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# LEICESTERSHIRE JOINT STRATEGIC NEEDS ASSESSMENT 2018-2021

## Alcohol Misuse in Adults

MARCH 2019

Strategic Business Intelligence Team  
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Whilst every effort has been made to ensure the accuracy of the information contained within this report, Leicestershire County Council cannot be held responsible for any errors or omission relating to the data contained within the report.

## FOREWORD

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The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Leicestershire, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs. The JSNA offers an opportunity for the Local Authority, CCGs and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCGs and NHS England must be able to explain why.

The Health and Wellbeing Board has agreed that the JSNA will be published in subject-specific chapters throughout a three-year time period. Chapters will be developed in line with CCG and local authority commissioning cycles. As many of the relationships required for the JSNA in Leicestershire are wide ranging, involving representation from NHS England, CCGs, Leicestershire Partnership Trust, University Hospitals of Leicester, District Councils and the voluntary sector, a JSNA Reference Group has been established. This Reference Group supports the JSNA work across the Health and Wellbeing Board. To examine the detail of the chapters, Task and Finish groups have been established to bring together local professionals, where they can share their expert knowledge on the work area being examined. The outputs of the JSNA will include:

1. Subject-specific chapters of an assessment of current and future health and social care needs
2. An online infographic summary of each chapter available on the internet
3. An online data dashboard that is updated on a quarterly basis to allow users to self-serve high level data requests

The JSNA has reviewed the population health needs of the people of Leicestershire in relation to alcohol misuse. This has involved looking at the determinants of alcohol misuse, the health needs of the population in Leicestershire, the impact of alcohol misuse, the policy and guidance supporting alcohol misuse, existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

Please note, the majority of indicators presented in this needs assessment are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. The term significance is used throughout the report and refers to statistical significance. This examines if the result presented is different to the national result, due to something other than chance. Most often, this is calculated using 95% confidence intervals.

## EXECUTIVE SUMMARY

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Compared to England, Leicestershire has a significantly lower (worse) proportion of its population who abstain from alcohol (16% nationally vs 8% locally). Alongside this, Leicestershire has a significantly higher proportion of adults who drink more than 14 units per week compared to the national average (30% vs 26%) and a significantly higher proportion who binge drink compared to the national average (21% vs 17%).

Furthermore, it is estimated that there are nearly 5,500 alcohol dependent adults in Leicestershire who may benefit from treatment for their alcohol misuse. While the numbers in treatment for alcohol misuse has risen by 29% compared to the previous year, there are currently 826 adults reported to be in treatment which equates to an unmet need of 85%.

When engaged in treatment, people consume less alcohol, commit less crime, improve their health, and manage their lives better. Preventing early drop out and keeping people in treatment long enough to benefit contributes to these outcomes. For those leaving treatment in an unplanned way, the benefits are reduced. Although the proportion of unplanned exits from treatment is lower (better) locally compared to the national average (9% vs 14%), this equates to 40 people in 2017/18 who did not successfully complete treatment.

Alcohol misuse is often concurrent with drug misuse, tobacco use, and mental health and wellbeing problems. In Leicestershire:

- 2 out every 10 individuals in treatment for alcohol misuse also report drug misuse
- 60% of individuals accessing substance misuse treatment services report smoking tobacco compared with 12% of the general population
- Out of those who started treatment in 2017-18, almost half were identified as having a mental health treatment need for reasons other than their alcohol misuse. This is higher than the national average of 41%.

Alcohol is the leading risk factor for ill-health, early mortality and disability among men and women aged 15-49 years in the UK and the harm from alcohol affects a range of other public health outcomes. In Leicestershire in 2016/17 there were almost 4,000 admissions to hospital due to alcohol related causes and 186 deaths during 2015-17.

Furthermore, evidence shows that alcohol misuse is linked to crime. It is estimated that around three-quarters of those who come into contact with the UK's criminal justice system have a problem with alcohol, and over a third are dependent on alcohol.

The consequences of alcohol dependence impact on the individual, the family, the community, the economy, and on public sector resources. Furthermore, the relationship between alcohol consumption and deprivation is complex. While those on higher incomes have an increased propensity to drink, the adverse effects of alcohol are more apparent in those from lower socio-economic groups. Consequently, preventing and reducing the harms caused by alcohol misuse will contribute to reducing health inequalities and contribute to improving the health and wellbeing of the population.

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## 1. Introduction

A wide range of terminology is used when talking about alcohol misuse. The main language now used is dependent, higher risk, increasing risk and low risk drinking. These phrases have therefore been used where appropriate in this chapter. However, throughout the document references are made to historical language (based on older publications) which refer to harmful drinking, hazardous drinking and binge drinking.

