population estimates, they are equivalent to approximately 276,000 people before lockdown and between 281,000 and 311,000 during the three national lockdowns, peaking at 338,00 people during the tiered restrictions of December 2020.

Figure 8: Proportion of respondents aged 18+ who consumed >14 units of alcohol during a typical week in England

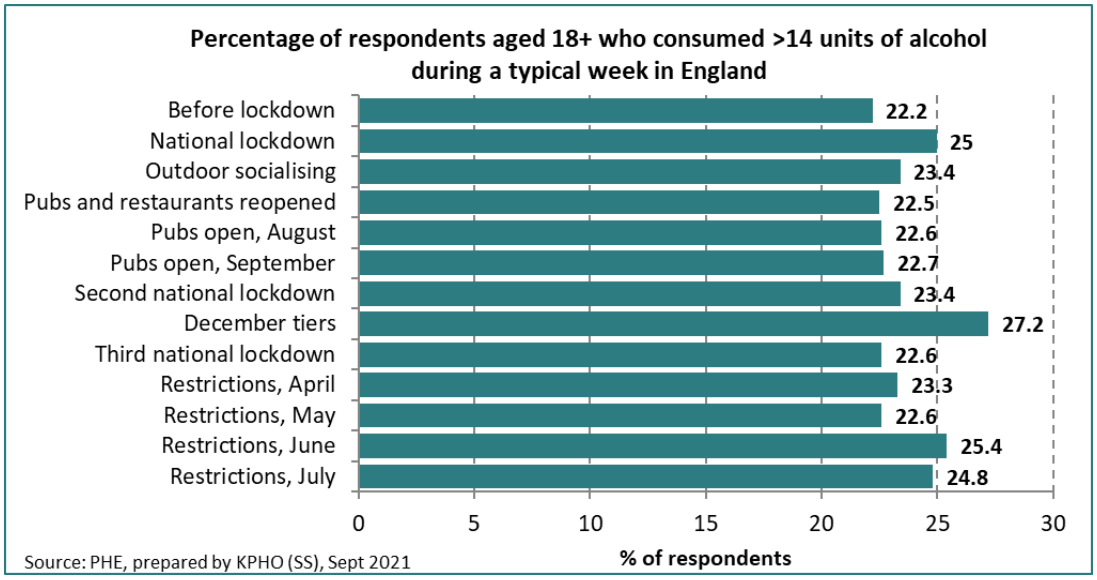


Figure 8- This table shows the proportions of respondents ages 18 that consumed more than 14 alcoholic units during a typical week in the UK. This data shows before lockdown(s) and also during the stages of these lockdowns.

Figure 9 shows a stark difference in alcohol consumption between the genders with a considerably higher proportion of men consuming over 14 units of alcohol per week than women at every time period covered by the YouGov survey. However, while the baseline rate of drinking was higher in men, the previous section on changes in alcohol consumption showed that a higher proportion of women had increased their alcohol intake during the first lockdown, compared to men.

Figure 9: Proportion of respondents who consumed >14 units of alcohol during a typical week in England by gender

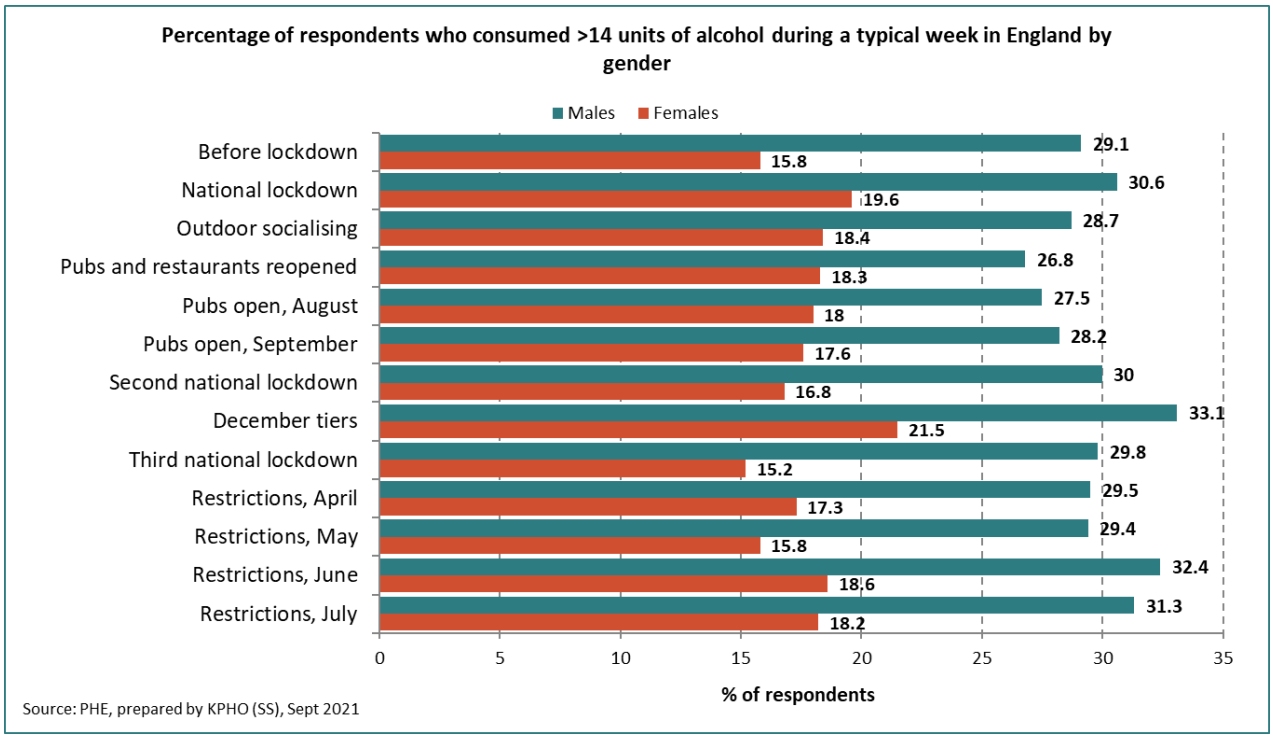


Figure 9- This table shows the proportion of those who consumed more than 14 alcoholic units of alcohol during a typical week in the UK. This has been separated by gender.

Differences in alcohol consumption can also been seen between age groups (see Appendix 2). Overall, the proportion of respondents drinking over recommended levels of alcohol rose with age up to the 55-64 age group, after which it fell again. Table 18 shows the estimated number of people in Kent in each age group that consumed more than 14 units of alcohol in July 2021 when lockdown restrictions had eased, but before they were removed completely. These were again calculated by applying PHE YouGov survey analysis to Kent resident population estimates. This suggests around 308,000 in Kent were drinking above the recommended levels of alcohol in July 2021.

Table 18: Estimated number of adults in Kent drinking > 14 units of alcohol per week in July 2021

Age band	Estimated number of adults
18-24	22,000
25-34	42,000
35-44	46,000
45-54	56,000
55-64	56,000

65-74	47,000
75+	45,000
All ages	308,000

Note: Figures may not add up due to rounding

3.2.2 Estimated Prevalence of Alcohol Misuse in Kent (pre-COVID)

The main way prevalence of alcohol misuse is estimated in Kent is via the Adult Psychiatric Morbidity Survey. This is a large-scale survey of a variety of mental health issues and alcohol consumption is included. Data from the ONS is also used via Household Survey data.

The data shows there are estimated 300,000 drinking at harmful and hazardous levels and 50,000 people at risk of becoming dependent drinkers (Higher Risk Drinkers).

The PMS uses a too called Alcohol Use Disorders Identification Test (AUDIT) and AUDIT-C (Consumption)[32] which are WHO developed self-reported assessment measures. Using this estimate there are 12,000 dependent drinkers in Kent.

Another source of data for estimating alcohol misuse the 'Sheffield Estimates'. This data is modelled by the University of Sheffield (using research data) is thought to be more accurate as it factors in deprivation and hospital admissions. This estimate shows a higher number of dependent drinkers (Audit 20+) in Kent at c.**14,000**.

The different estimates are compared in Figure 2. This shows that there are between 12,000 and 14,000 dependent drinkers in Kent – depending on which estimate is used (figure 2).

3.2.3 The AUDIT/AUDIT C test

AUDIT-C starts with 3 questions - if the combined score is 5 or higher the full AUDIT comprising a further 7 questions should be carried out and a final combined score should advise the clinician the appropriate course of action for the patient. A score of less than 5 on the AUDIT-C or 7 on the AUDIT indicates low or zero risk, 8 – 15 indicates 'brief advice' as appropriate, 16 – 19 indicates extended brief advice or referral to drug and alcohol practitioner, and 20+ indicates dependence and likely need of treatment services[33].

3.2.4 Using the APMS to estimate harmful drinking in Kent

The Adult Psychiatric Morbidity Survey (APMS, 2014)[34] is used by Public Health England as the basis to estimate harmful drinking and dependence rates. It is published at national and regional (South-East England) level. This data is applied to in the Kent population and are

[32] https://www.gov.uk/government/publications/alcohol-use-screening-tests
[33] https://www.gmmh.nhs.uk/download.cfm?doc=docm93jijm4n639.pdf&ver=1017
[34] https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

presented below (Table 19). The current estimate of binge drinkers in Kent comes from the ONS opinions and Lifestyle survey 2017[35].

3.3 Estimated Levels of alcohol misuse in Kent (Pre-COVID)

Table 19: Estimated number of categories of alcohol misuse in Kent

Type of Drinking	Estimated number in Kent	Consumption in Units	Risks
Harmful drinking	300,000	More than 14, up to 35/50 units a week	Danger of long-term physical harm to self and others.
Hazardous drinking	300,000	More than 14, up to 35/50 units a week with no 'free days' and/ or binge drinking	Significant impact on physical and mental health and wellbeing, likelihood of social and economic harms.
Higher Risk drinking	50,000 – 57,000	Over 35/50 units a week	Physical harm as a result of ethanol present and high likelihood of social, economic, and mental harm. Risk of physical dependency.
Binge drinkers	15% of Kent's adult	Over 6-8 units in one sitting	Danger of rapid intoxication,

35

	population		violence, accident, poisoning and being a victim of crime.

Source: 2019 Health Survey for England

Figure 14: UK population and Drinking Behaviour

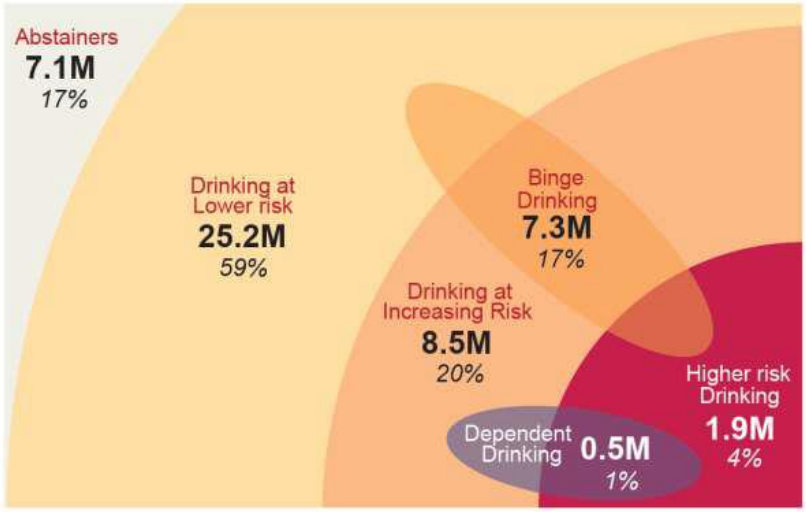


Figure 1- This image shows the current numbers and percentages of each category of harmful and hazardous drinking.

Each category of harmful and hazardous drinking has its associated risks. For example, binge drinking can be associated more with town centre violence and risk of accidental self-poisoning. Harmful drinking can lead to physical problems that can remain undetected (e.g., hypertension). Higher risk drinking can lead to dependency.

UK government recommendations state, "No one can say that drinking alcohol is absolutely safe. Current guidelines suggest avoiding harm people should not drink more than 14 units a week". One unit of alcohol is 10ml of pure alcohol and this is half a pint of normal strength lager or a single measure of spirit. A standard bottle of wine has approximately 10 units.

- Nationally, about 23% of the adult population are drinking above the recommended maximum levels of 14 units of alcohol a week[36].
- **This equates to approximately 294,869 adults across Kent.**

[36] Calculated based on Health Survey for England data on adults drinking over 14 units of alcohol a week (2019), applied to the mid-2019 18+ resident population for the East Kent CCGs.

- Regular drinking at higher and hazardous levels above 35 [female] /50 [male] units a week has remained steady at around 4% of the population, equating to around 50,000 – 57,000 people in Kent.
- About 14,000 severely dependent drinkers in Kent equating to 1% of the population[37].
- A further 1.6% (circa 20,000 in Kent) of the population is estimated to have mild dependency or are drinking at harmful levels and may also benefit from treatment or extended brief intervention from a professional or lifestyle services.
- An estimated 15% are regular binge drinkers.

Table 20: Modelled drinking prevalence estimates for adults by age band in Kent in 2014, based on Alcohol Use Disorders Identification Test (AUDIT) score

2014 Estimates by age band	Non-drinker/low risk (0-7)	Hazardous drinking (8-15)	Harmful drinking/mild dependence (16-19)	Probable dependence (20+)
16-24	120,186 (71.1%)	41,609 (24.6%)	4,538 (2.7%)	2,609 (1.5%)
25-34	133,626 (76.5%)	33,376 (19.1%)	4,602 (2.6%)	3,035 (1.7%)
35-44	148,535 (79.1%)	31,234 (16.6%)	4,312 (2.3%)	3,710 (2.0%)
45-54	176,684 (80.9%)	35,435 (16.2%)	3,535 (1.6%)	2,671 (1.2%)
55-64	138,735 (78.5%)	33,066 (18.7%)	3,526 (2.0%)	1,474 (0.8%)
65-74	141,714 (88.0%)	17,581 (10.9%)	1,294 (0.8%)	533 (0.3%)
75+	105,028 (78.7%)	23,841 (17.9%)	2,738 (2.1%)	1,776 (1.3%)
All Kent Adults	**967,146 (79.2%)**	**219,998 (18.0%)**	**21,420 (1.8%)**	**12,210 (1.0%)**

Source: APMS & ONS mid-year populations

3.3.1 Low Risk Drinking

Table 16 shows that over 79% of the adult population drink responsibly. There has been an overall increase in responsible drinking from 2007 and 2014. The figures have increased 8% in the 16-24 years old's and 6% increase in the 25–34-year-olds.

3.3.2 Hazardous Drinking / Harmful and Dependent Drinking.

The APMS estimates that 18% of the population is drinking alcohol in a hazardous way. This group of risky drinkers has decreased over time in all age groups apart from the 55–64-year-olds. There is a likelihood of 1.8% of the Adult population to have mild dependence and 1%

[37] https://www.sheffield.ac.uk/polopoly_fs/1.693546!/file/Estimates_of_Alcohol_Dependence_in_England_based_on_APMS_2014.pdf

to have severe dependence. These figures have remained fairly stable apart from the 55–64-year-olds where there is an increase in dependence. This indicates that the greatest age group at risk of dependent drinking is from 45–74-year-olds.

Table 21: Modelled drinking prevalence for adults in Kent by gender, 2014, based on AUDIT score

2014 Estimates by gender	Non-drinker/low risk (0-7)	Hazardous drinking (8-15)	Harmful drinking/mild dependence (16-19)	Probable dependence (20+)
Male	**427,529 (72.3%)**	**140,876 (23.8%)**	**12,042 (2.0%)**	**11,066 (1.9%)**
Female	**542,919 (86.2%)**	**76,360 (12.1%)**	**9,244 (1.5%)**	**965 (0.2%)**

Source: APMS & ONS mid-year populations

Women are on the whole less at risk from hazardous and harmful drinking than men.

However, both genders carry risks from alcohol dependence. Women of reproductive age are also vulnerable due to risk of harm to their unborn babies. Women may also bare associated risks if they are the main care givers to children – although this issue can impact on males also. (Table 18).

Table 22: Modelled binge drinking prevalence for adults in Kent by age and gender, 2017

Binge drinking 2017 estimates by age and gender	All Adults	Males	Females
16-24	32,072 (19.7%)	15,315 (18.4%)	16,691 (21.0%)
25-44	66,129 (17.8%)	32,689 (18.0%)	33,517 (17.7%)
45-64	68,111 (16.6%)	40,218 (19.8%)	28,071 (13.5%)
65+	19,546 (6.3%)	12,562 (8.9%)	6,754 (4.0%)
All Adults	**189,463 (15.1%)**	**101,720 (16.7%)**	**87,805 (13.6%)**

Source: Opinions and lifestyle survey & ONS mid-year populations 2017

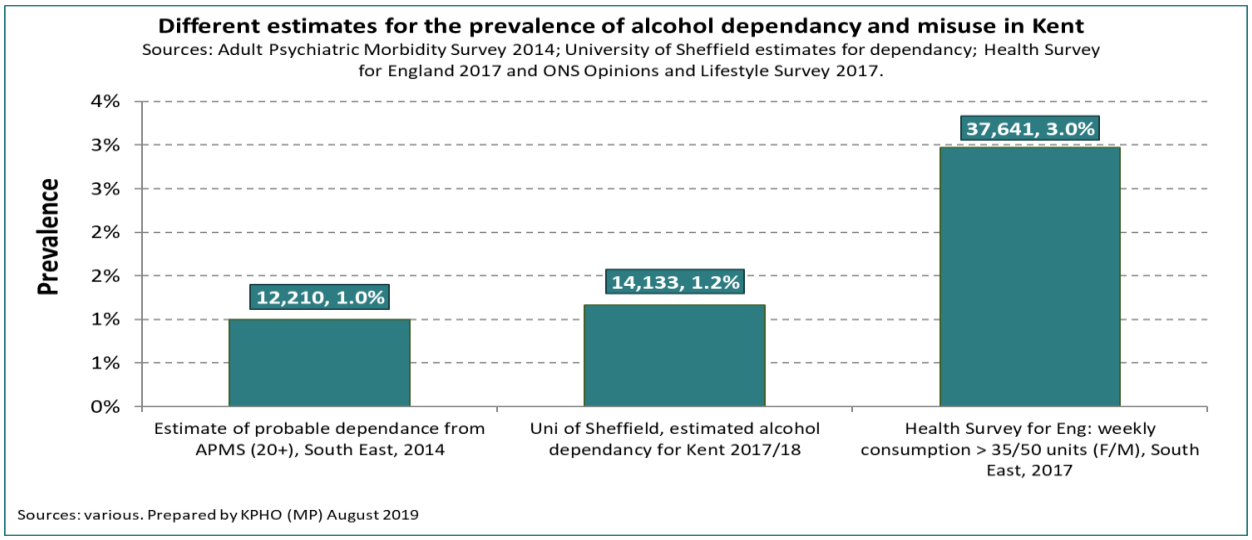
The Health Survey for England and Wales (2017)[38] measures alcohol consumption and estimates those at the highest risk with a weekly consumption of over 35 units for females and 50 for males at 3% in the South-East. This works out to **37,000** in Kent age 16+ drinking at high risk levels. The ONS Opinions and Lifestyle Survey reports 15% of people regularly

[38] https://digital.nhs.uk/pubs/hse2017

binge drink (>6 units for female, >8 for male on heaviest drinking day in previous week), circa 190,000 in Kent.

Figure 6 shows that there are between 12,000 and 14,133 people in Kent who have alcohol dependency (i.e., are physically dependent on alcohol). The Health Survey for England predicts there will be 37,641 people drinking at levels that place them at risk of developing a dependency (addiction).

Figure 11: Measures of Alcohol dependence and misuse prevalence in Kent



3.4 Dependent Drinkers: What is Alcohol Dependency?

Alcohol is an addictive substance and can in some cases lead to very serious illness. It is more prevalent with people who have depression and post-traumatic stress disorder. Once the body becomes physically dependent on alcohol there is a danger of death if the 'withdrawal' of alcohol is not medically managed.

Harmful and hazardous drinking are defined in NICE[39] guidance as

"pattern of alcohol consumption causing health problems directly related to alcohol. This could include **psychological problems** such as depression, alcohol-related accidents, or **physical illness** such as acute pancreatitis. In the longer term, harmful drinkers may go on to develop high blood pressure, cirrhosis, heart disease and some types of cancer, such as mouth, liver, bowel or breast cancer."

3.4.1 Alcohol dependence

Alcohol dependence is characterised by craving, tolerance, a preoccupation with alcohol and continued drinking in spite of harmful consequences (for example, liver disease or

[39] https://www.nice.org.uk/guidance/cg115/chapter/introduction

depression caused by drinking) and an increased rate of significant mental and physical disorders.

The diagnostic criteria for dependence is the Severity of Alcohol Dependence Questionnaire (SADQ) [40]. This assessment is for severity of symptoms such as seizures, shaking, sweating, fear, craving, volume of units consumed daily and emotional despair.

3.4.2 Alcohol Withdrawal Syndrome

For the most dependent drinkers sudden withdrawal from alcohol can lead to panic, hallucinations, heart attack, strokes, and coma. Severe Alcohol Withdrawal Syndrome can be fatal. The withdrawal of alcohol can have long lasting physical impact (from 3 to 12 months). Regular medically unsupervised withdrawal can lead to brain damage. If a person goes into a regular withdrawal (and relapse) – the 'kindling effect' can take place. This is a serious form of brain damage where the symptoms of withdrawal become magnified and can lead to trauma, seizures, and death.

Recommendations: Treatment services should be focused on relapse prevention for their most vulnerable alcohol dependent patients.

3.5 Categories of alcohol dependency

Although alcohol dependence is defined in ICD-10 and DSM-IV and as with many psychiatric conditions; dependence exists on a *continuum of severity.*

Mild dependence: score less than 15 on the SADQ and do not need assisted alcohol withdrawal.

Moderate dependence: (with a SADQ score of between 15 and 30) usually need assisted alcohol withdrawal, which can typically be managed in a community setting unless there are other risks.

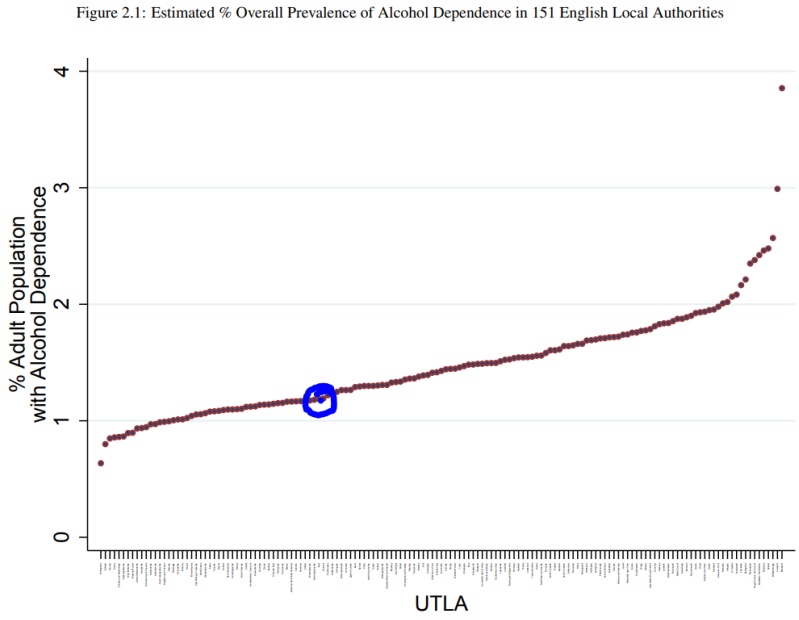
People who are severely alcohol dependent (with a SADQ score of more than 30) will need assisted alcohol withdrawal, typically in an inpatient or residential setting.

3.6 Has Kent higher rates of dependent drinkers then other Local Authorities?

The graph below (figure 12) shows Kent's position nationally out of all local authorities in estimated alcohol prevalence and ranks Kent within the lower third of LAs. It shows that Kent has relatively average rates of dependency compared to other areas. No detail is reported below Kent level. When treatment service figures presented in chapter 8 are compared to hospital admission data (see chapter 4 section 4.4) it is clear that there are differing levels of need in different districts within Kent.

[40] https://www.smartcjs.org.uk/wp-content/uploads/2015/07/SADQ.pdf

Figure 12: Estimated prevalence of alcohol dependence in English local authorities



3.6.1 Kent's District-level alcohol service needs

It may be possible to estimate more localised need using alcohol treatment service usage and triangulated with other relevant measures, such as alcohol sales, benefit claimants, rates in treatment and hospital admissions available at district level. Table 23 below presents estimates of dependent drinkers by district at the published Kent rate of **1.16%** of the population; other indicators may suggest an increased or decreased need in each district.

It will be important for treatment providers to digest the information in this needs' assessment at a localised level alongside their public health and commissioning teams to understand the variation between localities. An example of applying brief equity profiles for three localities is provided below.

Recommendations: Public health to work alongside treatment providers to understand the needs of dependent drinkers and develop localised prevention plans with each district and local Primary Care Network.

Recommendations: Commissioners and Public Health to work with local NHS to improve access and relapse prevention for dependent drinkers focused on equity. (equity audit).

Table 23 – Localised estimates for alcohol need (rank in brackets)

District modelled estimates (and district rank)	Modelled dependent drinkers @ 1.16%	Volume of alcohol sold in off trade (L per person)	Claimants of benefits due to alcoholism 2016	Rate per 1,000 population in alcohol treatment, 2017-18	Admissions for alcohol specific conditions, 2017/18	Years of life lost due to alcohol-related conditions, 2017
Kent	14,133	5.5	89.4	1.2	385.5	588
Ashford	1,164 (7)	4.8 (2)	54.7 (2)	1.2 (8)	379.5 (1)	334.5 (1)
Canterbury	1,587 (12)	4.9 (3)	90.2 (7)	1.1 (5)	580.5 (9)	777.7 (10)
Dartford	969 (2)	5.1 (5)	61.2 (3)	0.8 (3)	473.0 (6)	578.2 (7)
Dover	1,099 (5)	5.0 (4)	61.2 (3)	1.4 (9)	485.4 (7)	581.4 (8)
Gravesham	964 (1)	5.3 (6)	92.7 (8)	1.2 (7)	653.3 (11)	609.6 (9)
Maidstone	1,551 (11)	6.2 (10)	121.0 (11)	1.7 (10)	632.2 (10)	510.8 (5)
Sevenoaks	1,100 (6)	4.3 (1)	44.0 (1)	0.5 (1)	429.0 (4)	439.6 (3)
Folkestone & Hythe	1,064 (3)	5.8 (9)	110.9 (10)	1.8 (11)	569.3 (8)	801.2 (11)
Swale	1,348 (10)	5.8 (8)	70.7 (6)	1.1 (6)	437.1 (5)	575.0 (6)
Thanet	1,319 (9)	6.6 (11)	177.4 (12)	2.1 (12)	694.3 (12)	987.7 (12)
Tonbridge and Malling	1,180 (8)	5.4 (7)	66.9 (5)	0.8 (2)	393.9 (2)	396.2 (2)
Tunbridge Wells	1,085 (4)	6.7 (12)	101.1 (9)	1.0 (4)	426.5 (3)	501.9 (4)

Table 23 shows that there are clear differences in localities in Kent.

Tunbridge Wells

Tunbridge Wells has the highest level of alcohol sales from off licences in Kent and scores high (9th out of 12) for benefits claims for alcohol and yet has relatively low rates for alcohol related hospital admissions. However, Tunbridge Wells scores average (5th out of 12) in its rate per population in treatment services. This might indicate that although there may be high consumption the relative affluence of the locality and the access to treatment services may be a protective factor for dependent drinkers. When hospital admission rates for alcohol specific conditions are compared by ward it is clear there is a health inequality – and there are higher rates for people from the deprived wards e.g., Sherwood, Fant and North.

Dover

Dover has a similar modelled estimate of dependent drinkers as Tunbridge Wells and far lower rate of volume of alcohol sold in off licence and also fairly low rate of benefits claimed due to alcoholism. Yet it has the second highest rate of people in treatment in Kent. It has higher hospital admissions then the Kent average but is lowering its alcohol hospital admission rates. This shows the importance of referral to alcohol treatment services in preventing illness and death.

Thanet

Thanet, by contrast, has high estimated rates of alcohol dependency and the highest rate of benefits claimants for alcoholism in Kent, the highest proportion of people in treatment services, the highest hospital admission rates due to alcohol and just about the similar levels of alcohol sales in off licence as Tunbridge Wells. The population of Thanet are particularly vulnerable to a range of indicators and as such the treatment journey/ pathway to recovery must be planned alongside the local NHS providers and partner organisations e.g., Margate Taskforce and other Thanet health action plans.

Table 24: Localised estimates for people in alcohol treatment services across districts in Kent

District modelled estimates (and district rank)	Modelled dependent drinkers @ 1.16% of the population, 2017	Rate per 1,000 population in alcohol treatment, 2017-18
Kent	14,133	1.2
Ashford	1,164 (7)	1.2 (8)
Canterbury	1,587 (12)	1.1 (5)
Dartford	969 (2)	0.8 (3)
Dover	1,099 (5)	1.4 (9)
Gravesham	964 (1)	1.2 (7)
Maidstone	1,551 (11)	1.7 (10)
Sevenoaks	1,100 (6)	0.5 (1)
Folkestone & Hythe	1,064 (3)	1.8 (11)
Swale	1,348 (10)	1.1 (6)
Thanet	1,319 (9)	2.1 (12)
Tonbridge and Malling	1,180 (8)	0.8 (2)
Tunbridge Wells	1,085 (4)	1.0 (4)

Table 24 shows differences across districts in Kent of people in treatment.

Given the complexity and difficulty of people accessing treatment and the large treatment gaps in Kent it will be important to ensure services in all localities are accessible and high

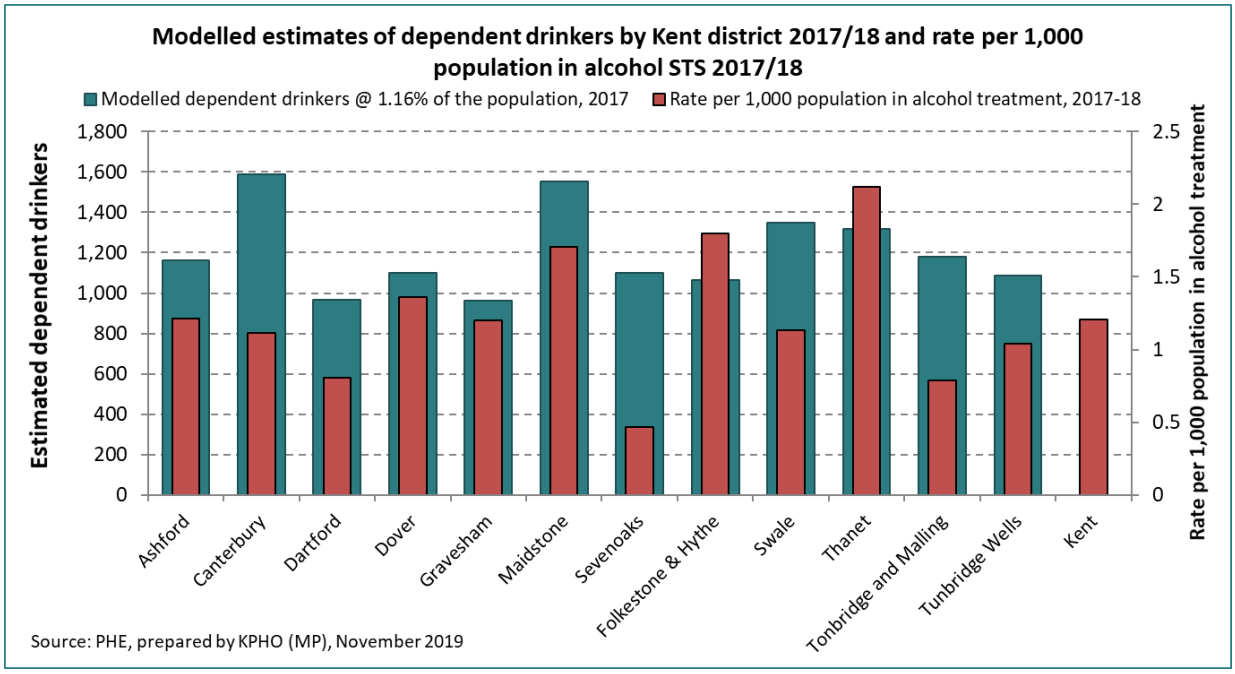
quality. There are notable differences between rates in treatment between Dartford (0.8) and Gravesham (1.2) for example. Overall East Kent has higher rates then West Kent districts.

The graph below (figure 13) plots the estimated numbers of dependent drinkers by Kent district from the University of Sheffield against the population rate seen within the treatment services.

Deprivation and inequality is a large driver of likelihood of dependence, and this is not reflected in the modelled district estimates.

Recommendation: Treatment services in areas of less deprivation still will see large treatment gaps given the rates of dependent drinkers. However further audit in services is needed to understand the levels of complexity of service users in need – in areas like Dartford, Canterbury and Sevenoaks and different services offers may be needed to ensure that those services are meeting the needs.

Figure 13: Modelled dependent drinkers and rate of population in alcohol treatment services by district



3.7 Estimating 'problem drinkers', Moderate and severe alcohol dependency, the need for services and unmet need

The University of Sheffield provides the official figures that Public Health England use to estimate numbers of problem drinkers highly likely to need treatment, estimated to be around 14,000[41] in Kent, at a rate of 1.16 per 100,000 adult population. The APMS estimated figure is slightly lower (estimated 12,000).

The published rate for the Southeast is 1.07 per 100,000, and 1.34 per 100,000 for England.

In Kent 2018/19, **2,312** clients were listed as being in alcohol treatment (with or without drug use), at around 16% of the population of dependent drinkers.

This is a treatment gap of 84% in Kent Alcohol Treatment Services. With a treatment gap that is this big, it is important that the whole system is integrated to support dependent drinkers and that the Kent Alcohol Treatment Services ensure that those with the highest complexity of need are supported.

Table 25: Estimated numbers of dependent drinkers not in treatment.

Proportion of dependent drinkers not in treatment 2017/18	% not in treatment	Total estimated in need, Kent	Total estimated not in treatment, Kent
Midpoint	84%	14,133	11,821
Lower estimate	79%	10,936	8,624
Upper estimate	88%	19,142	16,830

Source: PHE & University of Sheffield

It is up to local alcohol pathways to understand the access to treatment and recovery for people with alcohol problems. The current data in Kent shows a high unmet need and this is in line with the national picture.

[41] https://www.sheffield.ac.uk/polopoly_fs/1.693546!/file/Estimates_of_Alcohol_Dependence_in_England_based_on_APMS_2014.pdf

The term ‘treatment’ in this section refers to ‘structured’ treatment provided by the Treatment and Recovery Services funded from the Public Health Grant.

Harmful and Hazardous drinkers will benefit from a range of services to aid behaviour change and recovery. Services that can be helpful for behaviour change are:

- Counselling and Therapy
- Peer support groups
- Identification and Brief Advice (in various settings)
- Recovery groups and community action
- Health Coaching
- Online support
- Primary Care health checks
- Social Care assessments and Carer Assessment

Many of the above services will also be suitable for those with a ‘mild’ dependency and it is important that assessments for dependency are carried out. It is important to note that mild dependency can turn into a more severe condition, if not treated.

Recommendation: Given that mild alcohol dependency does not need medical supervision in withdrawal management, it is feasible that community services outside of the current treatment and recovery services can provide psychosocial and prevention support alongside other health behaviour change programmes, e.g., weight management and tobacco control.

The Range of Services that those with moderate to severe alcohol dependency may need:

- Medical and psychological assessment
- Therapeutic and trauma-based therapies
- Detox (in patient or community)
- Social Care assessments and Welfare Advice
- Keywork
- Outreach for vulnerable groups :
- Assessment for complexity and increase links with social care
- Medical supervision (both psychiatric and alcohol related)
- Residential Rehabilitation
- Community rehabilitation and relapse prevention
- Peer support and peer support group

Quality checks

It is important that service user voices be understood and patient journeys and barriers to care assessed. The Dame Carol Black Report has stated that quality of treatment services has taken a blow due too national cuts to the provision of the above range of services. It will be important to keep the assessment of quality as integral to service delivery and throughput.

3.8 Predicting future need for reducing harms from alcohol misuse in Kent

Only time will tell if the lower alcohol consumption in younger age groups leads to a reduced need for alcohol treatment services in the long-term.

The prevalence of problem drinking appears to increase with age, although binge drinking remains more prevalent in the young and appears to be increasing. It is likely the average age of alcohol treatment clients will increase if these trends continue.

3.8.1 Trends for predicted prevalence of Alcohol Misuse

Using simple linear regression models applied to available data potential demand for services based on past measurements can be made.

Based on the University of Sheffield estimates of highly dependent drinkers in Kent are largely expected to stay at current levels.

Table 26: Trends in Prevalence of highly dependent drinkers in Kent

Regression model of estimated dependent drinkers in Kent	2015-16	2016-17	2017-18	2018-19 (projected)	2019-20 (projected)	2020-21 (projected)	2021-22 (projected)	2017-18 lower confidence limit (95%)	2017-18 upper confidence limit (95%)
Kent Adults age 16+	13,999	13,902	14,133	**14,174**	**14,215**	**14,256**	**14,296**	10,936	19,142

Source: APMS and University of Sheffield

The Health Survey for England and Wales asks respondents about their weekly consumption. The table below shows national estimates applied to the Kent adult population, those in the highest drinking bracket are declining gradually at around 1% per year. A larger proportion of the population who are drinking over recommended levels but not at the highest rates appear to be declining more rapidly, closer to 2% per year. This portion of the population is more likely to need IBA or lifestyle intervention. However, there is still a considerable treatment gap for those highly dependent drinkers and an increase of alcohol related mortality (see Section 4).

Table 27: Prevalence of moderate and high alcohol consumption reported 'within previous week'

Regression model of 'alcohol units consumed in previous week' question from HSFE, modelled Kent estimates	2013	2014	2015	2016	2017	2018 (proj)	2019 (proj)	2020 (proj)	2021 (proj)
More than 35 units (Female) or 50 (Male)	37,157	39,167	34,930	40,479	37,451	36,891	36,330	35,769	35,209
Between 14 and 35 (Female) / 50 (Male)	257,629	252,096	253,591	247,590	228,081	222,839	217,597	212,355	207,112

Source: Health Survey for England and Wales

These people will have both physical health needs and mental health needs as well as needing help to reduce their alcohol consumption.

Binge drinking estimates however appear to be gradually increasing based on 2011 – 2017 data, and the population potentially at risk of associated harms or need of intermediate services could grow.

Table 28: Prevalence of binge drinking

Regression model of binge drinking (more than 6/8 units F/M on heaviest drinking day), modelled Kent estimates	2013	2014	2015	2016	2017	2018 (proj)	2019 (proj)	2020 (proj)	2021 (proj)
Prevalence age 16+	7.7%	7.8%	9.2%	8.1%	8.0%	8.2%	8.3%	8.4%	8.5%
Kent Adults age 16+	93,112	95,175	113,102	100,435	100,888	103,376	105,894	108,441	111,017

Source: Health Survey for England and Wales

These people will be at risk of violence, poisoning and physical health problems. There may also be a cost to local areas and town centres.

Recommendations: PREVELANCE

What does this mean for Commissioners of Kent Alcohol Treatment Services?

- There is an 'at risk' population of over 37,000 people across Kent.
- This means that clear awareness of the risks of alcohol dependency need to be communicated across all health care settings in Kent. It will be important to identify and give 'brief interventions' (IBA) to a large proportion of the Kent population.

- A coverage of IBA of 3-4% in vulnerable groups in primary care is recommended. IBA can also be targeted in health care settings where vulnerable groups are e.g., Mental Health settings and acute hospitals (e.g., Cancer care).
- 15% of the Kent population will binge drink – and this means that a clear awareness campaign that highlights the risks should be rolled out and evaluated. Services such as One You Kent and Live Well Kent can promote 'Know Your Score' and other evidence-based awareness raising approaches.
- Evidence based Treatment for hazardous and risky drinking is similar to all behaviour modification e.g., weight loss and referrals via IBA should be made to health coaching type services and do not need specialist treatment. However good training must be provided for generic staff as alcohol (similar to tobacco) is a poison if misused.
- All behaviour modification services and treatments should have awareness of mental wellbeing and trauma. Those people with a history of trauma and problematic adult attachment will be more likely to develop addiction and require longer and more intense interventions. There may be scope to consider joint working with psychological therapy providers (IAPT) services in order to increase success rates in behaviour change.[42]
- There will be between **12,000-14,133** people across Kent in need of alcohol treatment.
- This raises important capacity issues for current treatment services and using available data to model capacity is an important step particularly for inpatient medical detox beds.
- Given the costs of alcohol dependency across the health care system, e.g., ambulance, police, mental health, social services, and criminal justice – it will be important to ensure that there are multiple routes of entry into treatment and a more co-ordinated system of recovery across Kent to ensure that people have enough access to opportunities for treatment and recovery and relapse prevention.
- It may be important for commissioners of Substance misuse treatment services to prioritise alcohol detox and rehabilitation for the most vulnerable in Kent while exploring multiple places where recovery and behaviour change might happen across Kent. (see later sections on co-occurring conditions and co-morbidities).
- It will be important for Kent substance misuse commissioners to work alongside the developing NHS ICP (Local Care Partnerships) in order to tackle the level of need in Kent for much of the burden of costs for alcohol dependency still falls on the NHS.
- Given the variation between districts in alcohol indicators – it will be important to ensure there is an ease of access to treatment (regarding referrals) across all of Kent

[42] https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-survey-survey-of-mental-health-and-wellbeing-england-2014

to ensure services for the most vulnerable are taken up. There are pockets of high hospital admissions across all of Kent, e.g., Thanet, Gravesham, and Maidstone.

- Treatment services in areas of less deprivation still will see large treatment gaps given the rates of dependent drinkers. However, further audit in services is needed to understand the levels of complexity of service users in need – in areas like Dartford, Canterbury and Sevenoaks and different services offers may be needed to ensure that those services are meeting the needs.
- Recommendation: Ensure local campaigns for reducing alcohol consumption target women and men.
- Recommendations: Work with off licences in areas of economic deprivation to tackle the sales of high strength alcohol to dependent drinkers

Treatment Recommendations

- There is a treatment gap of 84% in Kent Alcohol Treatment Services. With a treatment gap that is this big it is important that the whole system is integrated to support dependent drinkers and that the Kent Alcohol Treatment Services ensure that those with the highest complexity of need are supported. Clarify the pathway for alcohol misuse at different levels of need.

4 Morbidity and Mortality (Illness and death) as a result of alcohol misuse in Kent.

4.1 Illness and death

4.1.1 Mortality:

Mortality means the rate of death to conditions both wholly specific to alcohol (80% of this is Liver disease) and those conditions that are related to alcohol causing acute poisoning, accidental and violent injuries, and chronic overconsumption, which can cause liver disease, cancer, stroke, and heart disease amongst others. Premature mortality is often a consequence.

Deaths (Mortality) and disability caused by alcohol occur earlier than in other long term health conditions, e.g., obesity and therefore contributes to many years of life lost. The average age of death for people with alcoholic related illness is 55-65 years old and 90% of all alcohol liver deaths are preventable.[43] The latest links to be identified with alcohol misuse are with infectious diseases such as tuberculosis and HIV/AIDS and pneumonia.[44]

Compared to the England and Southeast Average for Alcohol Specific Mortality, Kent was making progress and continuing to be below Southeast Average from 2013 to 2018. However more recent data from 2017-19 has shown a Kent wide increase. (Figure 14).

For Alcohol related mortality the picture is different. The Southeast fares considerably better than the national average indicating better overall health of the population. For Kent the figures have fluctuated since 2012 and the trend is overall good for Kent, as alcohol related mortality is around the Southeast average. (Figure 15).

4.1.2 Public Health Call to Action: Alcohol Specific Mortality

This indicates that the key target for public health action is Liver Disease and Alcohol specific disease. This links to the data showing that the higher risk drinkers are at risk of death and tipping into dependency and maybe either not getting to treatment or accessing treatment too late.

Thanet, Swale, Folkstone and Hythe and Canterbury are all areas that see increased levels of alcohol related mortality benched marked against the South-East and England averages. (Figure 16)

[43] ONS 2014
[44] https://www.who.int/substance_abuse/msbalcstragegy.pdf

Figure 14: Alcohol-specific mortality

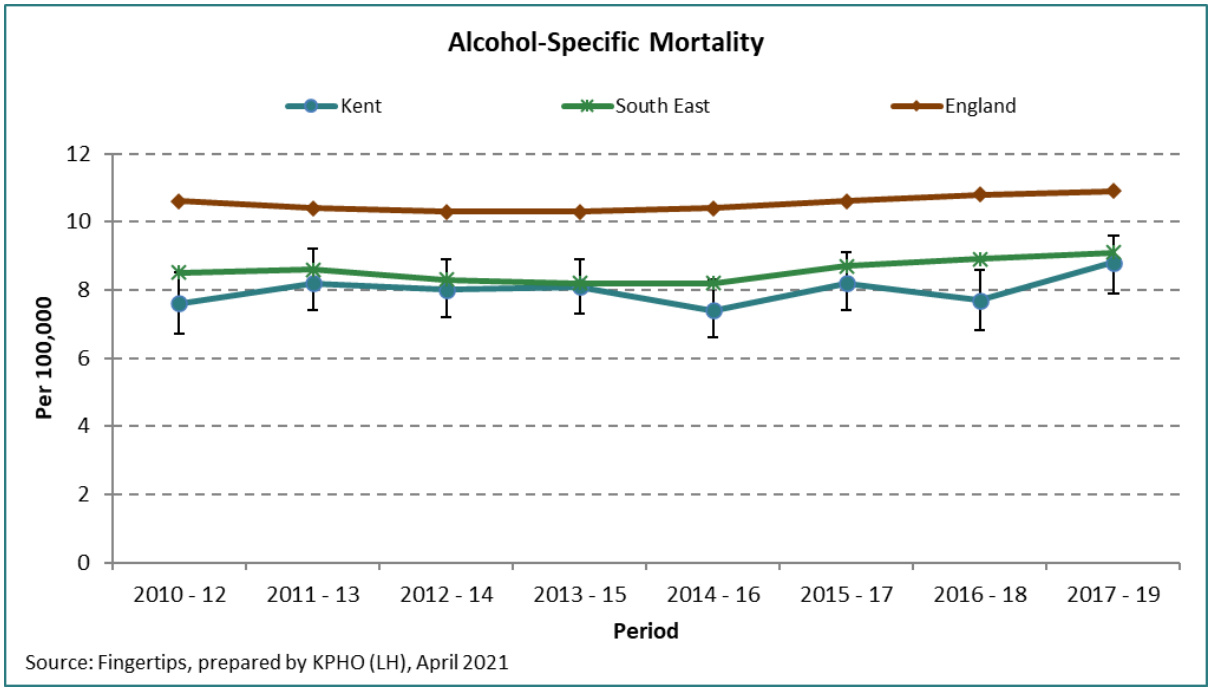


Figure 15: Alcohol-related mortality

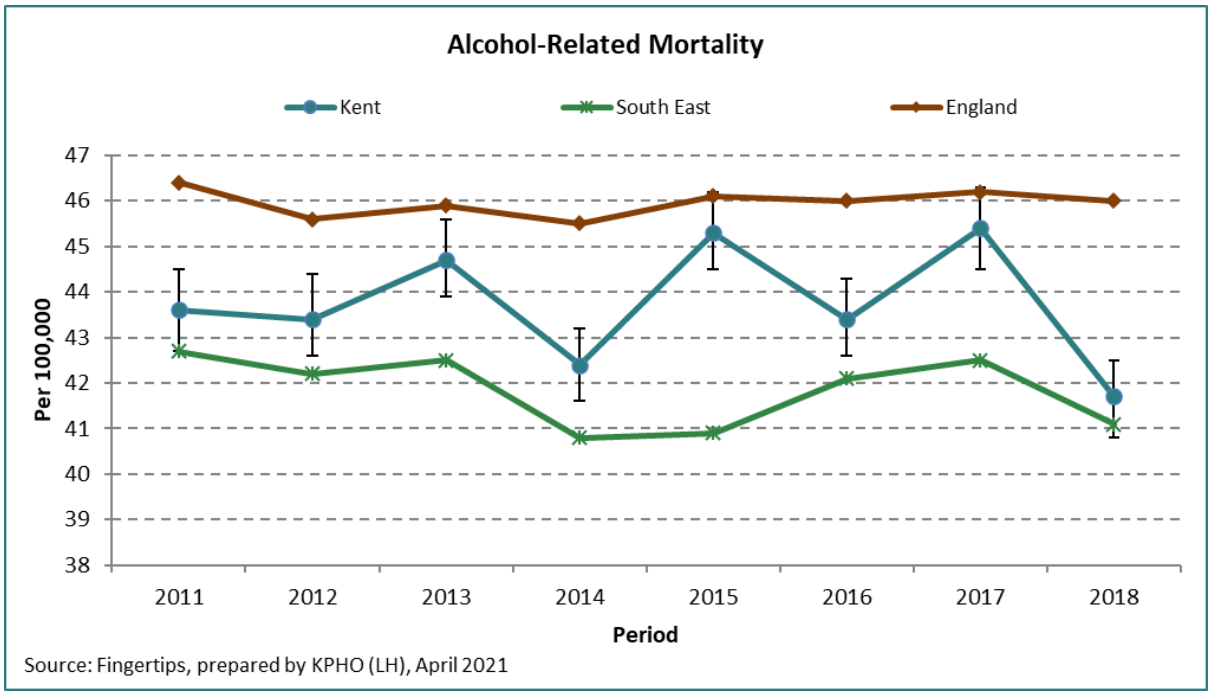
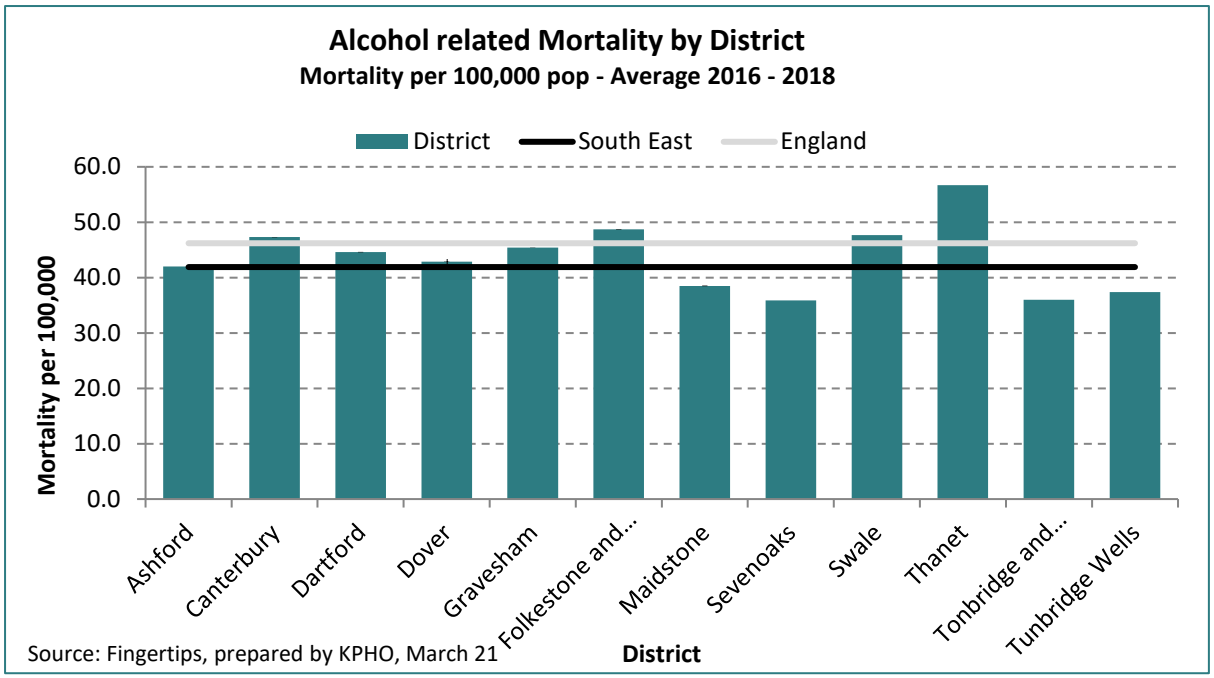


Figure 16: Alcohol-related mortality by district



4.2 Morbidity: Alcohol and Harm to Mental and Physical health, contribution to the burden of disease

Morbidity refers to the levels of illness in a population. There are two measures of this in epidemiology: new cases (incidence) and total proportions (prevalence). There were diseases that are wholly attributable to alcohol (see Appendix) and also diseases that had high relative risks (RR) or where alcohol is highly attributable.

Alcohol consumption has toxic impact on all major body systems. The effects vary according to a number of factors including age, gender, body mass index (BMI), pattern and volume of alcohol consumption and the length of time someone has been consuming alcohol. The health effects of alcohol can be acute, for example poisoning or injury, and chronic (long term), for example liver cirrhosis, cardiovascular disease, or female breast cancer. Of more than 200 International Classification of Disease (ICD-10) disease and injury codes for which alcohol consumption is a component cause, more than 30 include alcohol in their name or definition.

The relative risks for developing diseases and causes of mortality amongst those who drink alcohol now has important new evidence. The national public health study found the largest risks are for **oral cancers** (e.g., RR=5.13 (4.28-6.83) for heavy drinking males and females combined) and **oesophageal SCC** (e.g., RR=4.69 (3.49-6.31) for heavy drinking males and

females combined). No relative risks were disaggregated by age group. However, some relative risks by drink type (e.g., wine, beer, spirits) were found[45]

Excluding chronic and acute conditions which are wholly attributable to alcohol consumption (86% of all Liver Disease), the new results show that alcohol consumption is the largest contributor to new cases of cancers, digestive diseases, and road/pedestrian traffic accidents, which are consistent with results in the earlier report (Jones & Bellis, 2013). The new evidence is summarised below.