The UK Chief Medical Officer (CMO) guidelines for men and women is that to keep health risks from alcohol to a low level, it is safest not to drink more than 14 units a week on a regular basis<sup>1</sup>.

There are multiple levels of risk in relation to drinking:

- **Lower-risk drinking:** Consuming up to 14 units per week over three or more days, but also having drink-free days each week.
- **Increasing risk drinking:** Regularly drinking 15-50 units (men) or 15-35 units per week (women).
- **Higher-risk drinking:** Regularly consuming more than 8 units per day or over 50 alcohol units per week (men) or more than 6 units per day or over 35 units per week (women).
- **Possible dependence:** A pattern of alcohol consumption that is causing mental or physical damage. Consumption (units per week): Drinking 35 units a week or more for women. Drinking 50 units a week or more for men<sup>2</sup>
- **Binge drinking:** a heavy drinking session in which someone drinks a lot of alcohol in a short period of time raising their risk of harm on that occasion

This JSNA does not include data, services or needs in relation to alcohol licensing, or community safety and crime. Whilst important areas of work for Public Health and district councils, licensing and community safety are not within scope of this chapter; information and data relating to community safety/crime is available at: <http://www.lsr-online.org/crime-and-community-safety.html>

## 2. Who is at risk?

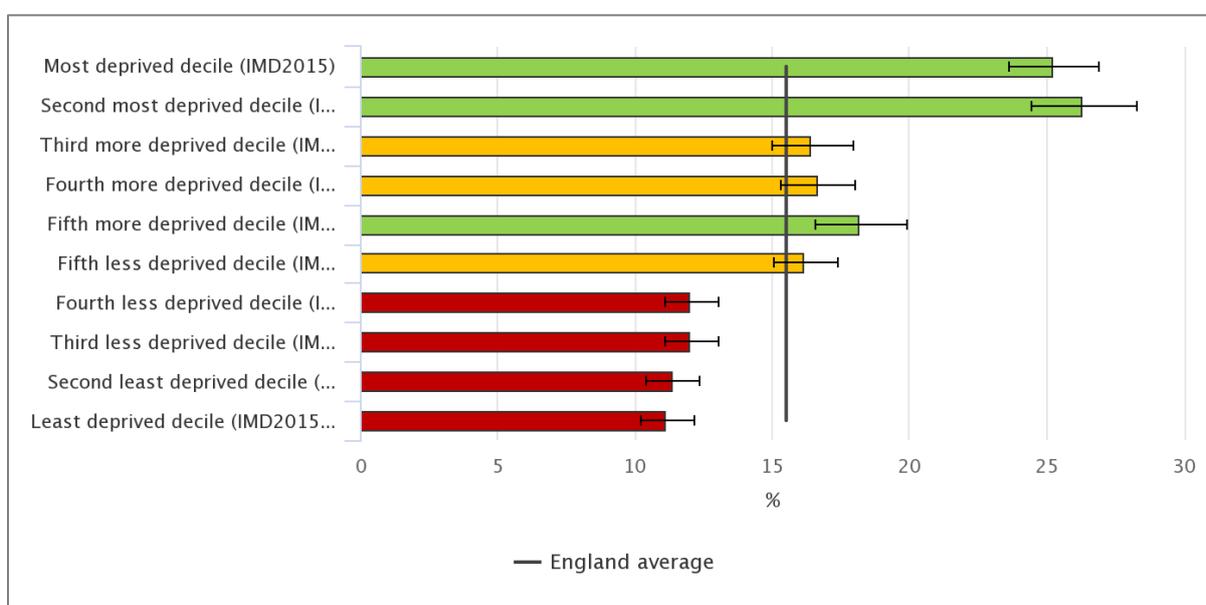
Several groups are identified in literature as being at high risk of misusing alcohol. These include those mentioned in this 'who is at risk' section. It is important to note that identification of the risk factors below does not mean an individual will inevitably misuse alcohol. Rather, evidence suggests these are some of the risk factors that increase the likelihood of this happening. These groups are not exclusive and individuals may have a range of interlinked vulnerabilities which increase their overall risk of alcohol misuse.

### 2.1. Socio-economic status

The relationship between alcohol consumption and socio-economic status is complex. While those on higher incomes have an increased propensity to drink, the adverse effects of alcohol, including hospital admissions for alcohol related causes and alcohol-related mortality are more apparent in those from lower socio-economic groups.<sup>6</sup> It is recognised that this may be exacerbated by interlinked variables such as ethnicity.