Cancer: There is strong evidence for an association between alcohol consumption and cancer including cancers of the oral cavity and pharynx, oesophagus, female breast, colorectum, larynx, liver, stomach, pancreas, lung, and gallbladder. For certain cancers, including breast cancer, any level of drinking increases your risk so there is no 'safe' level of drinking. In England in 2014/15, there were over 89,300 hospital admissions for cancer, accounting for 8% of all alcohol-related hospital admissions.

Recommendation: Given the strong association between Cancer and alcohol consumption make links between cancer prevention and alcohol reduction in awareness campaigns and offer IBA in screening programmes.

Cardio-Vascular Disease[46]

Hypertension, or high blood pressure, is a chronic medical condition in which the blood pressure in the arteries is elevated. In 2014/15 there were 449,000 admissions to hospital for hypertension in the UK, accounting for 84% of all admissions for cardio-vascular problems and 41% of all admissions.

Hypertension is a risk factor for **haemorrhagic stroke**, which results from bleeding in or around the brain. Ischemic stroke occurs when an artery to the brain is blocked. Observational studies show that the relationship between alcohol consumption and stroke varies according to *type of stroke*, and the nature of the outcome, in other words illness or death. Men aged 45-55 who smoke and drink, are the most at risk of stroke.

In the UK, 49% of all alcohol-related hospital admissions are as a result of **CVD**. As well as chest pain (angina), the main symptoms of heart disease are **heart attacks and heart failure**. However, not everyone has the same symptoms, and some people may not have any symptoms before heart disease is diagnosed.

[45]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/958648/RELATI_1-1.pdf
[46] PHE 2016

7% of all UK alcohol-related admissions are due to Atrial Fibrillation (AF). Cardiovascular problems associated with alcohol consumption can occur because of single episodes of binge drinking. Binge drinking, even at moderate levels, is a risk factor for atrial fibrillation, which is characterised by a severe, irregular heartbeat.

Other major contributions to illness from alcohol consumption:

Important health risks include risks to foetus in pregnancy, epilepsy, brain damage, dementia, injury, mental illness and sexual and intimate partner assault and domestic violence.

Alcohol and Mental Illness (Co-occurring conditions): 70% co-occurrence and link to suicidality.

Alcohol misuse also causes a range of behavioural and emotional disorders. The PHE and NICE guidance on the management of alcohol dependence has highlights that 70% of people with an alcohol dependency also have a treatable mental illness. The current NHS guidance states that whether alcohol causes mental illness OR mental illness causes addiction are not the issue, the issue is adequate identification and treatment and recovery options for this vulnerable group. The national confidential inquiry into suicides *(Appleby et all 2016)* highlights substance misuse (and alcohol dependence in particular) as a high-risk group for both suicide and suicidal ideation and self-harm.[47]

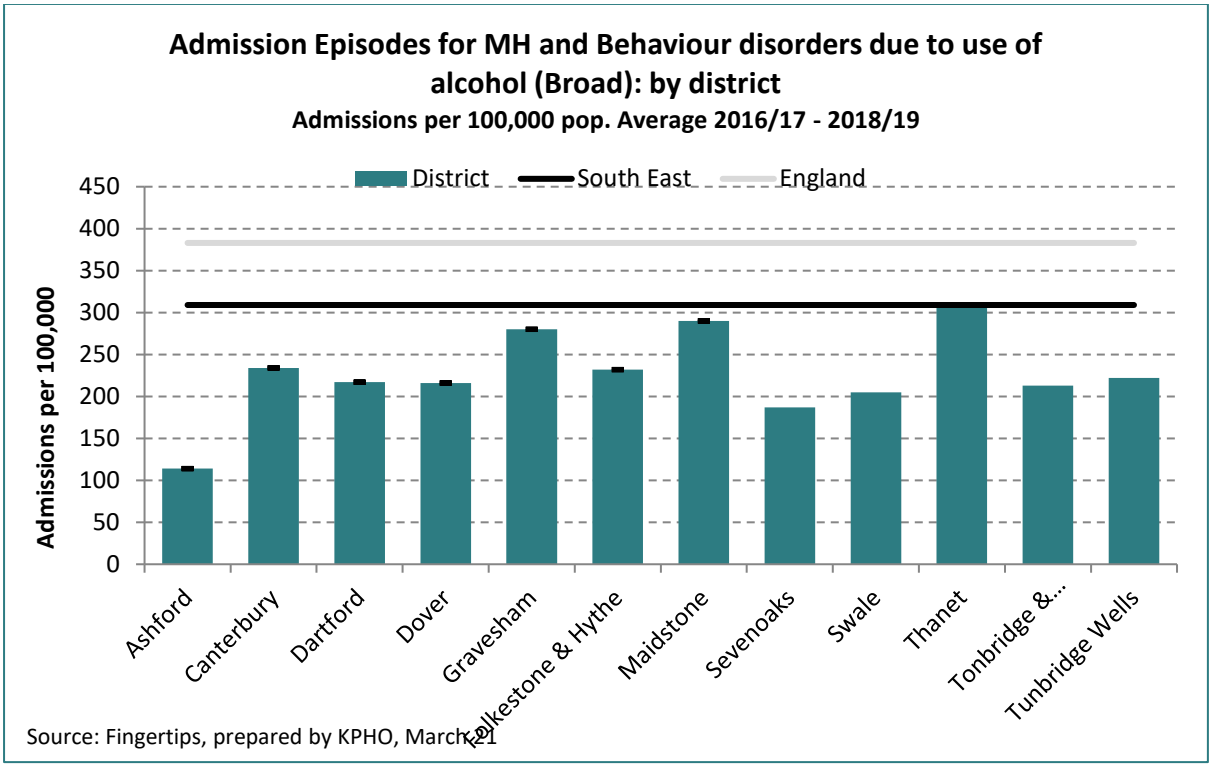
Given the wide scale prevalence and incidence of mental health co-occurring with substance misuse this topic has its own needs assessment and call to action. Mental illness should not be a barrier to care or treatment to substance misuse and substance misuse should no longer be a barrier to care and treatment to mental health support. This report also acknowledges the increased risks of early death and suicide to this cohort. The data in Fig 13 shows that there are higher needs for co-occurring conditions in Thanet, Gravesham, and Maidstone during 2016- 2019.

There are three key drivers to tackle this national and local issue: The NHSE quality standards for co-occurring conditions[48], the PHE[49] and NICE guidance[50], and the Mental Health Long Term Plan[51].

Also, locally, a series of productive meetings between providers and commissioners created a draft working protocol which is now in its final stages of development (see appendix).

[47] https://documents.manchester.ac.uk/display.aspx?DocID=38469
[48] https://www.nice.org.uk/guidance/qs188
[49] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf
[50] https://www.nice.org.uk/guidance/ng58
[51] https://www.longtermplan.nhs.uk/areas-of-work/mental-health/

Figure 17: Admission episodes for mental health and behaviour disorders due to use of alcohol (broad), by district



There are a variety of mental illnesses, and these have specific treatments.

International and national Data show high rates of comorbid substance use disorders and **anxiety disorders**—which include generalized anxiety disorder, panic disorder, and post-traumatic stress disorder. Substance use disorders also co-occur at high prevalence with mental disorders, such as **depression** and bipolar disorder, attention-deficit hyperactivity disorder (ADHD), psychotic illness, borderline personality disorder, and antisocial personality disorder. Patients with schizophrenia have higher rates of alcohol, tobacco, and drug use disorders than the general population, the overlap is especially pronounced with serious mental illness (SMI). Serious mental illness includes major depression, schizophrenia, and bipolar disorder, and other mental disorders that cause serious impairment. Around 1 in 4 individuals with SMI also have a substance misuse disorder.

Recommendations: Given risks associated from misuse of alcohol embed IBA into all public health programmes including stop smoking, wellbeing and sexual health. Ensure that IBA is part of all prevention programmes for CVD. Follow NICE Guidance and pathways to prevent Foetal Alcohol Syndrome Disorder.

Recommendations: Ensure there is training for all staff working in substance misuse on the range and nature of mental illness and training for mental health staff on the mental health

needs of substance misuse – including 'kindling effect' and brain damage. Train social care staff on links between care act and co-occurring conditions.

Public Health Call to Action:

Focus health prevention for alcohol on Cancers, Digestive Diseases and Road Traffic Accidents and Foetal Alcohol Syndrome Disorder.

Ensure that there are no barriers to treatment and care for people with both a substance misuse disorder and mental illness (in their broadest definitions) and thresholds should not be used as a barrier to care rather solutions for care appropriate to the needs of person should be found by collaborative working and joined up care plans. Use the Joint Working Protocol for Co-Occurring Conditions as routine.

Figure 18: AAFs for females in England , showing new values for each age group and a variety of conditions

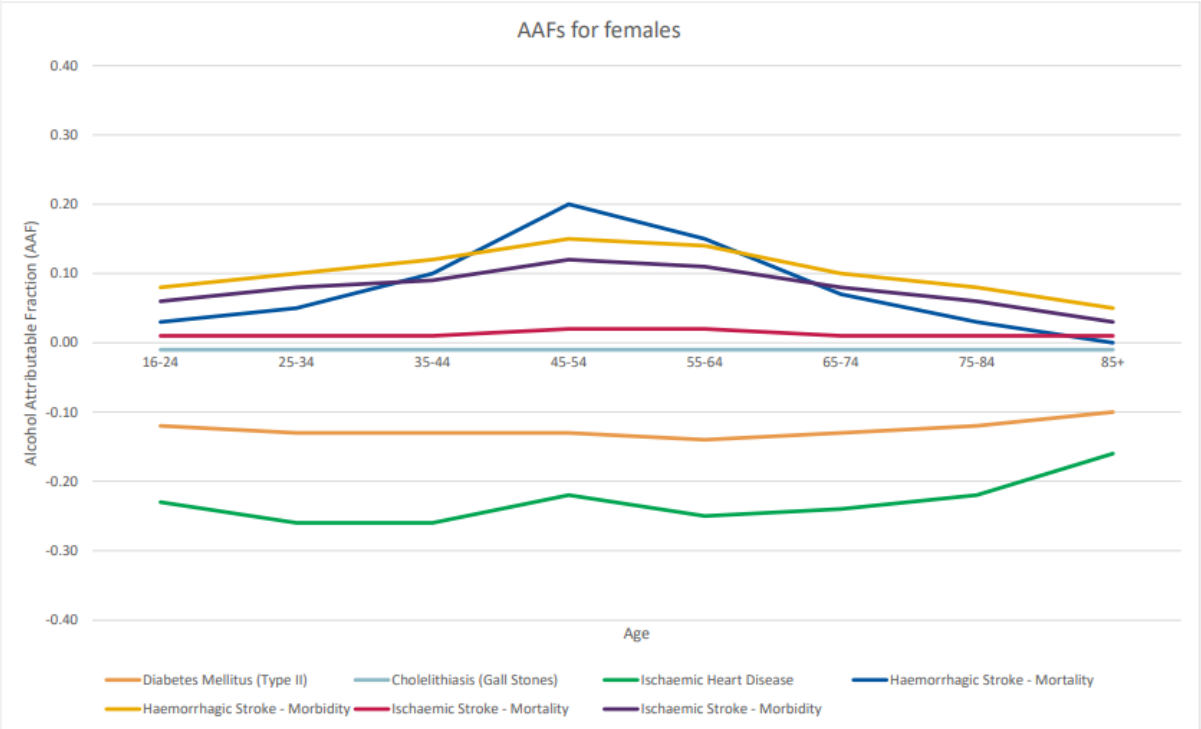
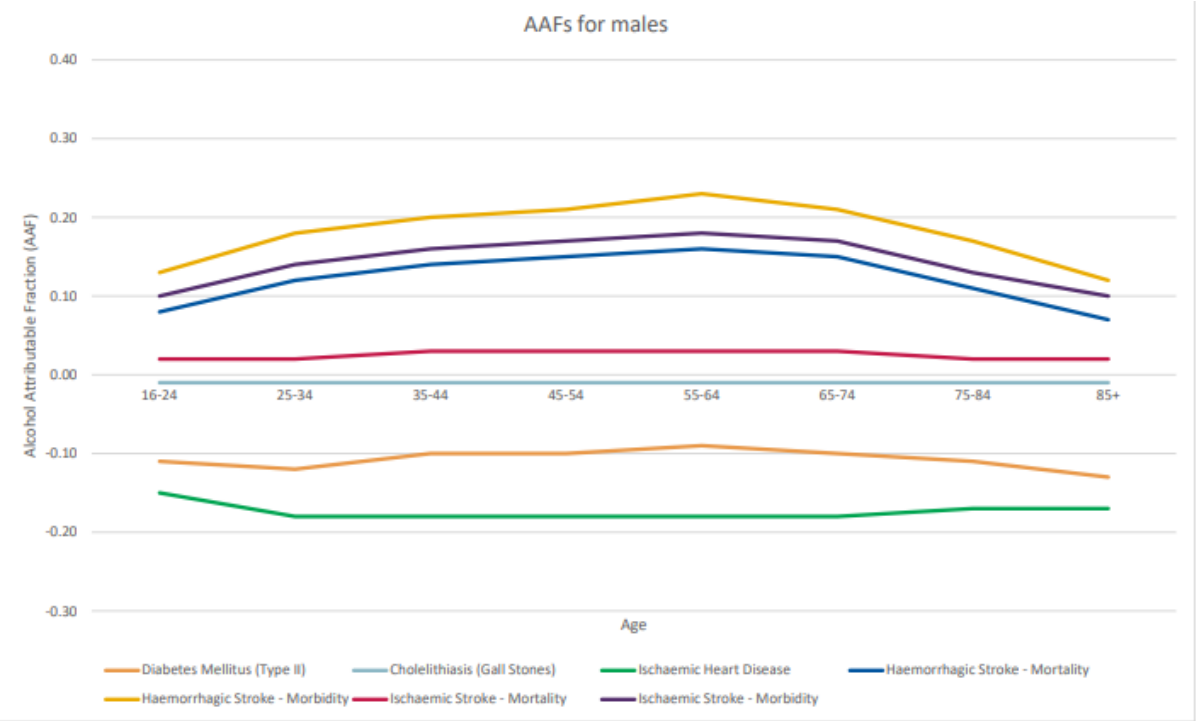


Figure 19: AAFs for males in England , showing new values for each age group and a variety of conditions



4.3 Emergency Treatment for alcohol misuse in Kent

People misusing alcohol can become violent and aggressive leading to increase in wounds and violent injuries that lead to emergency care. Many intoxicated people suffer from falls and fractures. Alcohol misuse can lead to poisoning both accidentally and deliberately which leads to the need for emergency care. Those dependent drinkers who are going into acute withdrawal can also be in need to urgent paramedic and A&E assistance for detoxification if unmanaged.

A&E data was investigated as part of this needs assessment but was found to be coded inconsistently between the main Kent providers and with no national datasets for comparison, it was not possible to present a fair representation of the burden alcohol places on emergency services.

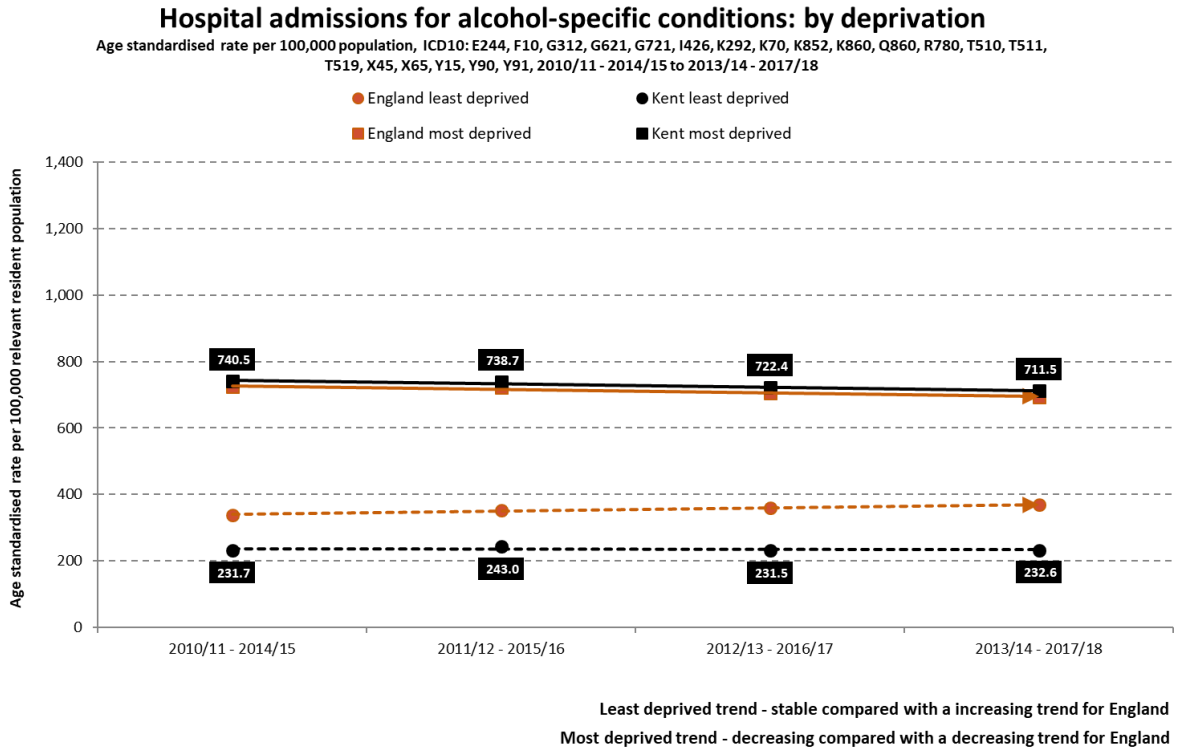
Some anecdotal evidence from the Kent Integrated Dataset suggests that the most deprived third of the population are seen in A&E for alcohol poisoning at roughly double the rate of the least deprived third. Utilisation in the 20-30 age group was highest, and females attended A&E at roughly the same rate as males.

Recommendation: Improve data collation at A&E on alcohol related attendances.

Recommendation: Improve assessment and referral at A&E for alcohol related attendances to treatment services (use IBA & SDAQ).

4.4 Alcohol Related Hospital admissions (see also Morbidity)

Figure 20: Hospital admissions for alcohol-specific conditions – by deprivation in Kent

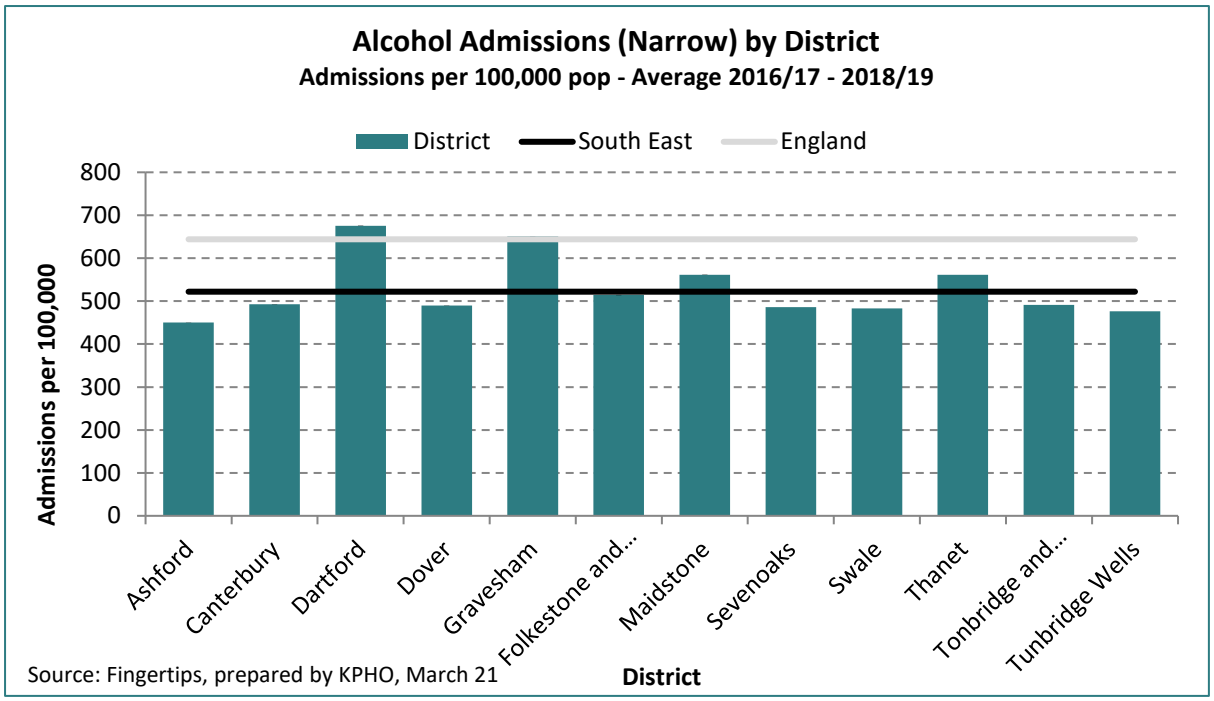


Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Jan-19

There is evidence that there is a decreasing trend for hospital specific conditions in Kent in the most deprived areas. Continuing this trend will be an important contribution to reducing health inequalities.

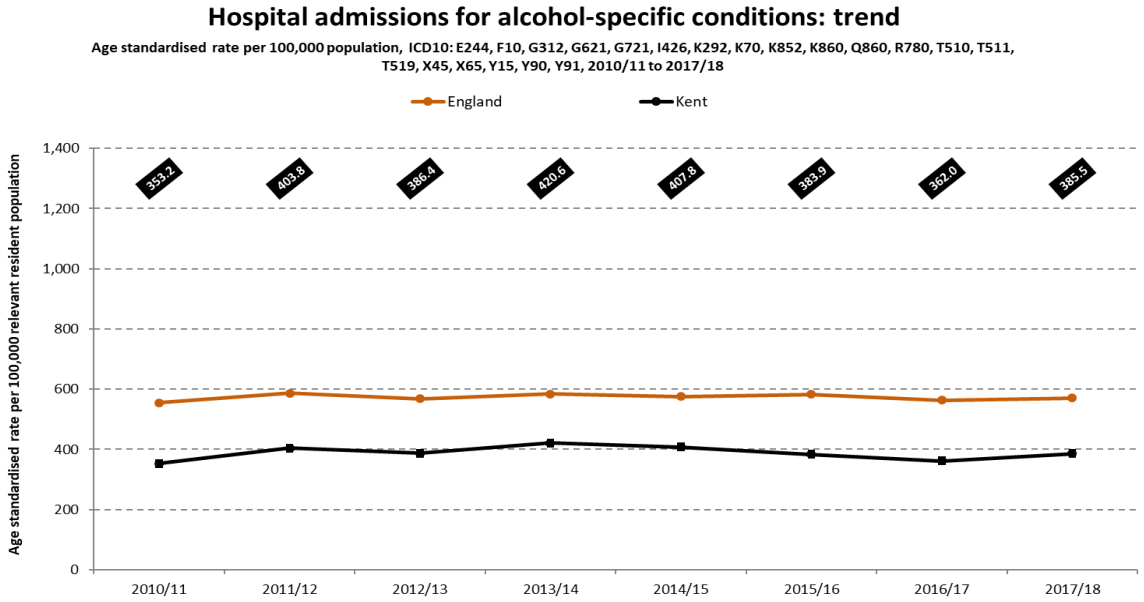
When looking at admissions for Alcohol Related Conditions (Narrow), when benched marked against the South-East and England, Dartford and Gravesham are the areas of concern. Maidstone and Thanet when bench marked against the South-East also saw increased levels.

Figure 21: Hospital admissions for alcohol-specific conditions – by district



The overall trend of admissions both nationally and in Kent has been stable for the past 8 years. The graph below (Fig x) shows a comparison of Kent with England, both of which have had fairly steady rates.

Figure 22: Hospital admissions for alcohol-specific conditions – trend



Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Jan-19

The most and the least deprived quintiles of the population typically drink the most. However, hospital admissions for alcohol specific conditions are considerably higher in the most deprived quintile, with nearly treble the rate in the most deprived areas of Kent compared to the least deprived areas. This difference is not as marked nationally but the most deprived areas still have roughly double the rate of admissions then the least deprived.

Recommendations: Target outreach and proactive care for the most vulnerable population in the most deprived areas (and wards) in Kent. Prioritise Thanet.

There is, also a considerable variation between electoral wards. The hospital admissions rate due to alcohol-specific conditions is higher than the Kent average can be found in Appendix 3.

4.5 Unintended injuries due to alcohol

Hospital Admissions for alcohol-related unintentional injuries are higher than the national average in Dover, Maidstone, Thanet, Tonbridge and Malling and Tunbridge Wells (though none are statistically significant). The highest in Kent are Maidstone and Thanet districts, The average Kent rate is similar to the national rate.

4.6 Deep Dive into Health Needs for Liver Disease Fatty Liver, Alcoholic Hepatitis (Inflammation), Cirrhosis and Cancer in Kent, and focus on East Kent :

Liver disease is a leading cause of premature mortality nationally. 2% of all deaths in UK are to Liver Disease. Liver disease is on the rise Since 1970, deaths due to liver disease have increased by 400%. Every day, over 40 people die from liver disease in the UK. This is in stark contrast to other major killer diseases, such as heart disease and cancer, in which the number of deaths has either remained stable or decreased.

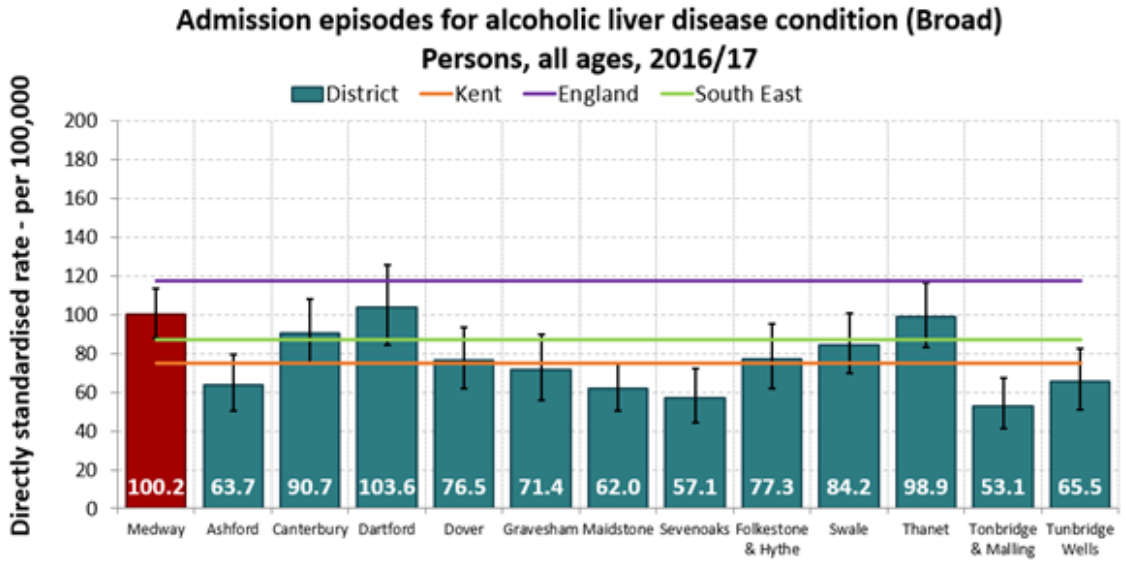
Alcohol and obesity are contributing factors and 90% of liver disease is considered 'preventable' meaning that deaths could be prevented through public health interventions or behaviour modification. Up to 35 percent of people with liver disease develop alcoholic hepatitis and between 10 and 20 percent develop cirrhosis. Alcohol-related cirrhosis is the most serious form of alcohol-related liver disease. The damage from alcohol-related cirrhosis is not reversible and can cause fatal liver failure. Thanet has significantly higher rates of premature mortality both from liver disease and preventable liver disease than Kent as a whole.

The rate of under 75-year-old mortality (early death) from alcoholic liver disease in Kent (only available at county level) is approximately half the rate of all preventable liver disease. This gives some indication of the proportion of deaths from preventable liver disease that are alcohol related.

Liver disease

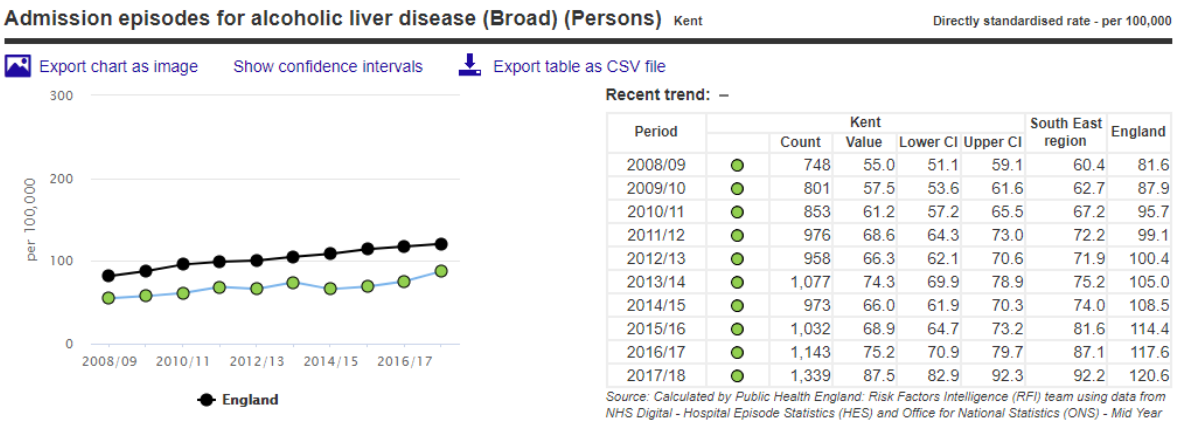
Dartford and Thanet districts showed a significantly higher rate of admissions for alcoholic liver disease than the Kent average in 2016/17. Admission episodes in Kent are below the national rate. The rate of admissions in both Kent and England have been increasing.

Figure 23: Admissions due to alcoholic liver disease



Source - PHE, prepared by KPHO (MP) Jan 2019

Figure 24: Admissions due to alcoholic liver disease: Trends

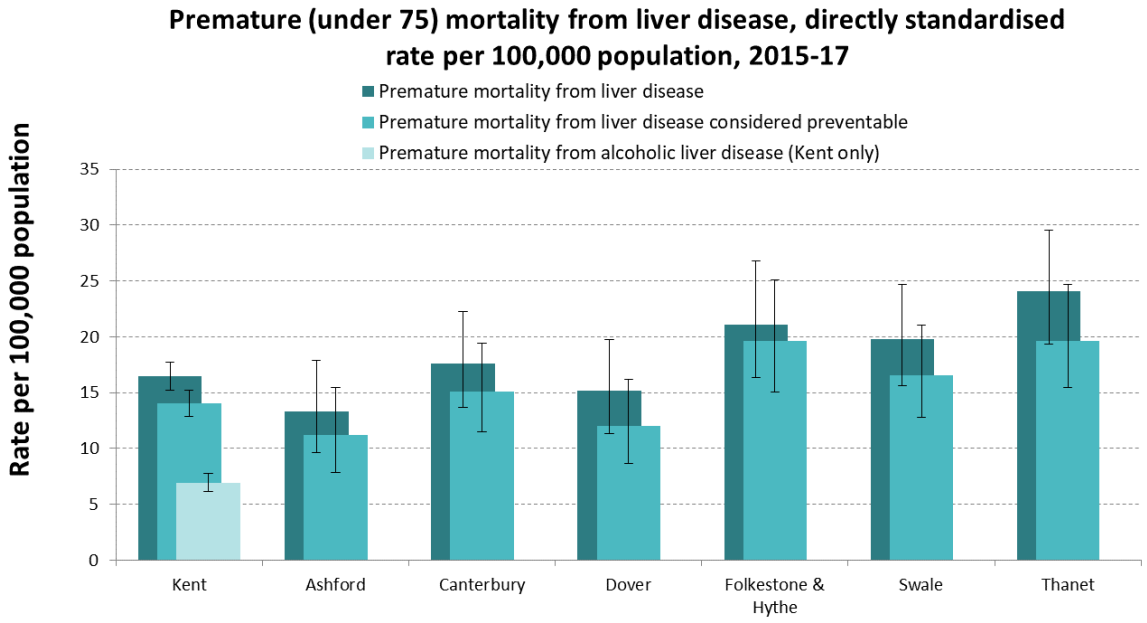


Recent trend: –

Period		Kent				South East region	England
		Count	Value	Lower CI	Upper CI		
2008/09	●	748	55.0	51.1	59.1	60.4	81.6
2009/10	●	801	57.5	53.6	61.6	62.7	87.9
2010/11	●	853	61.2	57.2	65.5	67.2	95.7
2011/12	●	976	68.6	64.3	73.0	72.2	99.1
2012/13	●	958	66.3	62.1	70.6	71.9	100.4
2013/14	●	1,077	74.3	69.9	78.9	75.2	105.0
2014/15	●	973	66.0	61.9	70.3	74.0	108.5
2015/16	●	1,032	68.9	64.7	73.2	81.6	114.4
2016/17	●	1,143	75.2	70.9	79.7	87.1	117.6
2017/18	●	1,339	87.5	82.9	92.3	92.2	120.6

Source: Calculated by Public Health England: Risk Factors Intelligence (RFI) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

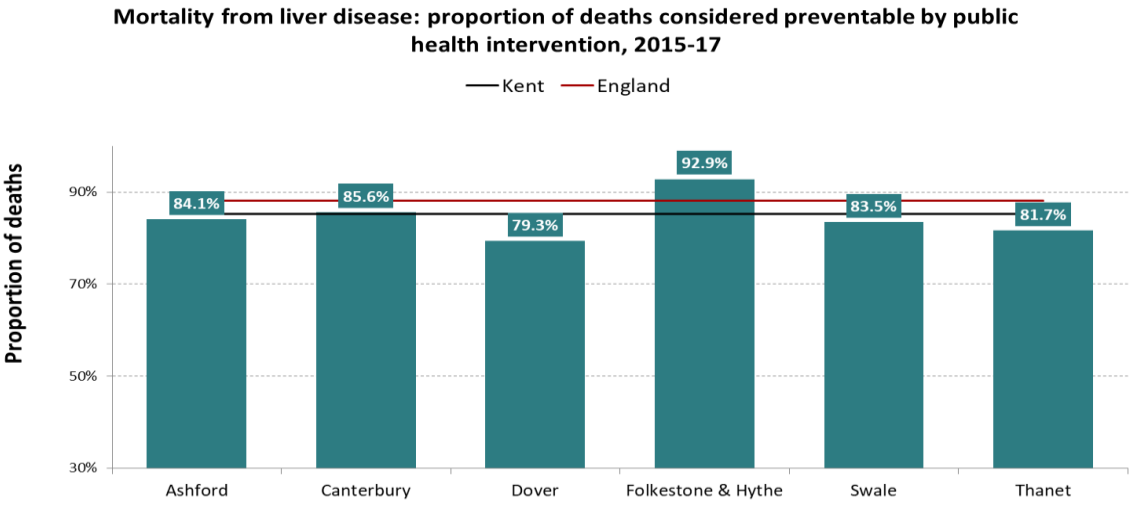
Figure 25: Premature mortality from liver disease in east Kent



Source: PHE, prepared by KPHO (SR), July 2019

Figure 26 below shows the proportion of deaths from liver disease that are considered preventable by East Kent district. Folkestone and Hythe district has a higher proportion of deaths that are considered preventable (92.9%) than the other East Kent districts and it is also higher than both the Kent and England averages.

Figure 26: Mortality from liver disease – proportion of deaths considered preventable by public health interventions, in east Kent



Source: PHE Fingertips, prepared by KPHO (SR), July 2019

5 Prevention of Alcohol Harm in Kent

There are a number of steps to take to prevent alcohol related harm and these form a public health approach. This public health approach is multifactorial and interrelated should form part of a strategic long-term plan. All plans should be informed by national and local needs assessments and evidence reviews.[52]

Recommendations for Kent's Alcohol strategy: These steps include:

- Identifying and **supporting families** at risk of disruption and harm from alcohol misuse. This includes ensuring there is a 'trauma informed' programme to tackle the lasting consequences of **Adverse Childhood Experiences**.
- **Domestic violence** and abuse strategies to include links between family-based approaches to conflict linked with substance misuse treatment services.
- **Employment and Sickness:** Employers to understand the risks and consequences of work stress and use of alcohol as a 'relief' and to enable employees to destigmatise the need to get help.
- **Crime Partnerships: through strategic assessment:** to work together to tackle illegal trading, disrupt supply, tackle antisocial behaviour and access to services, violence, and sexual assault.
- **Prison and release:** working together to ensure people on custodial sentences are able to access help and support for addictions.
- **Regulating the market:** working between councils**,** trading standards, the police, and businesses to ensure that there is a safer drinking environment.
- **Good quality local awareness campaigns:** reduce stigma and normalisation of harmful drinking.
- **Tackle drink driving**
- **Industrialise IBA (Identification and Brief Advice) across settings** including all public health services, acute settings, and primary care.
- **Targeted IBA** in areas and for populations at risk and populations where there is underrepresentation (i.e.: the equalities protected characteristics)
- **High quality treatment and recovery services:** targeted at vulnerable dependent drinkers.
- **NHS health services** that tackle the co-morbidities associated with alcohol use disorders including high quality mental health services.

[52]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/733108/alcohol_public_health_burden_evidence_review_update_2018.pdf

5.1 The prevention pathway

There is a pathway of actions starting with brief alcohol interventions which aim to raise awareness of the risks associated with alcohol consumption and help individuals reduce their drinking. People who are drinking harmfully or are dependent on alcohol may benefit from more structured treatment. Together, these interventions help to raise awareness of hazardous, harmful, and dependent drinking patterns, increase ability and capacity to change behaviour and reduce overall alcohol consumption.

NICE publishes national guidance and advice to improve health and social care in England based on the most recent evidence and scientific consensus.

NICE has published three key guidance documents which define the pathway and interventions for individuals with alcohol use disorders:

- preventing the development of hazardous and harmful drinking
- diagnosis, assessment and management of harmful drinking and alcohol dependence
- diagnosis and clinical management of alcohol-related physical complications

5.1.1 Raising Public Awareness

UK health surveys show that while many respondents can correctly identify liver disease as a potential harm caused by alcohol, fewer are able to freely recall other harms such as cancer.[53] Policies that provide information and education can help to reduce this knowledge deficit, while additionally overcoming the potential barrier of public opinion, because people who are aware that alcohol is a risk factor for cancer are more likely to support alcohol control policies, including increases in taxation and strict marking regulations.[54]

Furthermore, as with other products, consumers have a right to understand the risks associated with alcohol consumption, and policies in their area reflect the right. These polices are typically delivered as mass media, social norms, or social marketing campaigns, education programmes conducted in school and higher education settings and by the labelling of alcoholic beverages.

Alcohol education programmes in school and higher education settings are a popular intervention, but their effectiveness is poorly supported by the evidence, so are not cost-effective. Reported beneficial effects tend to be seen.

[53] Buykx P, Li J, Gavens L, et al. An investigation of public knowledge of the link between alcohol and cancer. University of Sheffield and Cancer Research UK, 2016 http://www.cancerresearchuk.org/sites/default/files/an_investigation_of_public_knowledge_of_the_link_between_alcohol_and_cancer_buykx_et_al.pdf

[54] Buykx P, Gilligan C, Ward B, Kippen R, Chapman K. Public support for alcohol policies associated with knowledge of cancer risk. *Int J Drug Policy.* 2015; **26**: 371-379

5.1.2 Identification and brief advice (IBA)

There are currently approximately 120,000 adults in East Kent and 135,000 across West Kent who are drinking over 14 units a week and could benefit from an alcohol brief intervention, often referred to as alcohol screening and brief interventions or identification and brief advice (IBA). In a diverse range of healthcare and welfare settings, IBA involves the administration of a short screening questionnaire about current drinking patterns, followed by personalised advice and information. Most IBA is delivered in a single, brief session while other programmes incorporate follow-ups after the screening and initial contact. IBA typically incorporates some or all of the following elements:

- feedback on the person's alcohol use and any related harm
- clarification as to what constitutes low-risk consumption
- information on the harms associated with risky alcohol use
- benefits of reducing intake
- motivational enhancement to support change
- analysis of high-risk situations for drinking
- coping strategies and the development of a personal plan to reduce consumption

Although the exact content of IBA may vary between studies, core features are that they are delivered by generalist health care workers, services target a population of drinkers that do not tend to be seeking help for alcohol problems and services aim for reductions in alcohol consumption and related harm. There is a large body of evidence that details the effectiveness and cost effectiveness of this intervention and is part of the 'Make Every Contact Count' NHS approach.

Primary health care is the most extensively studied setting for the evaluation of IBA, and reviews and meta-analysis consistently report that IBA reduces hazardous and harmful consumption at 6 months and 12 months.[55, 56, 57, 58, 59] Modelling the delivery of IBA to every patient at their next registration with a new general practitioner (GP) in England estimated that over 20 years, IBA would reduce alcohol-related deaths by almost 2,500 and alcohol-related hospital admissions by almost 125,000.[60] People in the lowest socio-economic

[55] Álvarez-Bueno C, Rodríguez-Martín B, García-Ortiz L, Gómez-Marcos MÁ, Martínez-Vizcaíno V. Effectiveness of brief interventions in primary health care settings to decrease alcohol consumption by adult non-dependent drinkers: a systematic review of systematic reviews. *Prev Med 2015*; **76** (suppl)**:** S33–38.

[56] Kaner E, Bland M, Cassidy P, et al. Effectiveness of screening and brief alcohol intervention in primary care (SIPS trial): pragmatic cluster randomized control trial. *BMJ.* 2013; **346**: e8501

[57] Jonas DE, Garbutt JC, Amick HR, et al. Behavioral counseling after screening for alcohol misuse in primary care: a systematic review and meta-analysis for the U.S. Preventive Services Task Force. *Ann Intern Med.* 2012; **157**: 645-654

[58] Kaner E, Dickinson H, Beyer F, et al. Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database Syst Rev.* 2007; **2** (CD004148.)

[59] Elzerbi C, Donoghue K, Drummond C. A comparison of the efficacy of brief interventions to reduce hazardous and harmful alcohol consumption between European and non-European countries: a systematic review and meta-analysis of randomized controlled trials. *Addiction.* 2015; **110**: 1082-1091

[60] Angus C and Ally AK. Modelling the potential impact of duty policies using the Sheffield Alcohol Policy Model, Version 3. University of Sheffield, 2015
https://www.shef.ac.uk/polopoly_fs/1.661443!/file/finaldurymodellingrpt.pdf

groups experience the greatest absolute reduction in harm but the lowest relative reduction because they have a higher baseline level of alcohol-related harm. Delivery is cost saving, with net savings estimated at £282 million, a finding supported by a systematic review.[61]

The following settings had highly cost-effective outcomes for IBA:

- Primary Care
- Hospital & A&E
- Criminal Justice
- On-Line

Where IBA is less effective: (early research shows a more nuanced intervention is needed).

- Young people (under 18)
- Workplaces
- Pharmacies
- Sexual health clinics

5.2 IBA in Kent: Online 'Know your score'

The IBA is available on the Kent County Council website as part of the council's public health role. It is presented in the form of an on-line quiz, which includes questions on alcohol consumption,[62]. In 2018 the 'Know Your Score' data was analysed and evaluated (Table 29). Overall, a higher proportion of survey respondents fell into the probable dependence category (a score of 20+) than would be expected in the general population (around 1% of the population). The 'Know Your Score' online tool has increased its coverage year on year since 2015. From the results it shows that those people who are concerned about their drinking are finding their way to the quiz.

Figures 34-36 shows data from March 2016 to September 2017. From the responders, men are more likely to have harmful drinking habits. The analysis also showed that people aged 40-59 living in more affluent areas have unhealthier drinking habits, and that medium risk drinking increases as deprivation decreases.

Recommendation: Spread coverage of the online tool further and in a variety of population groups and on men aged 40-59.

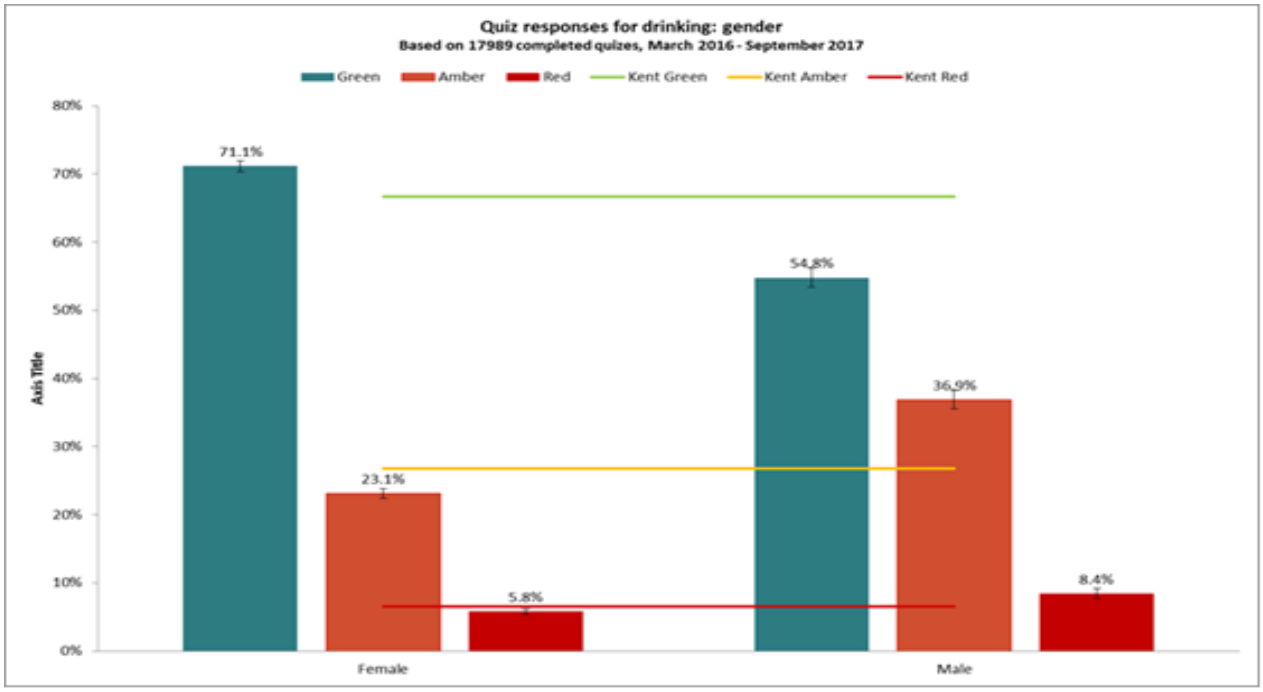
[61] Angus C, Latimer N, Preston L, Li J, Purshouse R. What are the implications for policy makers? A systematic review of the cost-effectiveness of screening and brief interventions for alcohol misuse in primary care. *Front Psychiatry.* 2014; **5**: 114

[62] https://www.kent.gov.uk/social-care-and-health/health/one-you-kent/drink-less/know-your-score-quiz

Table 29: Analysis of the Kent 'Know your Score' results.

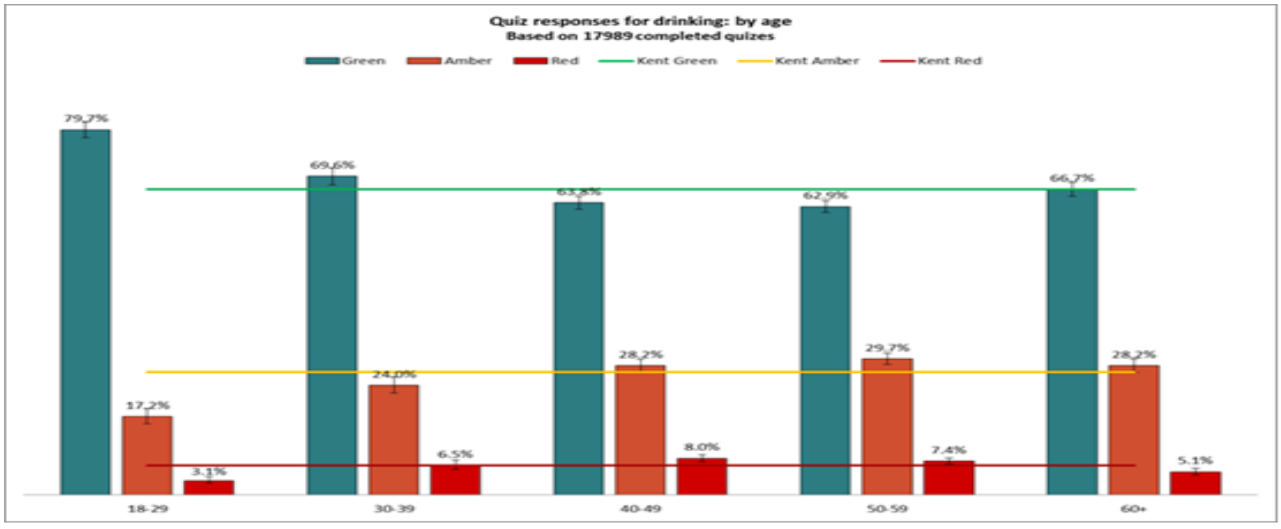
Know Your Score Rating	Rating Description	Total Results	% of Total Results (by Year)
2015		**1,936**	
0	Lower risk	81	4.2%
01-7	Lower risk	829	42.8%
08-15	Increasing risk	697	36.0%
16-19	Higher risk	155	8.0%
20-40	Possible dependence	174	9.0%
2016		**4,397**	
0	Lower risk	165	3.8%
01-7	Lower risk	1,517	34.5%
08-15	Increasing risk	1,733	39.4%
16-19	Higher risk	438	10.0%
20-40	Possible dependence	544	12.4%
41+	Possible dependence	*	*
2017		**9,296**	
0	Lower risk	328	3.5%
01-7	Lower risk	3,570	38.4%
08-15	Increasing risk	3,420	36.8%
16-19	Higher risk	846	9.1%
20-40	Possible dependence	1,132	12.2%
41+	Possible dependence	*	*
2018		**19,995**	
0	Lower risk	807	4.0%
01-7	Lower risk	7,204	36.0%
08-15	Increasing risk	7,300	36.5%
16-19	Higher risk	2,041	10.2%
20-40	Possible dependence	2,643	13.2%
41+	Possible dependence	0	0.0%
Total		**35,624**	

Figure 27: Quiz responses by gender



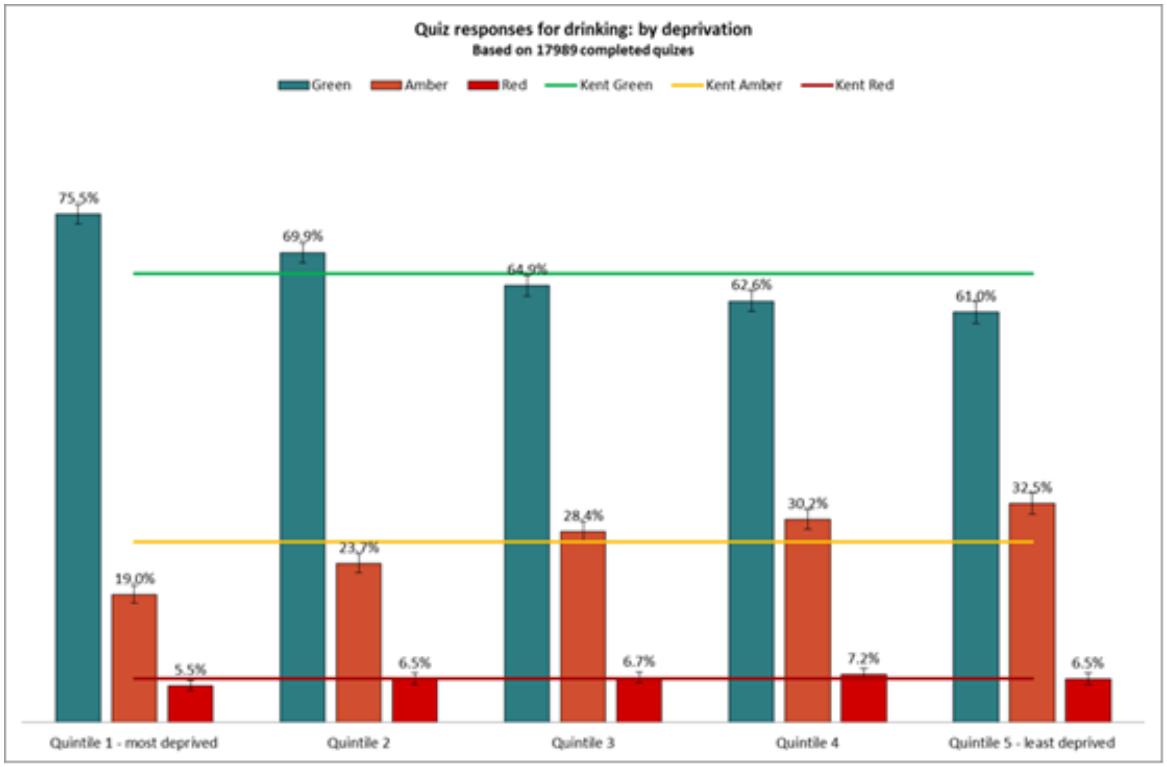
People in the 40 – 59 age groups were more likely to be medium to high-risk drinkers. The results also support the national evidence that younger people are drinking less, as the highest proportion of low-risk drinkers were seen in the 18-29 years age group.

Figure 28: Quiz responses by age



The results also showed a linear gradient with moderate risk, with the more affluent tending to drink more than the least. Those in the high-risk category showed less variation, but there were significantly fewer in this category than the Kent average in the most deprived fifth of the population.

Figure 29: Quiz responses by deprivation



5.3 IBA in Kent: Primary Care interventions and AUDIT

To support delivery of IBA in health care settings , PHE previously produced resources including the basic AUDIT-C pathway (Fig 34)) and 'scratch card' version (Fig 35), a short e-learning course, and a set of infographics which demonstrate the case for implementing alcohol IBA including a potential Return on Investment (ROI) of £27 per patient over four years.

The initial screening is the Audit-C (3 questions), the full questionnaire is Audit (10 questions) and a further question Audit 3 measures binge drinking.

Fig 30: The Alcohol Pathway via IBA for Health Care Settings

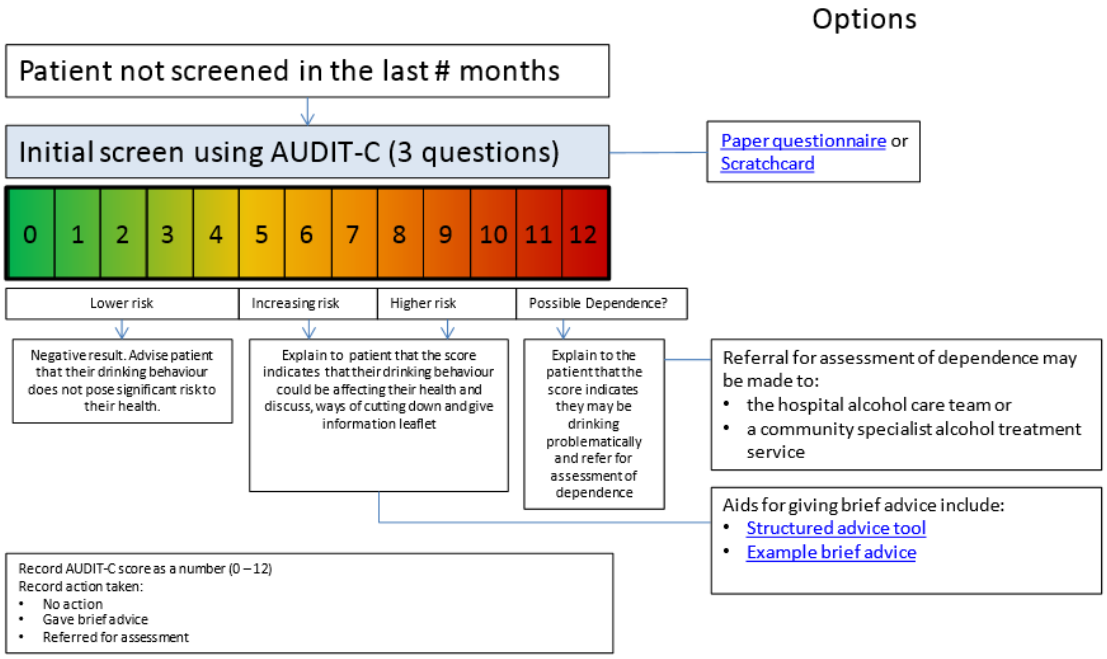


Figure 30 - This diagram shows the alcohol pathway via IBA for Health Care Settings based on the paper questionnaire

Figure 31: The PHE Scratch Card IBA

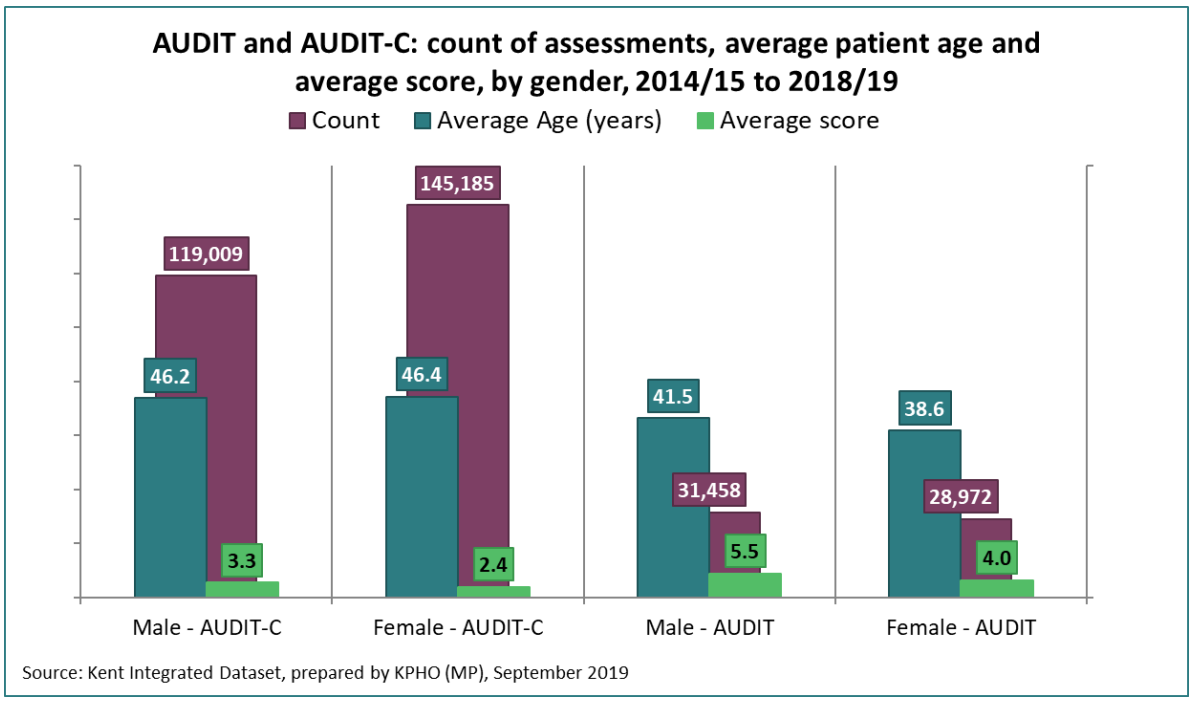
Figure 31- This colour chart shows a helpful guide of the ramifications of the level of risk you may be at based on your weekly total of units consumed each week.

The Kent Integrated Dataset (KID) contains primary care data for 91% of Kent residents from 2014, and it has good records of results of AUDIT-C and AUDIT used by GPs.

5 years of GP data was examined from April 2014 to April 2019, and the earliest AUDIT and AUDIT-C record was taken per patient, consequently some patients exist in both datasets. Patient age was taken at the date of the assessment. The information extracted was able to be cross-linked to other demographic information, as presented below.

The Figure 39 shows counts and average ages and average AUDIT scores of males and females undertaking the AUDIT-C and full AUDIT. Over the five-year period, **324,624, or 20%** of the population age 15+, had a recorded AUDIT-C and 60,430 (4.6%) a full AUDIT. More females than males were shown to have AUDIT-C records with an average score of 2.4, compared to males with 3.3. Marginally more males than females had records of the full AUDIT, with a higher average score of 5.5 compared to 4 in females. This shows more females are being assessed than males overall, although there may be a greater need in males as their measured scores tend to be higher.

Figure 32: Counts of assessments, average scores, and ages by gender:

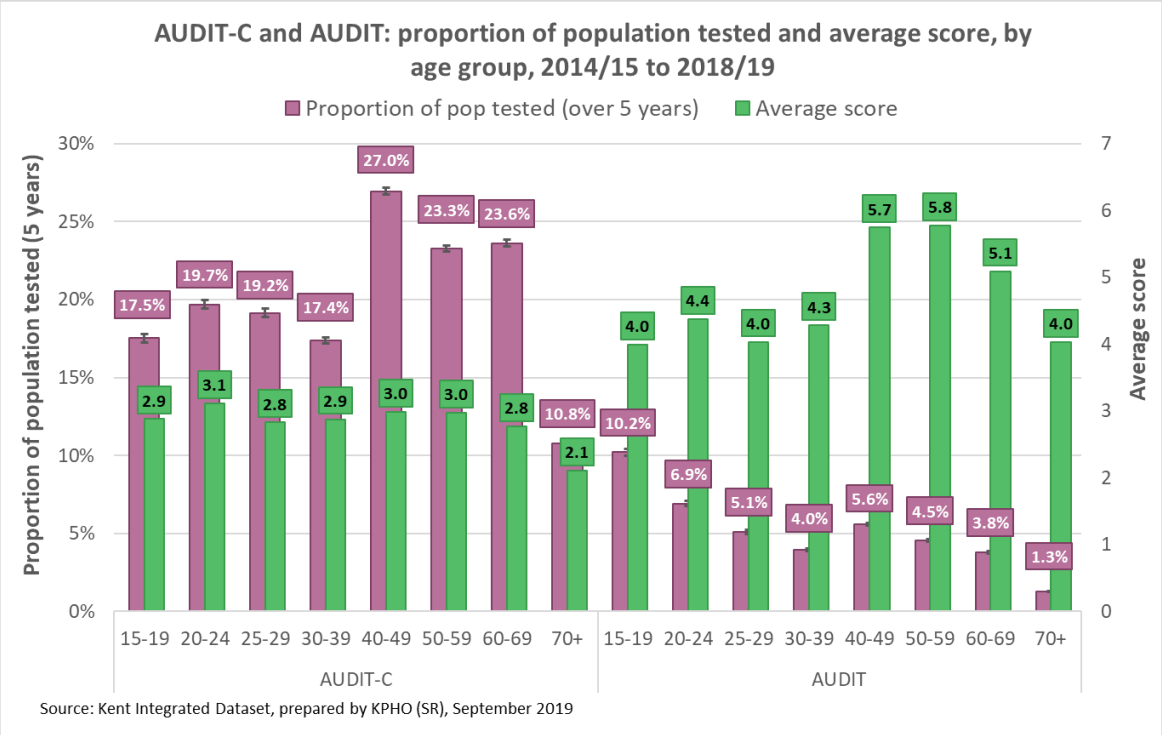


Source: Kent Integrated Dataset, prepared by KPHO (MP), September 2019

Further detail by age band shows people aged 40 to 69 are more likely to have an AUDIT-C record, although scores are broadly similar across age bands. More AUDIT questionnaires were done in the younger age groups 15 – 24, although the higher average scores were seen in the 40 to 69-year-olds.

More older people are being questioned about their general alcohol use in the AUDIT-C. More young people undertake the full AUDIT, although scores tend to be higher in the 40-69 years age group.

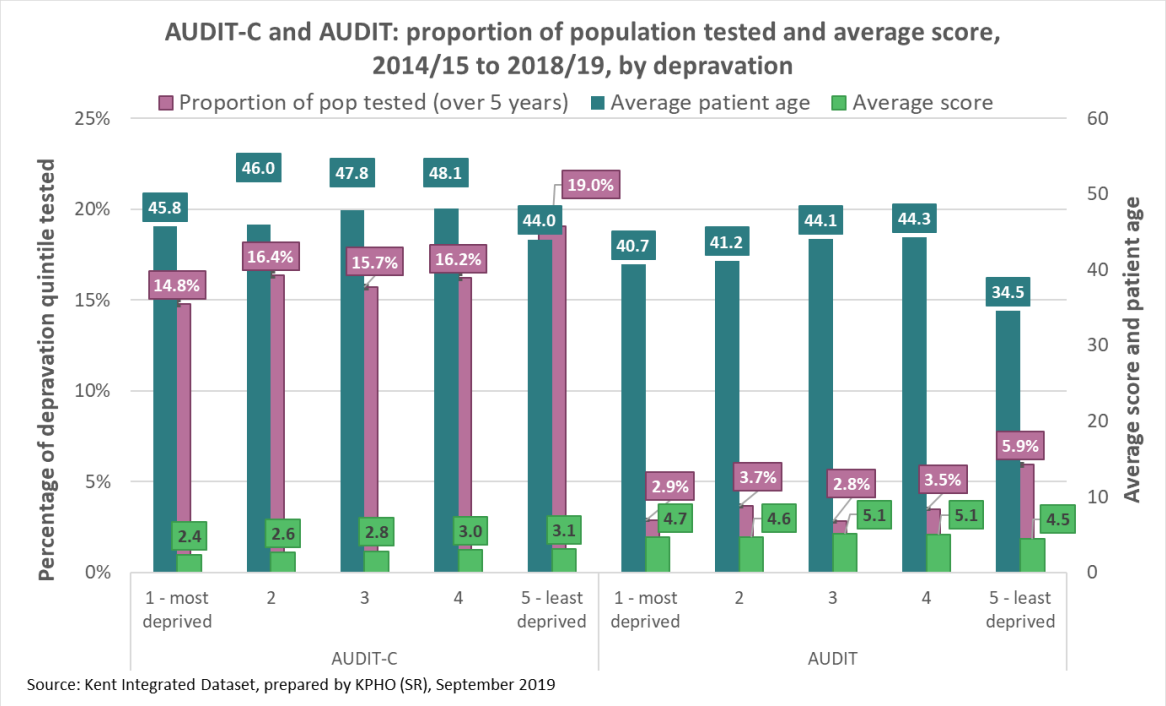
Figure 33: AUDIT assessments by age band



Source: Kent Integrated Dataset, prepared by KPHO (SR), September 2019

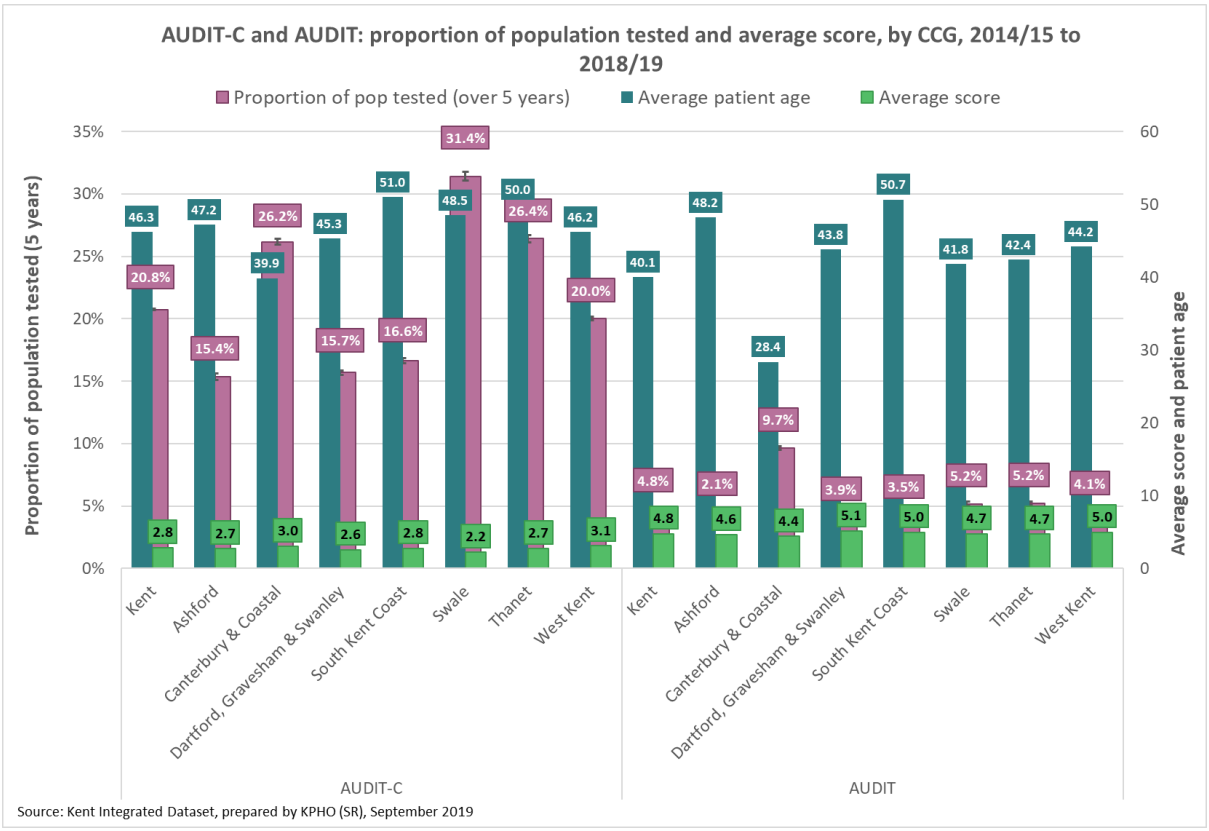
Deprivation was investigated by profiling the Index of multiple deprivation (IMD) quintiles for Kent. An increasing proportion of the population in each quintile are having either an AUDIT or AUDIT-C as depravation decreases. Average score is also increasing in line with this, apart from in the least deprived for full AUDIT.

Figure 34: AUDIT assessments by deprivation



Source: Kent Integrated Dataset, prepared by KPHO (SR), September 2019

Figure 35: IBA (using AUDIT/C) by CCG



Source: Kent Integrated Dataset, prepared by KPHO (SR), September 2019

Fig 35 shows that overall, there is good population coverage by CCGs in Kent. A score over 4 is regarded as increasing risk drinking. For AUDIT.

5.4 Targeted IBA and Health Inequalities

The Older Persons' Substance Misuse Working Group of the Royal College of Psychiatrists report "Our Invisible Addicts"[63] concludes that both alcohol and illicit drugs are among the top ten risk factors for mortality and morbidity in Europe and substance misuse by older people is now a growing public health problem.

Although prevalence of high-risk drinking is consistent across Kent and Medway, the harms are generally more marked in disadvantaged communities. In June 2016, Kent Public Health published "Mind the Gap: Health Inequalities Action Plan for Kent[64]". This report outlines the key wards and populations in Kent who are at risk, for example Margate Central and Folkstone. The report urges local communities to work in partnership to tackle some of the reasons why people in disadvantaged communities have greater harms than others, e.g.,

[63] https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/our-invisible-addicts-2nd-edition-cr211-mar-2018

[64] https://www.kpho.org.uk/__data/assets/pdf_file/0011/58835/Mind-the-Gap-Analytical-Report-D2.pdf

greater availability of poor-quality alcohol, higher levels of stress, family breakdown, social isolation and increased crime and violence. The report recommended targeting men from vulnerable communities as they are at higher risk of early death.

Recommendations: Kent NHS prevention plan to have robust monitoring and evaluation and delivery of the CQUIN targets for alcohol and tobacco control.

Recommendations: Target AUDIT in multiple settings in areas of greatest deprivation.

6 Conclusions & recommendations

The aim of this needs assessment was to quantify the need for alcohol misuse services in Kent and assess how well services are responding. To achieve this, the needs assessment considered demographic and epidemiological data; examined relevant national mental health policy and guidelines for services and interventions and analysed data from current service providers. The key messages and recommendations arising from findings are set out below:

Recommendations for Prevention to Treatment pathways

- **For Public Health and All: Ensure there is Good quality local awareness campaigns** reduce stigma and normalisation of harmful drinking.
- **For KCC Comms** spread coverage of the online tool 'Know your Score' further and in a variety of population groups and on men aged 40-59.
- **For Public Health: Prioritise and industrialise IBA awareness**
- **For Public Health and NHS: Targeted IBA** in areas **and** for populations at risk and populations where there is underrepresentation (i.e., the equalities protected characteristics)- assess via equity audit.
- **For NHS Population Health CCG:** Kent NHS prevention plan must have robust monitoring and evaluation and delivery of the CQUIN targets for alcohol and tobacco control.
- **For NHS CCG and Public Health:** A&E data needs to include additional codes that would distinguish different types of drinkers as mentioned in the needs assessment. This could be developed as part of the Population Health Management programme where there are incentivisation payments to providers to encourage them to use the codes. The codes can be used not just for analyses but for targeting IBA interventions as and when necessary. Supplementing this would be additional incentivisation to GPs to adopt similar kind of consistent coding in their data if not already implemented. This would improve needs assessment development considerably going forward, which currently rely upon weighted formulae and apportionment rules e.g. alcohol related admissions, which attempt to estimate the true burden of alcohol in the population, but this is not based on real time data.
- **For CCG and Public Health Inequalities Plan:** Target AUDIT&C in a multiple setting in areas of greatest deprivation. (Health Check)
- **For NHS CCG:** Given the strong association between Cancer and alcohol consumption make links between cancer prevention and alcohol reduction in awareness campaigns and offer IBA in screening programmes.
- **For KCC commissioners:** Given risks associated from misuse of alcohol embed IBA into all public health programmes including stop smoking, wellbeing and sexual health. Ensure that IBA is part of all prevention programmes for CVD.

- **For non-physically dependent drinkers:** Improve the pathway for alcohol prevention using community support at One You Services and Live Well Services as well as routine IBA (Identification and Brief Advice) at primary care to help them cut down their alcohol intake. Pregnant women and people with a history of depression/ anxiety and suicidal ideation must be prioritised.
- **Industrialise Making Every Contact Count** for all people in the NHS and frontline services to help people become confident in having difficult conversations regarding substance misuse and cutting down.
- **For Kent and Medway substance misuse services:** improve clarity of their outcomes data, investigate and audit relapse rates and outreach to vulnerable and complex groups via a series of equity audits shared with commissioners.
- **For commissioners and providers:** A longer period in treatment for complex patients should be prioritised and models of care improved regards access to detox and rehabilitation for the most vulnerable.
- **For Kent Public Health**: Prioritise deep dive needs assessment for inpatient detox and rehabilitation.
- **For all Services:** align and co-ordinate social prescribing, recovery, and social support so that those recovering from addictions have access to all community resources.
- **Public Health & All partners:** Each partner agency to have clearly defined links and action for the Kent and Medway Drug and Alcohol Strategy

Recommendations for Alcohol Supply and Enforcement & Crime

- **For Kent Public Health & Districts:** Map the number of off license and licensed premises in Kent districts against areas of deprivation and risk factors for harm.
- **For Kent Public Health & Districts:** Work with districts to challenge license applications in areas with risk for potential harms using 'cumulative impact'.
- **For Kent Public Health and Trading Standards:** Understand and audit the issues and barriers for Kent districts for Late Night Levies and work in areas of greatest alcohol risks in a place-based approach.
- **Kent Public Health and District Vulnerable People Teams:** Work with retailers and treatment services in areas of greatest risk in Kent districts to tackle the availability and sale of cheap white cider to vulnerable groups.
- **For Kent PH:** Revisit the impacts of the Local Alcohol Areas (LAA) to see if lessons can be brought back to the Kent Substance Misuse Alliance regarding sales of high strength alcohol to vulnerable groups.
- **For Kent PH:** Understand the impact via additional scoping - of 'on-line' and 24-hour internet alcohol supply.
- **For Kent PH and All Partners:** To Use the Alcohol Clear assessment findings to monitor continuous improvement of the Partnership's goals in relationship to current needs for enforcement and impact on demand and legislation.

- **For ALL:** Create a strong action and outcome-based plan to tackle alcohol related harms in Kent, strengthening links between crime, alcohol, violence, and treatment services. Embed Alcohol prevention into criminal justice pathways.
- **For children and families and health and social care:** to ensure that the care act responsibilities for carers and families are taken into account and further harm prevented.
- **For Police and Crime System:** Identify and support families at risk of disruption and harm from alcohol misuse with better trained staff. This includes ensuring there is a 'trauma informed' programme to tackle the lasting consequences of Adverse Childhood Experiences.
- **For KCC and Partners in Domestic violence** and abuse strategies: include links between family-based approaches to conflict linked with substance misuse treatment services.
- **ALL Crime Partnerships: strengthen the Crime strategic assessment:** create clear 3-year action plan to tackle illegal trading, disrupt supply, tackle antisocial behaviour and access to services, violence, and sexual assault.
- **For Prisons: ensure that there are exit care plans for those** on custodial sentences to improve access, help and support for those with addictions.
- **For Police and Crime Partnerships**: Increase reach of drink driving risks via local media and evidence based young people's prevention initiatives.
- **Industrialise IBA (Identification and Brief Advice)** across criminal justice settings
- **For Trading Standards:** work with off licences in areas of economic deprivation to tackle the sales of high strength alcohol to dependent drinkers

Workforce

- **For Employers:** Employers to understand the risks and consequences of work stress and use of alcohol as a 'relief' and also enable employees to destigmatise the need to get help. Improve communication and support.
- **For Employers of statutory and Voluntary Services:** Improve joint training for links between alcohol and mental illness.

Further Recommendations for Commissioners & Providers of Treatment Services: Treatment and Recovery Pathway

- **For Treatment Services:** Improve the quality treatment and recovery services: targeted at vulnerable dependent drinkers: Instigate audits into intake and throughput of high complex and vulnerable people.
- **For Mental health and NHS Health Services:** tackle the co-morbidities associated with alcohol use disorders including high quality mental health services. Ensure pathways to treatment are open and use the joint working protocol.
- **For Treatment Services and Mental Health Services and NHS services:** Use and Strengthen current Joint Working Protocol.

- **For NHS and Public Health:** Create Alcohol support teams linked to Emergency Departments can help with ensuring people are linked to continuing community care and recovery support.
- **For Public Health& Commissioners:** Instigate Modelling and audit to understand shared costs so that better outcomes in treatment can be made for vulnerable patients who disproportionately use multiple health services.
- **For Providers:** Create shared and multidisciplinary treatment plans that are co-operative that plan care for the vulnerable client/patient e.g., alcohol relapse medication**.**
- **For Public Health and Commissioning:** Embed equity audit – as treatment outcomes vary according to deprivation and district.
- **For NHS Providers:** Redesign pathways using CQINNs and in collaboration with all agencies e.g., CCG and KMPT – ensuring NICE guidance is followed and services do not work in silos.
- **For KCC & NHS commissioners:** Explore linking up recovery services across whole system – not solely for substance misuse – Improve entry and access to recovery services for service users.
- **For KCC commissioners:** Clarify the pathway for alcohol misuse at different levels of need. Ensure the treatment gap for highly complex and dependent drinkers is addressed (via provision of outreach and IBA and links to acute hospitals).
- **Public health to work alongside treatment providers to understand the needs of dependent drinkers and develop localised prevention plans with each district and local Primary Care Network.** NOTE THIS: complexity is this repetition?
- **For Commissioners and Public Health:** to work with local NHS to improve access and relapse prevention for dependent drinkers focused on equity. (equity audit).
- **For KCC Commissioners** ensure that mildly dependent drinkers can access alternative treatment options in open access behaviour change services e.g. One You (as no need for medical assessment).
- **For NHS mental health system**: Ensure that mental health system has sufficient access and non-discriminatory practice in including substance misuse disorder patients and where necessary joint treatment plans. **KCC / KMPT to audit.**
- **KCC commissioners and Providers** Target outreach and proactive care for most vulnerable population in the most deprived areas (and wards) in Kent. Prioritise Thanet.
- **For Treatment Providers:** Increase proportion of people engaged with treatment providers and target people in more deprived communities.
- **For Treatment Providers:** An aging cohort of alcohol dependent clients will mean services will need to work closely with NHS and health care providers including social care and mental health for shared care plans**.**

- **For Social Care**: Improve access to referral for adult safeguarding reviews from substance misuse and take seriously the Serious Incidents and suicidality linked to increasing drug and alcohol sudden deaths in Kent.

7 Appendix

7.1 Appendix 1

WORKING PROTOCOL

Kent and Medway Joint Working Protocol

for

Co-occurring Mental Health and Substance Misuse Disorders

Version Date:	October 2021
Ratified by:	Dual Diagnosis Strategy Group
Date ratified:	
Title of Author:	Prosper Mafu – Head of Service KMPT NAME-JOB TITLE -Forward Trust NAME- JOB Turning Point NAME- JOB Change Grow Live (CGL)
Title of responsible Officer	Jess Mookherjee
Governance Committee	Dual Diagnosis Strategy Group
Date issued:	October 2021
Review date:	April 2022
Target audience:	All staff of agencies providing mental health and substance misuse services in Kent & Medway
Disclosure Status	Can be disclosed to patients and the public

Summary

This operational protocol is designed to give a clear framework within which all Kent and Medway Substance Misuse Services and Mental Health providers can operate with regard to providing comprehensive service user focused services to those with Co-existing Mental Health and Substance Misuse Disorders (Dual Diagnosis).

This Working Protocol describes locally agreed assessment and joint-working criteria and is an update on the *Dual Diagnosis Joint Working Protocol Kent and Medway for Co-existing Mental Health and Substance Misuse Disorders* produced in April 2016.

This protocol is to be used working in conjunction with the best guidance via PHE and NHS to tackle barriers in care and support for people who have both mental illness and substance misuse addictions/ problems.

The Co-existing Mental Health and Substance Misuse Disorders (Dual Diagnosis) Protocol must be shared with and understood by all staff working with service users with Co-existing Mental Health and Substance Misuse Disorders (Dual Diagnosis) as defined in this Protocol in:

- CGL (West Kent Substance Misuse Services) provided by CGL (change, grow, live)
- KMPT
- IAPT Providers (via NHS CCG Commissioners)
- Live Well Kent providers
- Forward Trust (East Kent Substance Misuse Services)
- Prison and Probation Trust Providers
- Police Mental health Teams
- Social Services KCC
- Public Health providers (One You) KCHFT
- Primary Care Mental Health Teams
- Any Multi-disciplinary team formed as part of care co-ordination.
- Inpatient detox and rehab facilities commissioned by Kent providers

Purpose

The purpose of this Protocol is to support effective and well-co-ordinated services for people with Co-existing Mental Health and Substance Misuse Disorders (Dual Diagnosis) within Kent.

To ensure that all individuals with co-existing mental health and substance use issues receive a service fit for their varying needs, irrespective of where and how they present.

The protocol is intended to foster joint working between services and maintain and build on each organisation's specialist role within the mental health and substance misuse system.

Responsibilities of Participating Agencies

In Kent, The Director of Public Health (and via his consultant PH deputies) is responsible for commissioning treatment services for those with drug and/or alcohol problems through the Public Health Commissioning Team.

Services are commissioned from a range of providers in both the statutory and voluntary sectors. The Public Health Commissioning Team have commissioned Kent and Medway Adult Substance Misuse Treatment Services to be the primary providers of substance misuse services within Kent with specification to support a Joint Dual Diagnosis Pathway with the mental health providers – in the main KMPT.

The Kent and Medway Adult Substance Misuse Treatment Services are commissioned to provide specialist multi-disciplinary care and treatment for those with complex substance misuse problems. The Medical Directors are ultimately responsible for the provision of substance misuse services to those with Dual Diagnosis in Kent and Medway.

The Integrated Health and Commissioning Team commissions services for those with the more severe mental health problems from KMPT. The Trust provides services to those with severe mental illness, a significant proportion of whom also have substance misuse problems, through a range of services including Community Mental Health Teams (CMHTs), Early Intervention in Psychosis Service, Acute Inpatient Units, Crisis Resolution and Home Treatment Team (CRHT) and Mental Health Liaison (A&E Liaison) Teams.

Effective joint working between all agencies is key to meeting the needs of those with co-existing mental health and substance misuse disorders (Dual Diagnosis).

Managers in these services have a responsibility to make their teams aware of this Protocol and related operational policies, and staff is expected to comply with these policies.

In some situations, there may be service users who do not wish to engage with any or specific services even though it may appear counter-intuitive to the providers. In these cases, involved organisations will try and contact the service user if they believe that the service that they can provide will be of benefit to him/her. If KMPT strongly believe that not engaging with them places the Service User at risk, either to self or public, then KMPT will make a judgement on whether a more assertive approach is needed in order to prevent harm to the service user or other individuals. KMPT will use collateral information provided by carers, GP's, and other organisations to assist KMPT with this judgement. KMPT will work within the guidance of the Mental Health Act, where appropriate. It is ultimately the service user's personal choice whether to engage Forward Trust/CGL's [Kent Adult Substance Misuse Treatment Services] or not. (for issues around Capacity – please refer to Appendix 1-point 3).

There are rare occasions when any provider is unable to offer a service to a client and in these circumstances the reasons need to be fully explained to the client in

writing. The clients and carers have the right to challenge the provider (refer to complaints section).

Target Service User Group

- Is aged 18 years and over
- Has a significant history or shows symptoms of serious mental health harm/illness?
- Is resident in Kent and Medway either permanently or temporarily
- Requires mental health services in respect of a mental health problem
- Requires specialist drug and alcohol services provided by CGL/Turning Point/Forward Trust
- May have identified eligible social care needs in respect of their mental health disorder/substance misuse
- Requires joint care involving more than one of the following agencies: primary care, substance misuse services, mental health services (not all service users with mental illness will be receiving specialist mental health services. For example, some will be self-managing and others may be supported by their GP.)
- May be involved with the criminal justice system, and related service providers

The protocol does not cover individuals with Dual Diagnosis needs who are under 18 years old. Services for this client group are provided by Child and Adolescent Mental Health Services (CAMHS).

Cooccurring Conditions

The locally agreed term for 'Dual Diagnosis/ Co-occurring condition' in respect of this Protocol refers to any individual who requires treatment and/or support for co-existing mental health and substance misuse disorders.

There is no gain in debating which causes what – as it has been agreed clinical presentation and care is more important as per national guidance. Mental health problems in this guideline can range between clinical diagnoses of:

- schizophrenia, schizotypal and delusional disorders
- bipolar affective disorder
- severe depressive episode(s) with or without psychotic episodes
- personality disorder / adult attachment disorder
- Complex Post Traumatic Stress Disorder.

and common mental health problems of mild to moderate severity including:

- phobias
- generalised anxiety
- obsessive compulsive disorder

- social anxiety
- single event trauma
- depression

Substance misuse refers to the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage." - (NICE guideline: Severe mental illness and substance misuse (dual diagnosis): community health and social care services)

The nature of the relationship between these two conditions is complex.

Possibilities include:

1. A primary mental health condition precipitating or leading to substance misuse.

2. Substance misuse worsening or altering the course of a mental health condition.

3. Intoxication of substance dependence leading to psychological symptoms.

4. Substance misuse and/or withdrawal leading to mental health symptoms or illness.

The decision as to which service has the primary responsibility for providing a lead role in the care for these service users depends on the severity of the mental health condition experienced. A significant majority of those with a Dual Diagnosis who have mental health issues which are not severe will be cared for predominantly within Substance Misuse Services, while those with Severe Mental Health conditions will be cared for predominantly by statutory Mental Health Services. A number of primary care (IAPT) or non-statutory mental health services may also provide significant support and care for service users experiencing mental health problems.

The underlying principle of this protocol is JOINED UP CARE PLANNING – particularly in the most vulnerable patients (*See Appendix 1 Expected Elements of Joint Working - Essential Guidance*). Also noting – that the history of vulnerability may mean that people need to step up and down over time.

The Service Users' Carers, subject to issues of consent on a case-by-case basis, will be given the opportunity to express their point of view with regard to which service needs to be involved. While this opportunity will be provided, decisions will ultimately be based on clinical judgement.

Referral to Services

<u>Referral to Substance Misuse Services</u>

All agencies can refer to substance misuse services for an assessment. Whilst substance misuse services will accept self-referrals from patients' professional referrals are very helpful as these may help identify the need for joint working at the earliest opportunity.

For some complex cases, it might be preferable for Mental Health clinician to present the referral in person at the substance misuse service MDT meeting. We encourage substance misuse services to offer a slot to the referrer to enable them to present the referral via video link. This is seen as a positive step to encourage joint working.

Referral to Secondary Care Mental Health Services:

Secondary Mental health services will accept referrals from substance misuse services.

- Referral by a consultant psychiatrist in substance misuse or other qualified mental health practitioner are preferable and will be accepted for assessment.
- Referral from the local care co-occurring conditions MDT will be accepted for assessment.
- Referrals from non-qualified MH professional will be accepted but may have to go through a triage process

For some complex cases, it might be preferable for Substance Misuse Practitioner to present the referral in person at the Mental Health service MDT meeting. We encourage Mental Health to offer a slot to the referrer to enable them to present the referral via video link. This is seen as a positive step to encourage joint working.

For the referral *Flowchart: Substance Misuse Services to Mental Health Services* see Appendix 2.

Referral to AIPT and Primary Care Mental Health Services:

Substance Misuse Services can refer directly to AIPT and Primary Care Mental Health Services. AIPT and Primary Care Services can also refer directly to Substance misuse services.

In all cases, referrals from Kent and Medway Adult Substance Misuse Treatment Services will outline the following: –

a) What is the mental disorder that the Kent Adult Substance Misuse Treatment Services practitioner thinks that the service user is experiencing?
b) How will the service user's substance misuse problem obstruct the treatment provided by mental health services?
c) What the service user subjectively hopes to gain from accessing mental health services?

Referral to third sector organisations such as live well Kent and One you Kent

These services will accept referrals from Kent and Medway Adult Substance Misuse Treatment and Mental Health Services and other agencies.

It is important to acknowledge that referral of people with cooccurring conditions can come from other sources such as G.Ps, Acute hospitals Local Care MDT meetings. Where the agency receiving the referral decides that the is need for another agency to be involved, they will take responsibility for onward referral or signposting to either Mental Health services or Mental health services without returning the referral to the G.P, Acute hospital, or local care MDT meeting.

Assessment

An initial Assessment will help practitioners to establish immediate risks and support needs. Service user experience and planning of care is improved if this is completed jointly between agencies involved, service user and carers.

The key factors to assess at this stage are:

a. Severity of Mental Health: mild / moderate / severe & enduring condition. Brief Mental Health Questionnaire, GAD7 & PHQ9 screening tools may be used to aid this process, available at: PHQ 9 and GAD 7: http://iapt.nhs.uk/silo/files/phq9-and-gad7.doc

b. Substance use patterns: current use, dependence, perceptions & readiness Assess motivation to change: AUDIT and ASSIST screening tools may be used to aid this process, available at:

- PHE AUDIT: http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&child=4896
- WHO ASSIST: http://www.who.int/substance_abuse/activities/assist_v3_english.pdf?ua=1
- NIDA DAST 10: https://www.drugabuse.gov/sites/default/files/files/DAST-10.pdf

c. Housing & support networks: e.g., homelessness, engagement with supported housing, social networks.

d. Risks: to self, to others, in relation to all of the above.

Key Question: can your service alone support the person's overall needs and manage any associated risks?

Practitioners must use clinical indicators and experience to consider if the mental health symptoms identified at initial assessment can be explained by alcohol or substance misuse. If the alcohol or substance use was addressed, would it be likely to address the mental health symptoms; could the situation change; or get worse? Support and advice should be sought from partner agencies and cooccurring conditions Champions.

If post-assessment, your service cannot support the care needs of the individual and / or manage the associated risks consider:

- Consulting with another service
- Offering collaborative/joint care with another service
- Assertively referring on to another service

The cooccurring conditions guide and locally agreed protocols are to assist practitioners to make decisions based on assessed need matched to service provision.

Model of Co-Occurring Conditions (Quadrant Model)

Co-existing Mental Health and Substance Misuse Disorders (Dual Diagnosis): exists along two axes

The vertical axis describes the severity of problematic substances misuse while the horizontal axis describes the complexity of mental health issues, giving four “quadrants”, or situations where people may find themselves, as depicted in the diagram below.

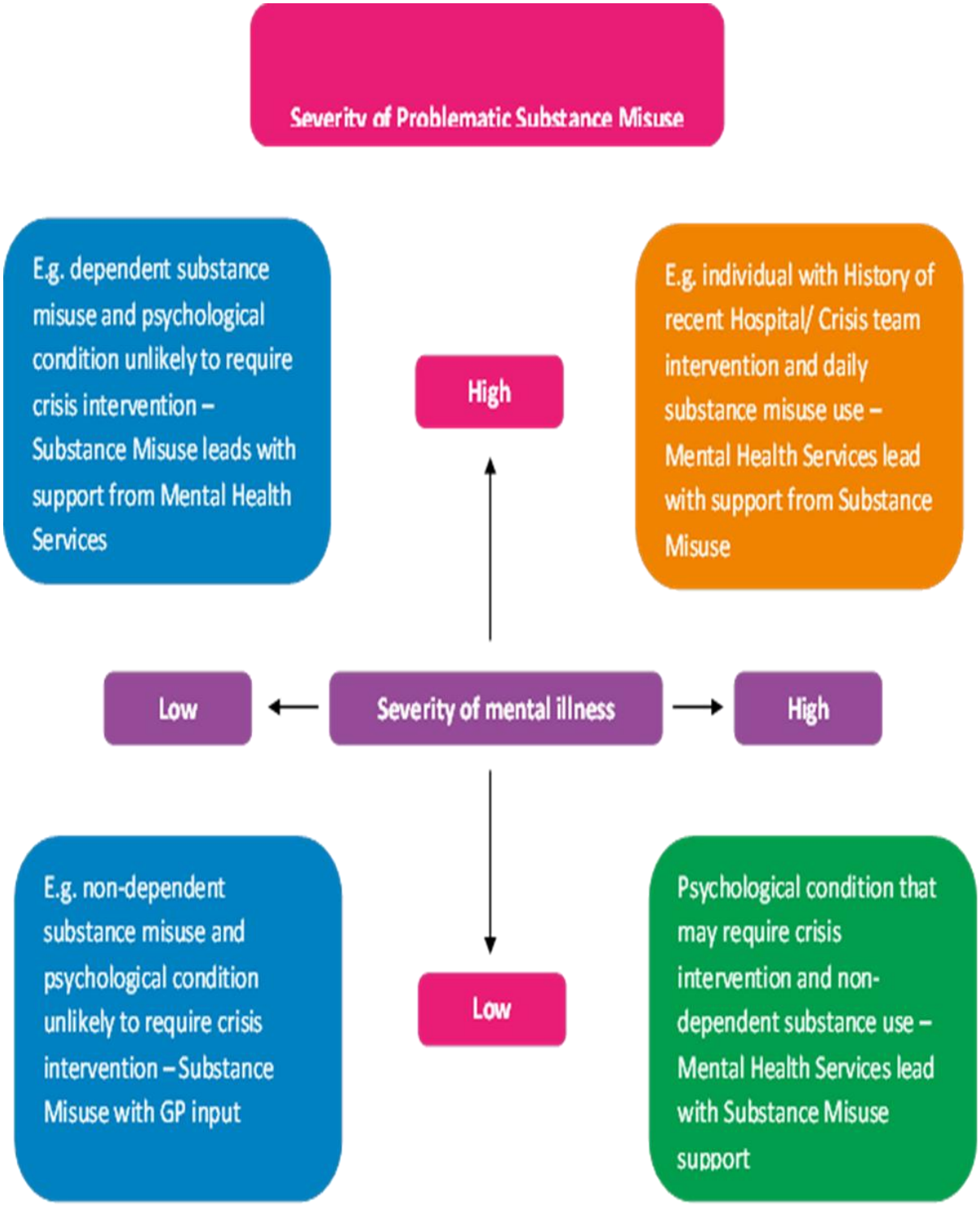


Figure 2- This chart shows the probability of psychological conditions that are long linked with substance and alcohol misuse.

Model of Co-Occurring Conditions (Quadrant Model)

Service users with co-existing mental health and substance misuse disorders can be broadly described as presenting in four categories –

1) Severe Mental illness with substance dependence-High mental illness and high substance misuse.

2) Severe & persistent mental illness with substance misuse-high mental illness and low substance misuse

3) Non-severe mental health problems and substance dependence-high substance misuse and low mental illness

4) Non-severe mental health problems and non-dependent-low mental illness and low substance misuse.

The quadrant model above serves as a guide however in practice, the service user's mental health and drug misuse can be very changeable and dynamic. People dynamically move between these quadrants and care should follow the patient in a safe and high-quality fashion. Service user life events impact significantly upon both elements and the service user may move between quadrants. A person-centred approach is needed so that the most appropriate service is accessed.

Therefore, it is important that vulnerability is assessed and identified, a key worker is assigned, a care plan is in place and that any change in quadrant is handed over appropriately with an adjusted care and safety plan, clearly communicated to patient (and if appropriate carer/family).

The care pathway gives clear direction as to which service leads and which service supports. This protocol ensures that there will be clear agreements about how to meet the needs of those with co-existing mental health and substance misuse disorders (Dual Diagnosis), as defined in this Protocol, under their care. These are based on the principle of working jointly to provide individualised packages of care that are most suited to individual service users, rather than allowing the ways services are organised to dictate how care is provided.

Management and lead responsibility for delivery of care will be dictated in line with aforementioned categories. Noting at all stages that people can change 'quadrant' and that for the most vulnerable patients an annual review of a care plan is good practice.

Lead Agency in joint working depending on Severity of Mental illness and Substance dependency.

<u>A) Severe Mental illness with substance dependence- high mental illness and high substance misuse.</u>

Lead Agency: Secondary mental health services local or forensic mental health services in consultation and collaboration with Substance Misuse Services as appropriate.

Case management responsibility for individuals with severe and enduring mental illness will remain the responsibility of the Mental Health Service. These clients will have severe and enduring mental illness and high levels of substance misuse or dependence e.g., an individual with schizophrenia who has alcohol dependence.

B) Severe & persistent mental illness with substance misuse-high mental illness and low substance misuse

Lead Agency: Secondary Mental Health Services or forensic MHS mental health services in consultation and collaboration with Substance Misuse Services as appropriate.

Case management responsibility for individuals with severe and enduring mental illness will remain the responsibility of Mental Health Services.

The service user can either be newly referred to the Specialist mental health services or previously known to services. In either case Specialist mental health services can refer to Kent and Medway Adult Substance Misuse Treatment Services for assessment to identify the most appropriate intervention.

If there is no dependency – then a risk assessment and treatment plan will be made. If the substance misuse is complex and problematic and cannot be managed via any other agency – the Kent Substance misuse Treatment services can provide support if needed.

If dependence is also diagnosed in addition to the Severe Mental Illness, then this service user will need the joint working protocol where the Kent Adult Substance Misuse Treatment Services Recovery Coordinator involvement in the CPA process. Other services such as ONE YOU KENT should not deny a patient a service due to mental illness.

C) Non-severe mental health problems and substance dependence-high substance misuse and low mental illness

Lead Agency: Substance Misuse Services (SMS).

This will be in accordance with National Training Agency Models of Care case management framework. These will be clients with primary substance misuse disorder with secondary low-level mental illness e.g., a dependent drinker who experiences symptoms of anxiety or depression, a dependent opiate user or regular stimulant user with symptoms of anxiety. This care will primarily be provided by SMS partner agencies.

Kent and Medway Adult Substance Misuse Treatment Services will initially be responsible for the assessment of mental health needs of service users and the necessity for onward referral to (IAPT).

As part of this assessment process, service users are offered a Health Care assessment, carried out by a Health and Wellbeing Nurse. The assessment may involve use of screening tools such as GAD-7, PHQ-9 and Mini Mental State as well as assessment by their Clinician.

If the assessment process identifies the need for onward referral the Kent and Medway Adult Substance Misuse Treatment Services clinicians will support referral to IAPT or primary care mental health if needed.

D) Non-severe mental health problems and non-dependent low mental illness and low substance misuse.

Lead Agency: Primary care with support from partner agencies.

These clients will be individuals who have low-level mental health and low-level substance use. This will include a recreational misuser of ecstasy who struggles with low mood after using the drug or a non-dependent drinker who feels they are not coping well with anxiety. This care will primarily be provided in Primary care settings in collaboration with Community Psychiatric link workers, SMS services and mutual aid organizations and support agencies as required.

The Kent and Medway Adult Substance Misuse Treatment Services will initially be responsible for the assessment of mental health needs of service users and the necessity for onward referral to LIVE WELL/ ONE YOU. As part of this assessment process, service users are offered a Health Care assessment, carried out by a Health and Wellbeing Nurse. The assessment may involve use of screening tools such as GAD-7, PHQ-9 and Mini Mental State as well as assessment by their Clinician.

If the assessment process identifies the need for onward referral the clinicians will support referral to services such as Live Well Kent, IAPT and Primary Care Mental Health Nurses.

Service users with non-severe mental health conditions, whether dependent on either illicit drugs or alcohol, may be referred for consideration for the Live Well or One You Kent.

Dependent drinkers

Once the service user has completed an alcohol detoxification and is abstinent then Kent and Medway Adult Substance Misuse Treatment Services will make the referral to Mental health services at this critical period where a person needs support.

Kent and Medway Adult Substance Misuse Treatment Services can make informal enquiries to the Specialist Mental Health services clinicians on the viability of the referrals and can state in the referral that the case has been informally discussed

with the Mental Health Service clinician which will guide the service on how these referrals are progressed.

The joined-up care plan will take note of the mental health risk and the support needed and a plan will be made and shared with the patient (and if appropriate – cares and family).

Non-dependent drinkers

The clinician can make a referral as above on a case-by-case basis.

Dependent Opiate users in receipt of substitute medication

Service Users assessed as stable enough to be on interim collection from the pharmacy can be deemed to have made sufficient progress in their recovery journey to make optimum use of the primary care mental health services and IAPT are capable of working with a service user only if the opiate use is not a barrier to treatment.

Kent and Medway Adult Substance Misuse Treatment Services can make informal enquiries to the IAPT clinicians on the viability of the referrals and can state in the referral that the case has been informally discussed with the IAPT clinicians which will guide the assessor on how these referrals are progressed. The IAPT team will aim to assess the service user within two-weeks of receiving the referral.

Other Drugs (Cocaine, Cannabis, NPS)

There are no objective methods to assess the impact of these drugs on the effectiveness of IAPT therapies. Therefore, the Kent and Medway Adult Substance Misuse Treatment Services needs to make a referral on a case-by-case basis.

Involvement of Carers / Significant Others

Carers are important partners in service user care and can play a vital role in recovery and preventing relapse but caring takes its toll and can have an impact on the carer's own health. It is essential to listen and respond to the voice and needs of carers and ensuring, where consent is given, that carers are invited to attend, exchange ideas with the treating team so that that they can have an active role in joint reviews.

Transfer from Inpatient Mental Health Services

When Service Users with cooccurring conditions are transferred to the community from inpatient mental health services, they will have:

- An identified Lead Health Care Professional from mental health services

- An allocated recovery coordinator from Kent and Medway Adult Substance Misuse Treatment Services who will have been invited to the transfer planning meeting
- A care plan that includes consideration of needs associated with both their severe mental illness and their substance misuse, and.
- Will have been informed of the risks of overdose if they start reusing substances, especially opioids that have been reduced or discontinued during their inpatient stay.

Patients with cooccurring conditions presenting to Kent and Medway Emergency Department and/or admitted to Acute General Hospitals

For all Mental Health patients referred to the Liaison Psychiatric Services (LPS) by the acute hospitals, the LPS staff will discuss substance misuse as part of the assessment and review process.

The outcome could be a referral to the local Substance Misuse service and if already open to substance misuse services LPS will notify the substance Misuse service of the presentation to the emergency department and subsequent admission where appropriate. ***In all cases the patient will need to be asked for their consent to this sharing of information*.**

Where there is also a referral to community and/or inpatient mental health services LPS will alert these mental health services of the involvement of substance misuse services.

The LPS discharge letter to the G.P will also notify the G.P of referral and signposting to substance misuse services.

Where joint working is identified substance misuse will be involved in the acute hospital discharge planning in the same way as the transfers from inpatient mental health wards as above.

Transition

In order to ensure that young people with cooccurring conditions who continue to need treatment for Dual Diagnosis are transferred smoothly to services for adult, refer to NELFTs & KMPTs Trust policy on Transition arrangements to Adult Mental Health Services.

Dispute Resolution

Disputes over case responsibility will be rare if full information is shared and if all services are willing to operate with some flexibility in the interests of the service user. In the cases where a dispute does arise, it will be referred to the respective service managers for resolution. Clinician to clinician discussion are encouraged.

If no resolution is achieved through this meeting, cases will be referred to relevant provider organisations Clinical Directors/Senior Management for resolution, with commissioner input as necessary.

Sharing of Information & Monitoring

Information should only be shared on a 'need to know' basis and strictly in compliance with duty of care.

There is an expectation that consent to share information is sought from the service user although this may differ in exceptional circumstances such as crisis/high risk scenarios.

Consent to share information should be re-considered/updated at regular review meetings.

Staff Training

Provider organisations will work with commissioners to carry out a training needs analysis for mental health and substance misuse services.

Clinical learning forums facilitated by public health are a good resource for both Substance Misuse and Mental Health Services.

Appendix 1 Expected Elements of Joint Working - Essential Guidance:

In all cases it is vital that a service user does not fall between services, and service users must be given every opportunity to engage with services.

- Assertive referral between care providers which demonstrates an understanding the partner agencies information need, including where possible completed tools (e.g., regarding alcohol consumption). This should involve enhanced actions to support engagement e.g., attending along with the service user for an appointment with substance misuse service or mental health service. *It is unacceptable to refer on to another service without following-up to ensure that suitable care/intervention has been offered.*

- Jointly conducted, formal comprehensive assessment of a service user's needs and risks, leading to the drawing up of a joint care plan with the service user.

- Joint approach to supporting and motivating engagement of dual diagnosis service users, to ensure every opportunity for services to be accessed.

- Wherever possible partner agencies must have a presence on each other's sites. Whether this be informally or with formal arrangements e.g., clinic sessions, attendance at clinical forum, risk forums, engagement sessions etc.

- Comprehensive & proactive handover, where a case is being closed by one service but picked up by the other.

- A clear agreement with the service user, within care planning, as to which person/service will where necessary, liaise with non-statutory agencies.

- Robust discussions and documented decision making shared between both services regarding any safeguarding work (adult & child), even at alert level.

- Within information governance and risk parameters, both services will share patient history. This will be with signed consent but can be without consent where risk issues dictate a need-to-know situation.
- Joint investigations of SI, with sharing of learning actions (see joint investigation of SI protocol – currently in draft)

- Assertive links with primary care.

- Where appropriate, contacts will be recorded on partners' clinical record.

- Working together to share understanding of the needs of dual diagnosis service users with partner services e.g. A&E Liaison, A&E staff training.

- Work together to provide advice for GPs on when to request joint assessment by mental health and substance misuse service providers.

- Joint home visits for the purpose of assessment, intervention, and monitoring.

- Clearly designated roles and actions within the care plan, reflecting recovery actions and interventions, relapse indicators, and risk issues.

- Proactive information sharing between service providers, in line with information governance, service users' wishes and risks. Ensuring signed consent to share is completed where possible.

- Collaborative working with the service user's carers, family members or advocates, as expressly agreed with the service user.

- Also, where appropriate a carer's assessment will be carried out jointly.

- The Care Act 2014 provides that where an individual provides or intends to provide care for another adult and it appears that the carer may have any level of needs for support, local authorities must carry out a carer's assessment.

- Rethink Dual Diagnosis leaflet for families, friends, and carers

- What it means to make a difference – Caring for people with mental illness who use alcohol and drugs
- Joint reviews and clinical meetings e.g., CPA review meetings, clinical risk forums, safeguarding meetings. Again, in line with information governance, service user wishes and identified levels of risks.

- Use of mutually accessible venues and times to see the service users/carers to facilitate good engagement.

- Joints staff training and sharing of best practice across agencies and localities.

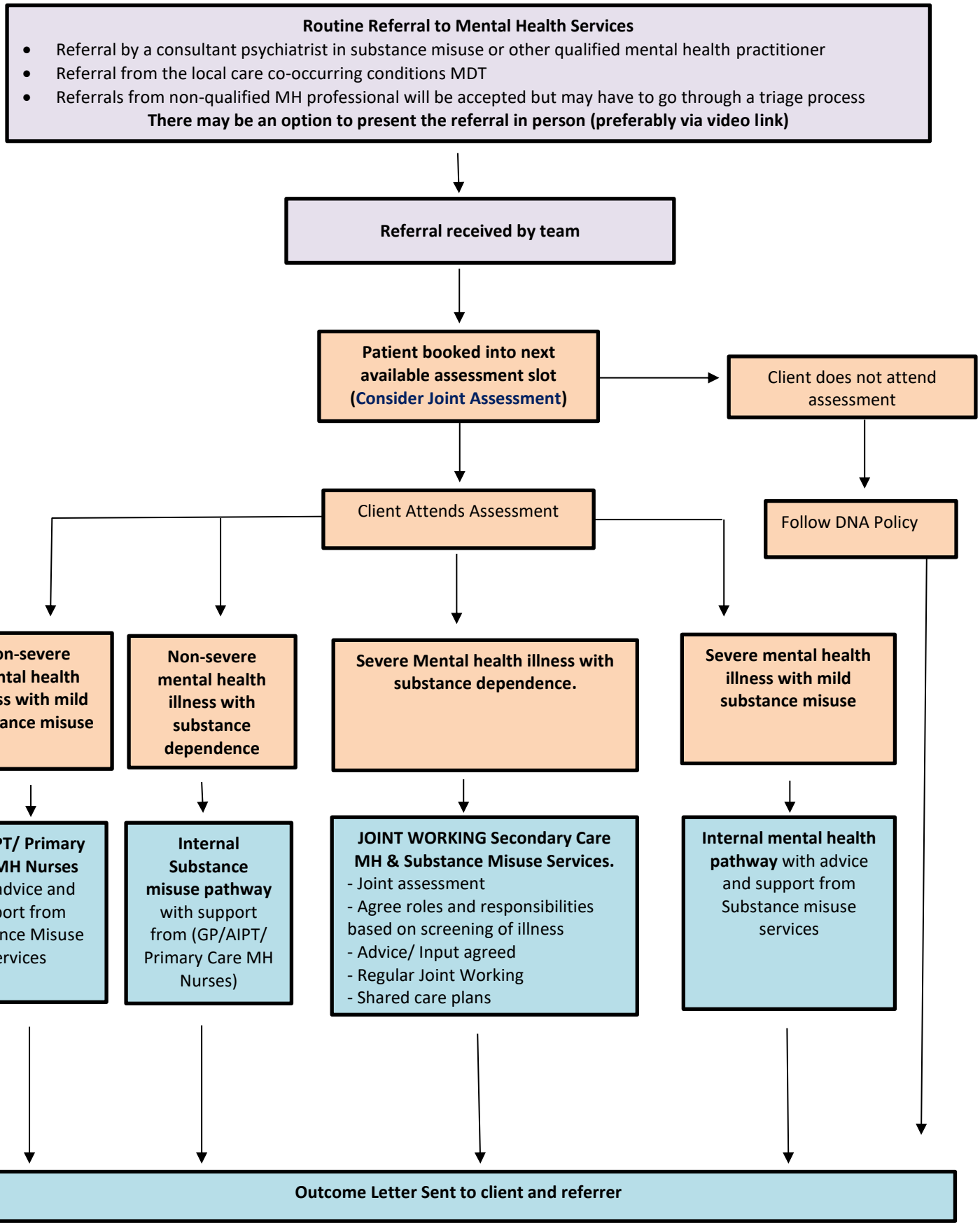
- Staff mutually and proactively, seeking and sharing information about the partner agency. Fostering a clear understanding of the remit, resources, interventions provided, and tools used by a partner service, and developing good working relationships.

- Full consideration given to inter-agency referrals, where necessary seeking more information to enable a decision about the need for joint assessment. Where this is not the case, a written recommendation should be provided for the referrer.

- Each agency/service to identified Dual Diagnosis Champions for each team, who will liaise regularly with other Champions in the locality, they will attend agreed Dual Diagnosis training and Champion

- Locality Dual Diagnosis Forums held regularly and owned by local service providers, dual diagnosis champs, service user & carer representatives, with other stakeholders in attendance. There will be an agreed term of reference for each group.

Appendix 2: Referral Flowchart SMS to MHS Services



Appendix 3 (Service referrals email addressed and Contact numbers TO FOLLOW.

Helpful Links

Coexisting severe mental illness and substance misuse: community health and social care services

NICE guideline [NG58] Published: 30 November 20

https://www.nice.org.uk/guidance/ng58

Coexisting severe mental illness and substance misuse Quality standard [QS188] Published: 20 August 2019

https://www.nice.org.uk/guidance/qs188

Dual Diagnosis Good Practice Guide 2002 / 2006 update - archived

Mental Health Policy Implementation Guide 'Dual Diagnosis Good Practice Guide' (DH, 2002)

A guide for the management of dual diagnosis for prisons

https://lx.iriss.org.uk/content/guide-management-dual-diagnosis-prisons

The Bradley Report 2009

http://www.prisonreformtrust.org.uk/WhatWeDo/Projectsresearch/Mentalhealth/TroubledInside/BradleyReport

Rethink Mental Illness

https://www.mentalhealthatwork.org.uk/organisation/rethink-mental-illness/

Dual Diagnosis toolkit: A practical guide for professionals and practitioners

Association of Mental Health Providers

Published: August 17, 2017

https://amhp.org.uk/dual-diagnosis-toolkit-a-practical-guide-for-professionals-and-practitioners/

https://amhp.org.uk/app/uploads/2017/08/dualdiagnosistoolkit.pdf

Dual Diagnosis - Turning Point

https://www.turning-point.co.uk/_cache_ec2f/content/dualdiagnosisgoodpracticehandbook-5090910000025794.pdf

Care Programme Approach NHS England and NHS Improvement position statement 1 July 2021 Version 1.0

https://www.england.nhs.uk/wp-content/uploads/2021/07/Care-Programme-Approach-Position-Statement_FINAL_2021.pdf

Dual Diagnosis toolkit: A practical guide for professionals and practitioners

Association of Mental Health Providers

Published: August 17, 2017

https://amhp.org.uk/dual-diagnosis-toolkit-a-practical-guide-for-professionals-and-practitioners/

Dual diagnosis toolkit - Association of Mental Health Providers

https://amhp.org.uk/app/uploads/2017/08/dualdiagnosistoolkit.pdf

toolkit for families affected by co-occurring conditions - Adfam

https://adfam.org.uk/files/Toolkit-co-occurring-conditions.pdf

Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit

Jack, Joseph, and Morton Mandel School of Applied Social Sciences 2011

https://case.edu/socialwork/centerforebp/resources/dual-diagnosis-capability-addiction-treatment-ddcat-toolkit

Capability Framework toolkit for co-occurring mental health and drug/alcohol released. Alcohol Policy UK 2019

https://www.alcoholpolicy.net/2019/06/capability-framework-toolkit-for-co-occurring-mental-health-and-drugalcohol-released.html

Better care for people with co-occurring mental health and alcohol/drug use conditions A guide for commissioners and service providers

Public Health England, 2017

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

The Bradley Report five years on an independent review of progress to date and priorities for further development. Centre for Mental Health.

http://www.mentalhealthchallenge.org.uk/library-files/MHC151-Bradley_report_five_years_on.pdf

The Bradley Report and the Government's Response: The implications for mental health services for offenders. Sainsbury Centre for Mental Health.

http://www.ohrn.nhs.uk/resource/policy/SCHMBradleyReport.pdf

7.2 Appendix 2: Impact of COVID-19 on Alcohol Consumption

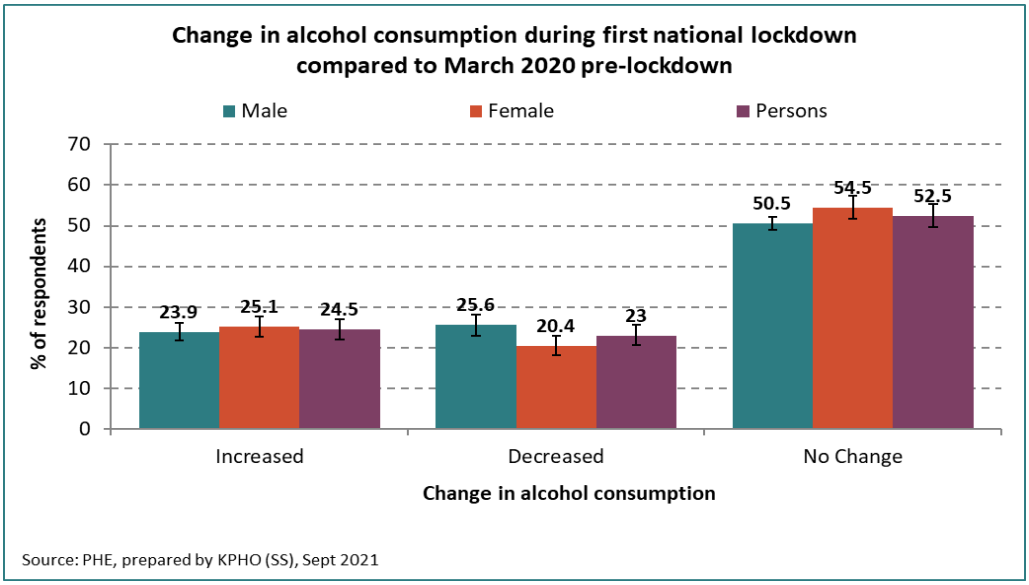
7.2.1 Introduction

Covid-19 is novel strain of coronavirus that first emerged in December 2019. By March 2020, the World Health Organization had declared the COVID-19 outbreak a pandemic. As part of their response to the pandemic, the UK government put in place measures to delay the spread of the disease, starting with a national lockdown on 16th March 2020 and ending on 19th July in England. The aim of this report is to give an overview of trends in drinking habits of the Kent population before and during COVID-19 restrictions. This report is partly based on PHE analysis of YouGov national survey data[65], and where possible includes estimated numbers of adults in Kent calculated from these data. Data on alcohol duty paid by traders and volumes of shop-bought alcohol were not included in this report as they will be affected by the closure of pubs and restaurants during lockdown and do not reflect when alcohol was consumed. In addition to alcohol consumption data, this report also includes an analysis of the trend in alcohol specific deaths before and during the Covid-19 pandemic.

7.2.2 Changes in alcohol consumption

Figures 1 and 2 below show changes in alcohol consumption from March 2020 to the first national lockdown[66] and September 2020[67] respectively, taken from the PHE analysis of YouGov survey data[68].

Figure 1: Change in alcohol consumption during first national lockdown compared to March 2020 pre-lockdown



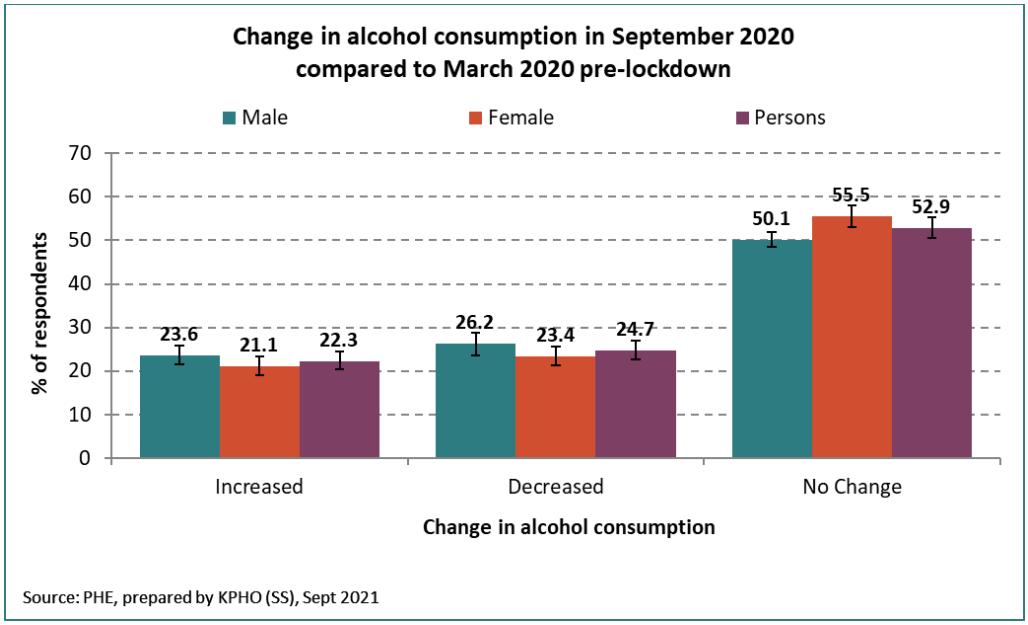
[65] PHE 2021, *Wider Impacts of COVID-19 on Health (WICH) monitoring tool*. Accessed 13th September 2021, https://analytics.phe.gov.uk/apps/covid-19-indirect-effects/#.

[66] 3 combined survey waves ending 25/05/2020 conducted during the first national lockdown

[67] 4 combined survey waves ending 26/06/2020 conducted during September 2020

[68] PHE 2021, Wider Impacts of COVID-19 on Health (WICH) monitoring tool. Accessed 13th September 2021, https://analytics.phe.gov.uk/apps/covid-19-indirect-effects/#.

Figure 2: Change in alcohol consumption in September 2020 compared to March 2020 pre-lockdown



Over half of respondents did not change their level of alcohol consumption during lockdown compared to pre-lockdown March 2020, and there was a fairly even split between those that drank more and those that drank less. However, there are differences between the sexes with a slightly higher proportion of men decreasing rather than increasing their alcohol consumption, whereas in women a significantly higher proportion drank more rather than less alcohol. During September 2020 the proportion that didn't change their drinking habits stayed roughly the same, however, a higher proportion of men and women were drinking less when compared to during the first national lockdown.

Tables 1 and 2 show estimates of the number of adults in Kent drinking more, less or the same, by age band and gender respectively, based on applying proportions from the above PHE analysis to Kent resident population estimates[69]. Table 1 indicates the number of adults consuming more alcohol per week in September 2020 compared to before lockdown ranged from 85,000 in young adults to 94,000 in 35–54-year-olds. However, in the older two age categories there were more people that had decreased their alcohol consumption over this period. Table 2 shows that for both men and women there were a higher numbers consuming less rather than more alcohol in September 2020 compared to pre-lockdown.

Table 1: Estimated number of adults in Kent drinking more, less or the same in September 2020 compared to pre-lockdown by age band

Change in alcohol	18-34	35-54	55+

[69] ONS 2021, *Mid-Year Population Estimates, UK, June 2020.* Accessed 16th September 2021, https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland.

consumption			
Increased	85,000	94,000	90,000
Decreased	84,000	102,000	117,000
No change	137,000	214,000	319,000

Table 2: Estimated number of adults in Kent drinking more, less or the same in September 2020 compared to pre-lockdown by gender

Change in alcohol consumption	Male	Female
Increased	142,000	135,000
Decreased	158,000	150,000
No change	301,000	356,000

7.2.3 Proportion of respondents who consumed >14 units of alcohol during a typical week in England by age band

Figure 3: Proportion of respondents aged 18-24 years old who consumed >14 units of alcohol during a typical week in England

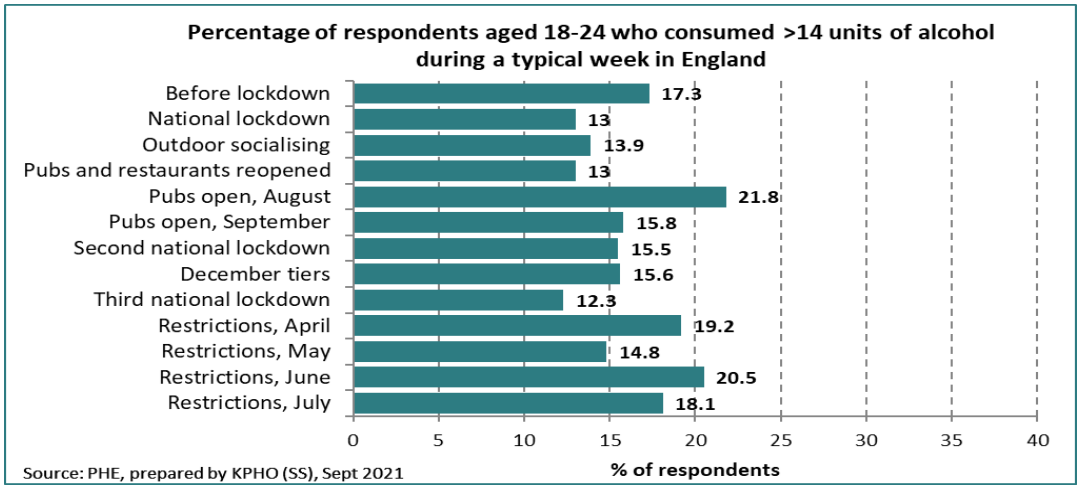


Figure 4: Proportion of respondents aged 25-34 years old who consumed >14 units of alcohol during a typical week in England

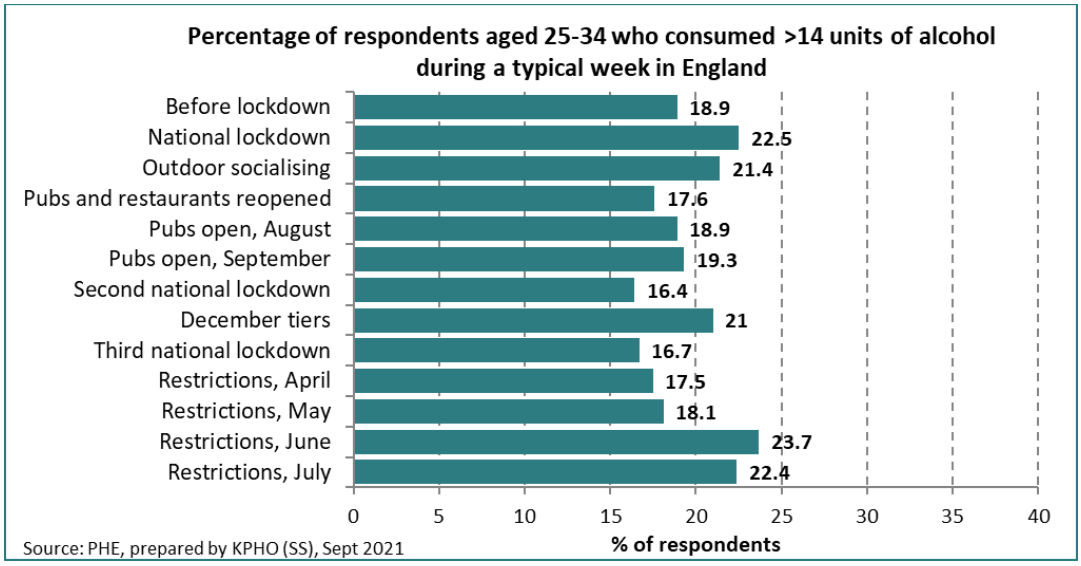


Figure 5: Proportion of respondents aged 35-44 years old who consumed >14 units of alcohol during a typical week in England

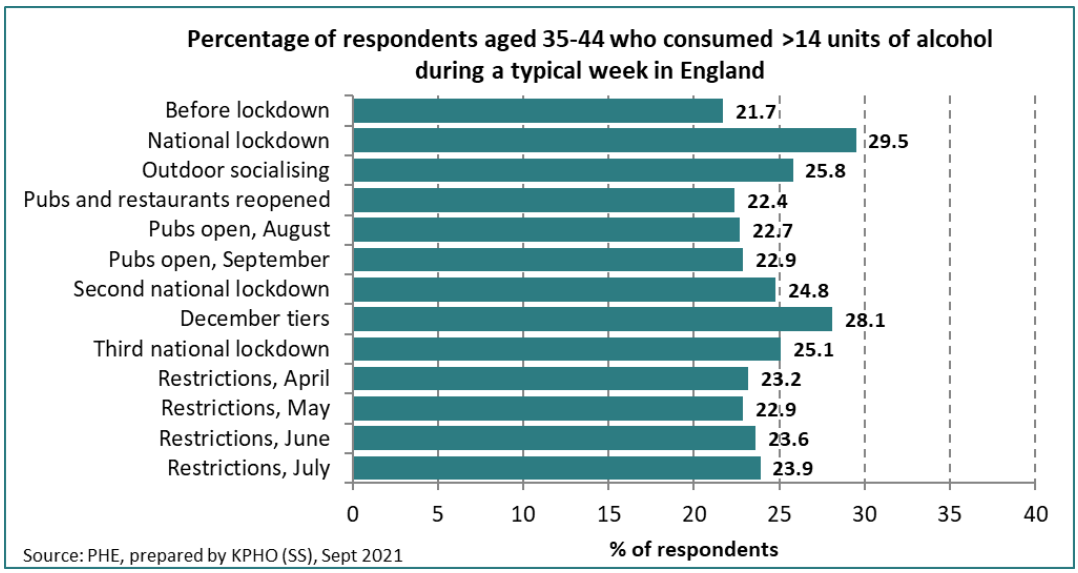


Figure 6: Proportion of respondents aged 45-54 years old who consumed >14 units of alcohol during a typical week in England

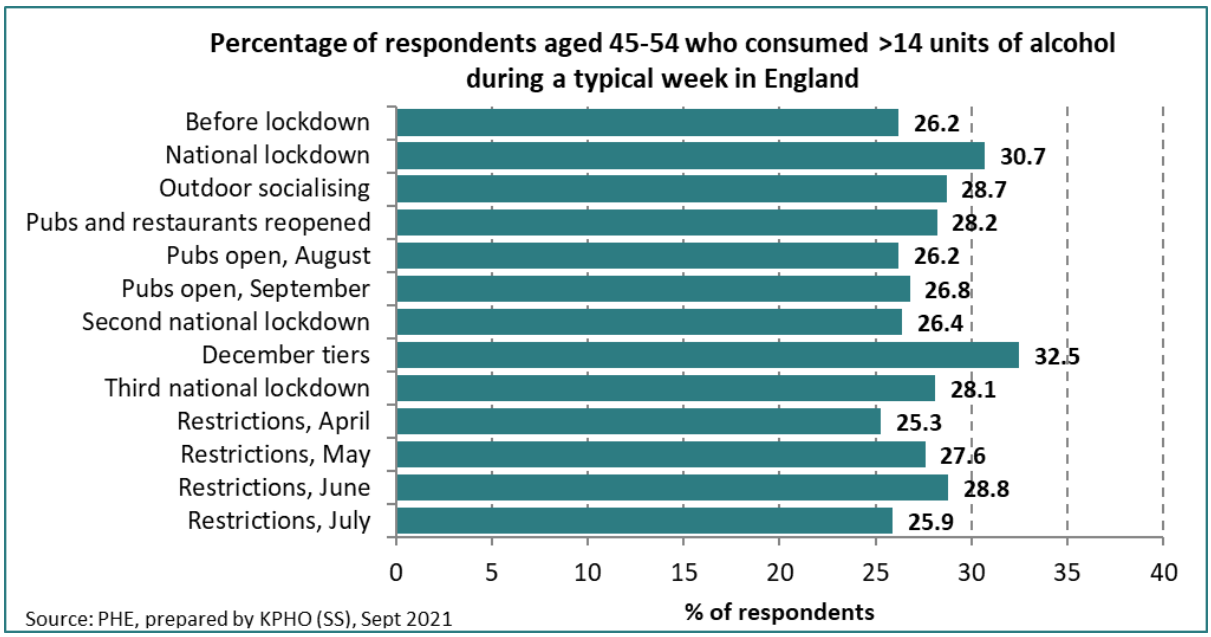


Figure 7: Proportion of respondents aged 55-64 years old who consumed >14 units of alcohol during a typical week in England

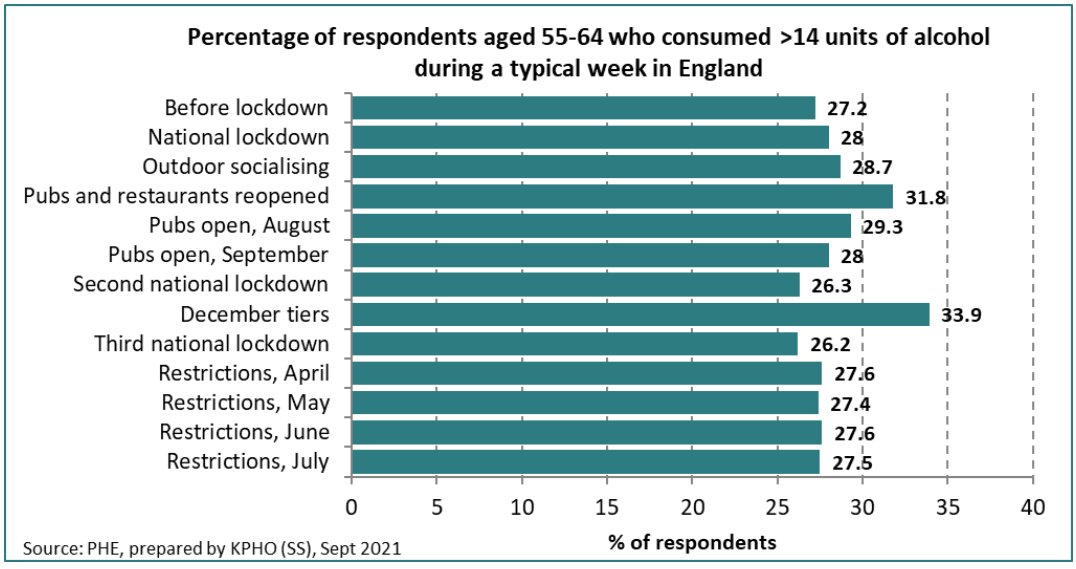


Figure 8: Proportion of respondents aged 65-74 years old who consumed >14 units of alcohol during a typical week in England

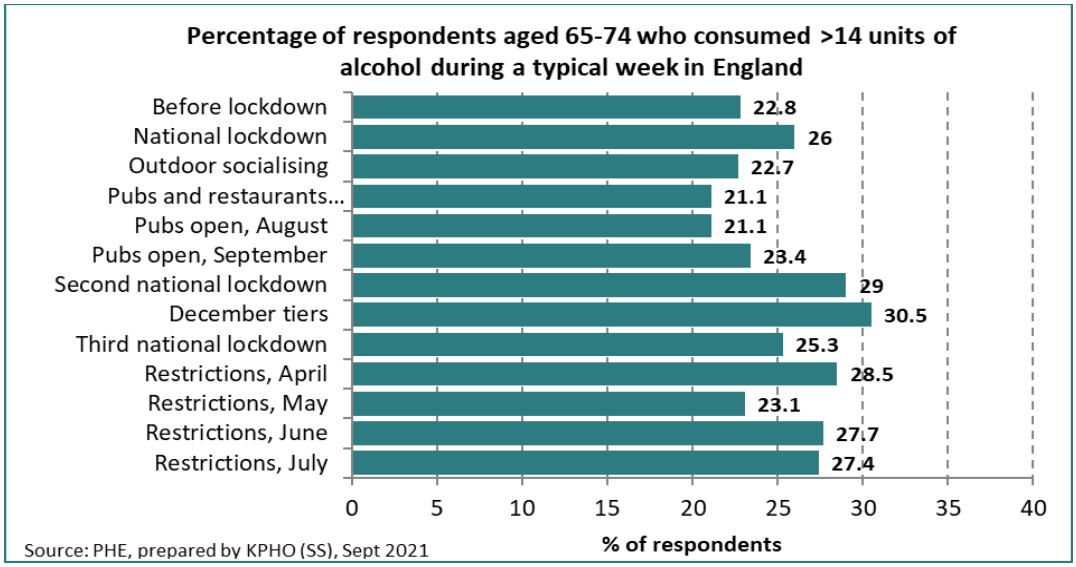
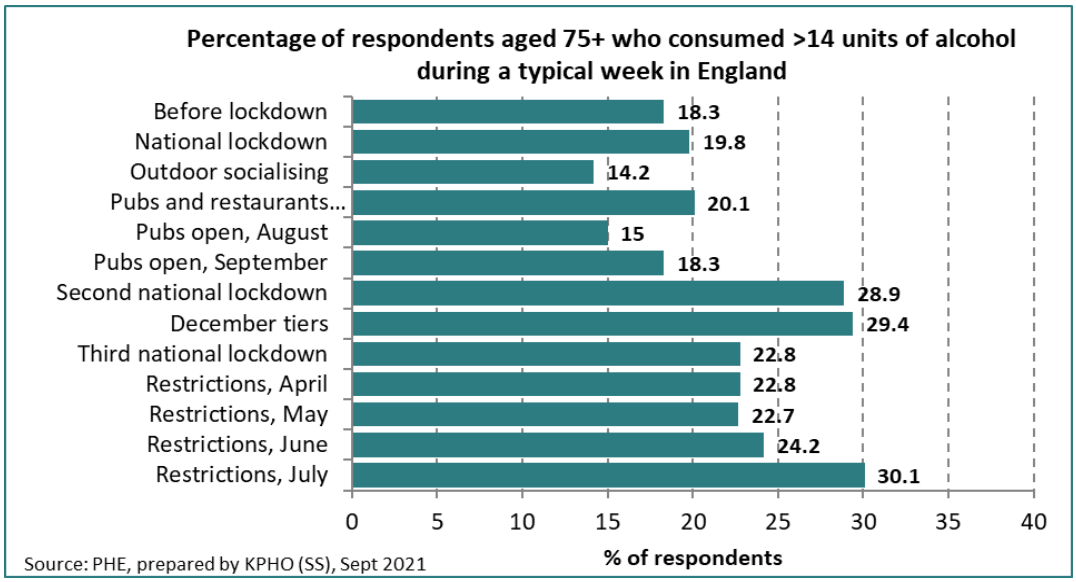


Figure 9: Proportion of respondents aged 75+ years old who consumed >14 units of alcohol during a typical week in England



7.3 Appendix 3: Kent Districts: Rates of Hospital Admissions for Alcohol Specific Conditions – by ward.

Figure 1: Hospital admissions for alcohol-specific conditions – by ward

Ashford:

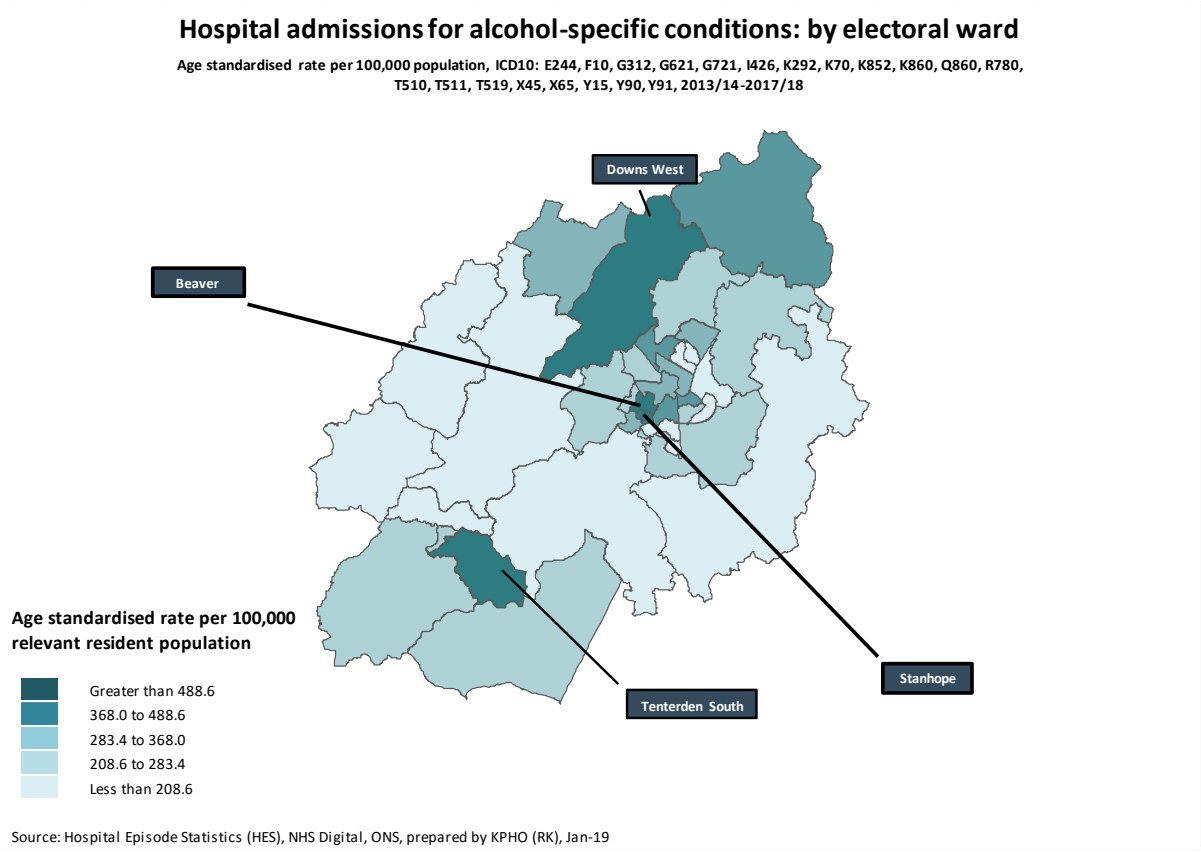


Figure 1- Data of hospital admissions for alcohol specific conditions in Ashford

Ashford CCG:

- Beaver
- Stanhope
- Downs West

Figure 2: Hospital admissions for alcohol-specific conditions – by ward

Canterbury

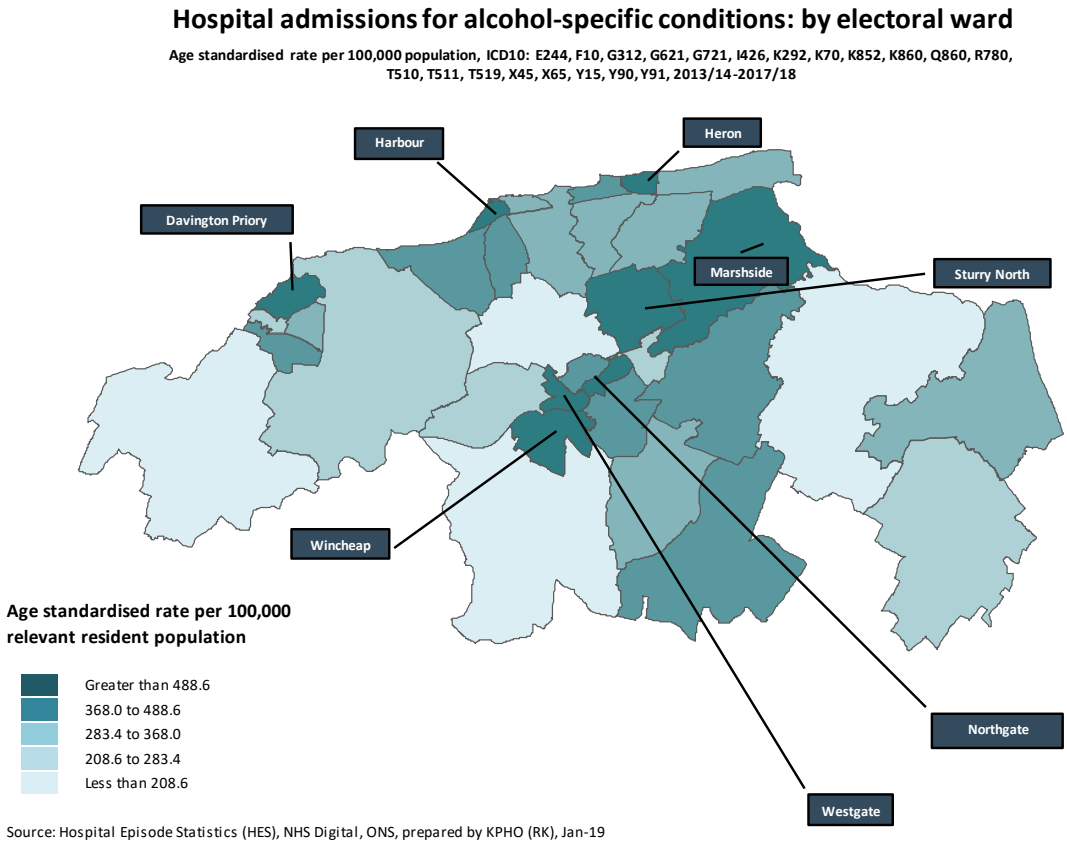


Figure 2- Hospital admissions for alcohol specific conditions in Canterbury

Canterbury & Coastal CCG

- Heron
- Northgate
- Sturry North
- Harbour
- Wincheap
- Davington Priory
- Marshside
- Westgate

Figure 3: Hospital admissions for alcohol-specific conditions – by ward

Dartford Gravesham and Swanley

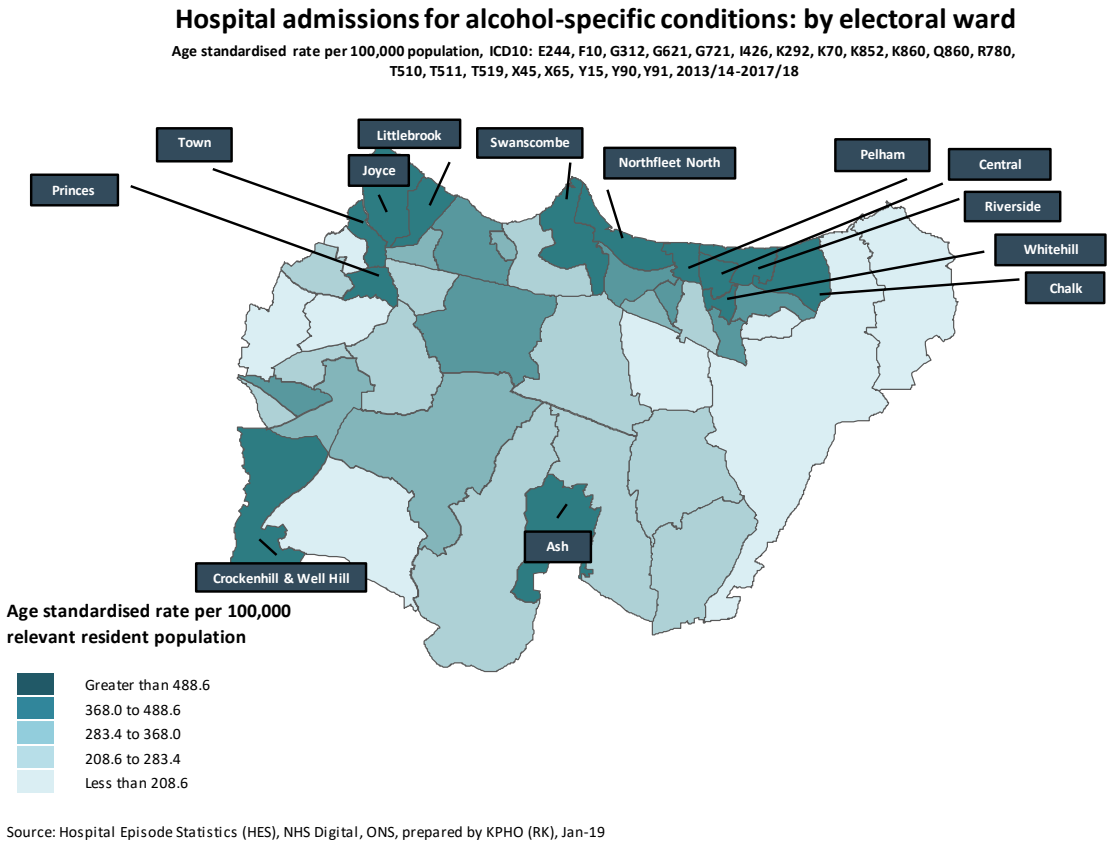


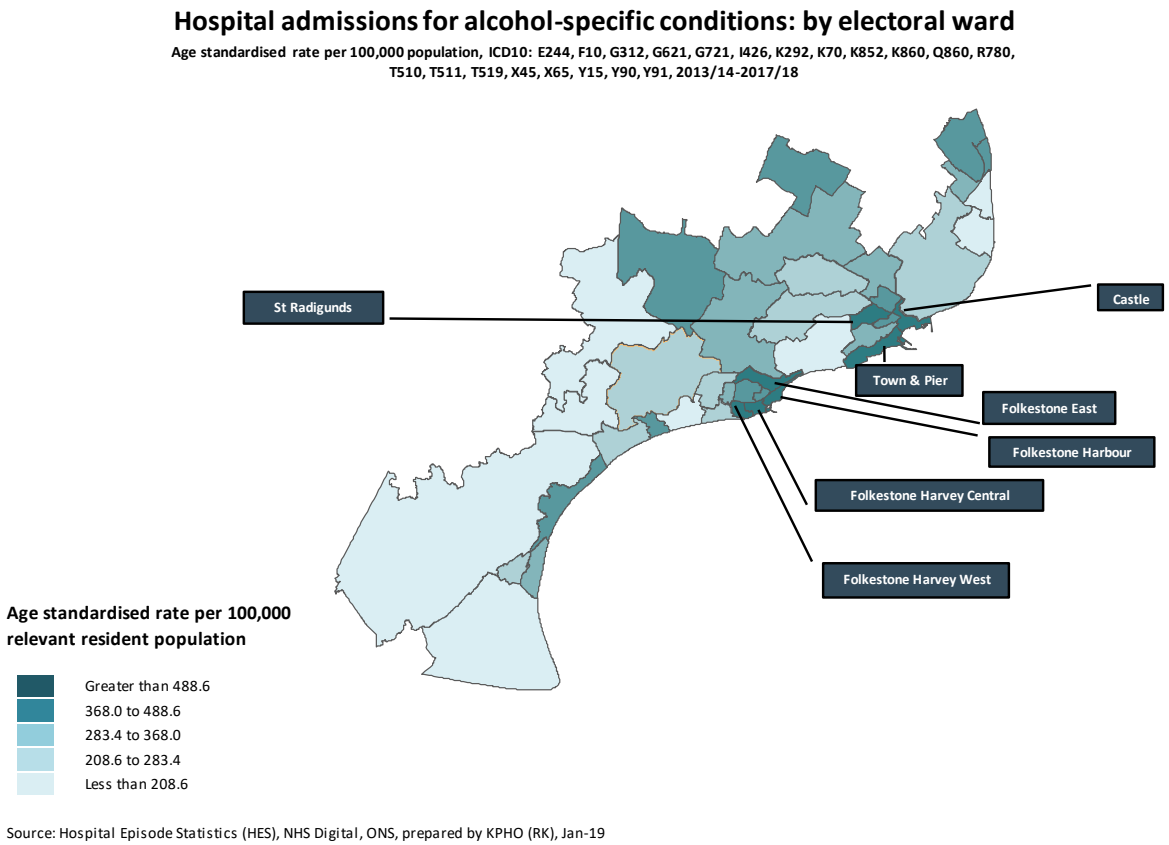
Figure 3- Hospital admissions for alcohol specific conditions in Dartford, Gravesham and Swanley

Dartford Gravesham and Swanley CCG

- Pelham
- Riverside
- Northfleet North
- Crockenhill and Well Hill
- Central
- Town
- Littlebrook
- Ash
- Swanscombe
- Whitehill

Figure 4: Hospital admissions for alcohol-specific conditions – by ward

South Kent Coast



Source: Hospital Episode Statistics (HES), NHS Digital, ONS, prepared by KPHO (RK), Jan-19

Figure 4- Hospital admissions for alcohol specific conditions in the South Kent Coast

South Kent Coast CCG

- Folkestone Harbour
- Castle
- Folkestone Harvey Central
- Folkestone East
- Folkestone Harvey West
- Town & Pier
- St Radigunds
- Middle Deal & Sholden

Figure 5: Hospital admissions for alcohol-specific conditions – by ward

Swale

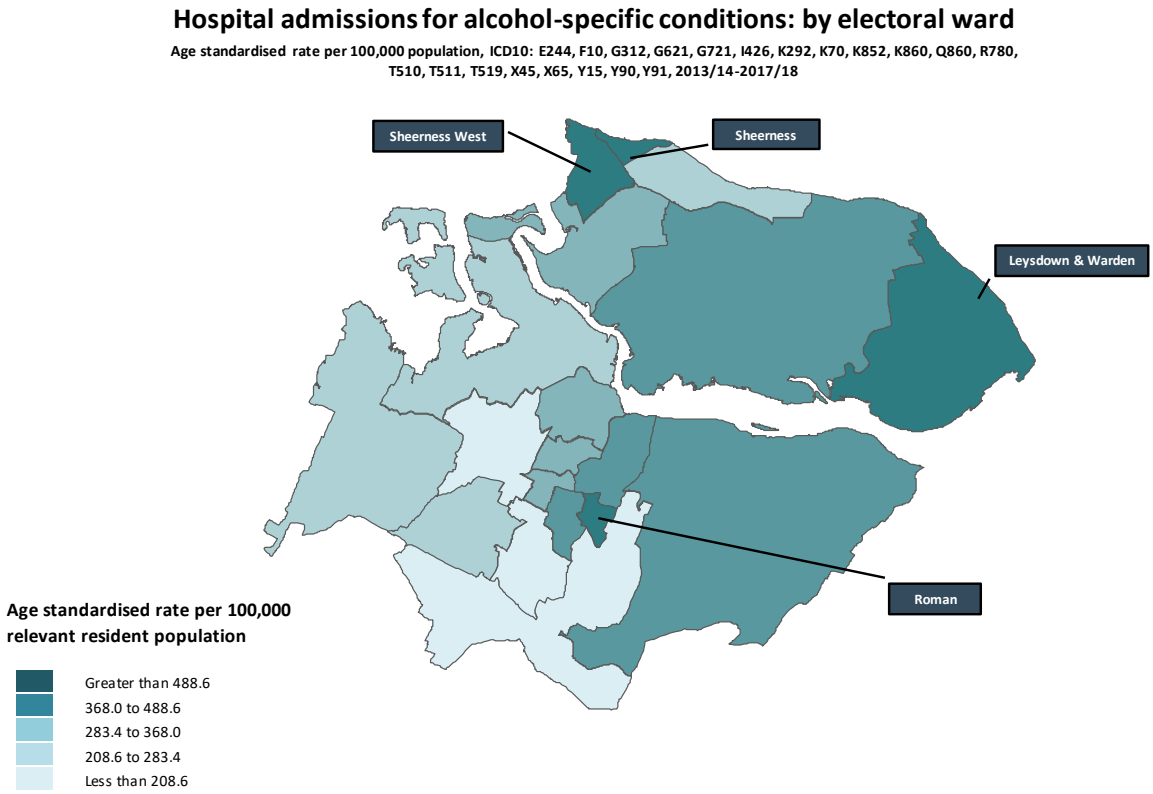


Figure 5 - Hospital admissions for alcohol specific conditions in Swale.

Swale CCG

- Sheerness East
- Roman
- Sheerness West
- Leysdown and Warden
- Murston

Figure 6: Hospital admissions for alcohol-specific conditions – by ward

Thanet

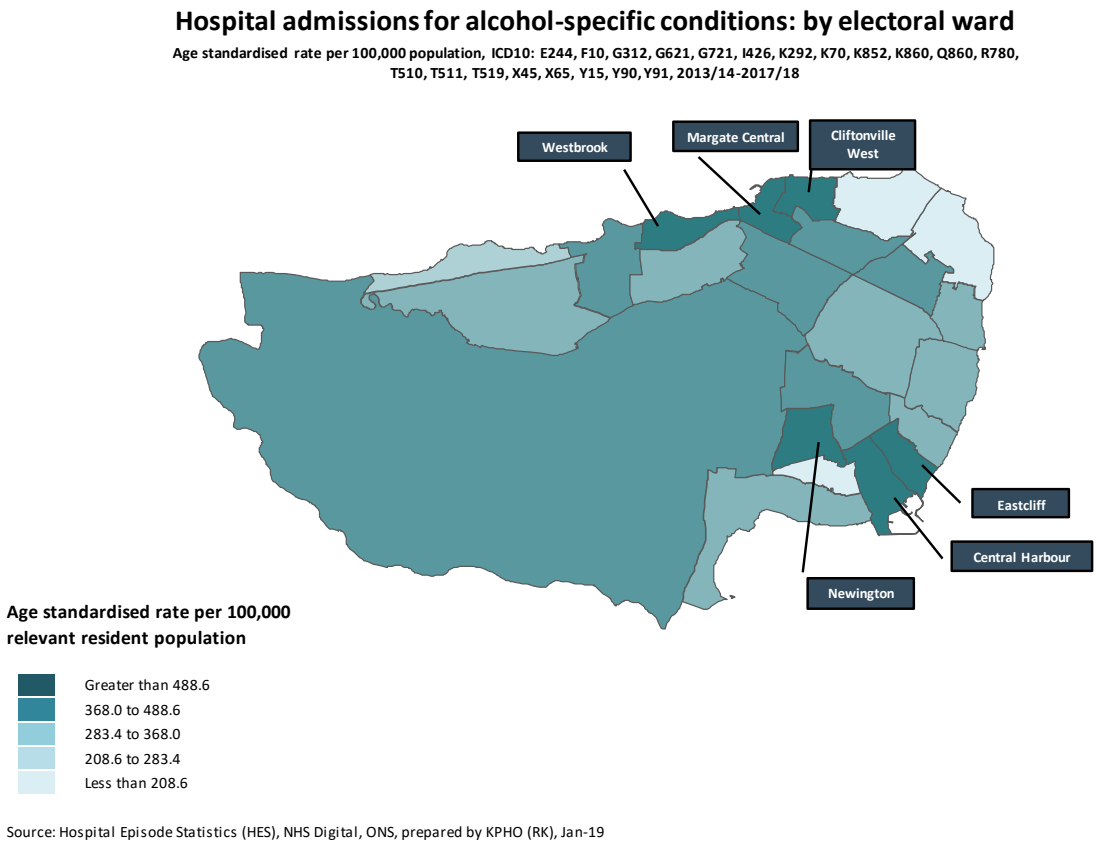


Figure 6- This is the map of hospital admissions for alcohol specific conditions by electoral ward via Thanet

Thanet CCG

- Cliftonville West
- Margate Central
- Eastcliffe
- Central Harbour
- Westbrook
- Newington

Fig 7: Hospital admissions for alcohol-specific conditions – by ward

West Kent

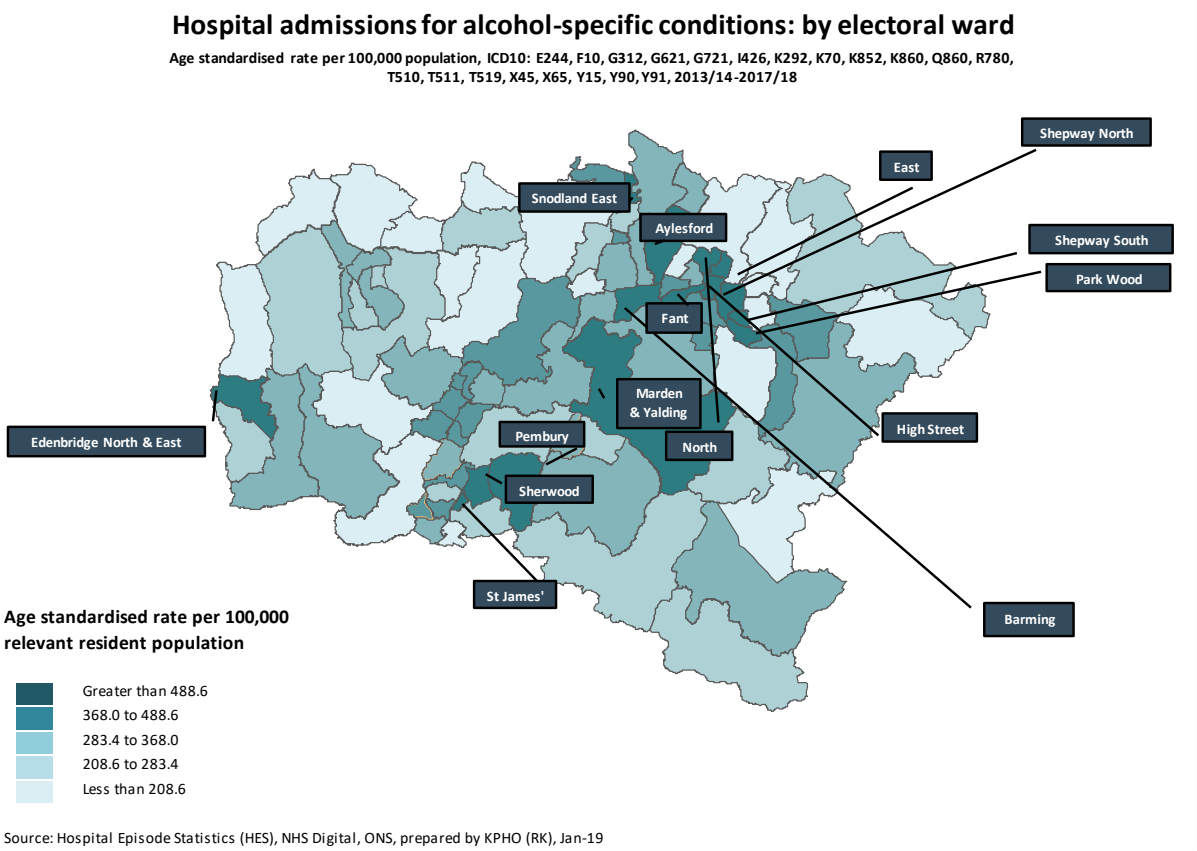


Figure 7 - This diagram shows the hospital admissions for alcohol specific conditions by electoral ward in West Kent.

West Kent CCG

- High Street
- Shepway South
- North
- Pembury
- Marden and Yalding
- St James's
- Park Wood
- Shepway North
- Fant
- Sherwood
- Aylesford
- East
- Edenbridge North and East

- Maidstone