Figure 1 shows that the counties which fall into the 40% most affluent areas in England have a significantly lower proportion of residents who abstain from drinking compared to the counties in the rest of the country. The abstinence proportions presented are based on Health Survey for England data combined for years 2011-14.<sup>3</sup>

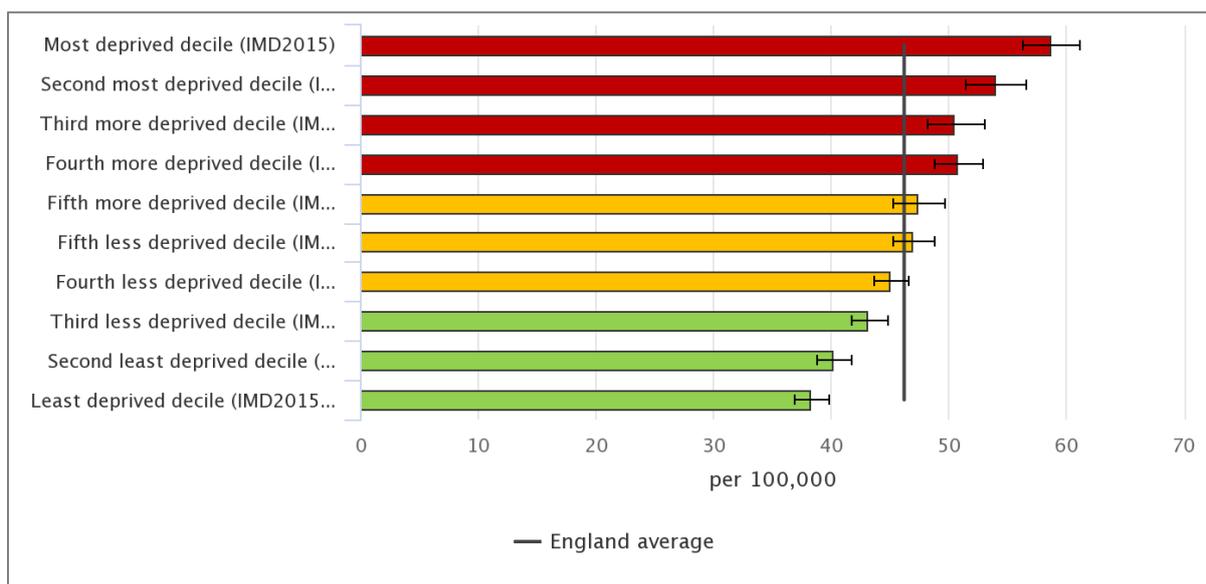
**Figure 1: Percentage of adults who abstain from drinking alcohol in England based on deprivation deciles (IMD2015) partitioned by county and unitary authorities<sup>3</sup>**



Source: Local Alcohol Profiles for England, Public Health England Fingertips

Mortality from alcohol related chronic conditions in 2017 is significantly higher in those living in counties which fall in the four most deprived deciles in England, compared to those falling in the least deprived deciles, as shown in Figure 2. The rate in the most deprived decile of England was 53% higher than in the least deprived decile<sup>3</sup>.

**Figure 2: Alcohol-related mortality in England based on deprivation deciles (IMD2015) partitioned by county and unitary authorities<sup>3</sup>**



Source: Local Alcohol Profiles for England, Public Health England Fingertips

In Leicestershire, just over 90,000 people (13.2%) in Leicestershire live in neighbourhoods falling in the four most deprived deciles nationally (out of a total population of over 680,000). Four neighbourhoods (of 396) in the county fall within the most derived decile in England. These areas can be found in Loughborough (Loughborough Bell Foundry and Loughborough Warwick Way LSOAs) and two in the Greenhill area of Coalville.<sup>4</sup>

For further information on the population and deprivation that exists throughout Leicestershire, please visit the Demographics JSNA chapter: <http://www.lsr-online.org/leicestershire-2018-2021-jsna.html>

## 2.2. Age and sex

The Health Survey for England (HSE) is a survey which monitors prevalence and trends of a range of health and care related indicators. It provides information about adults aged 16 and over, living in private households in England. One area of health that is measured within the

survey is alcohol consumption. In 2017, it was found that for men and women, the proportions of non-drinkers were highest in the youngest and oldest age groups. 50% of adults usually drank at least once a week or more often, with men more likely to do so than women, at 58% and 42% respectively. The proportion who drank once a week or more increased with age regardless of sex, before gradually decreasing from the age of 65. Within every age group, a higher proportion of men than women drank alcohol once a week or more. The harmful effects of alcohol are not often seen until older age.<sup>5</sup>

Whilst males consistently demonstrate higher levels of alcohol consumption than females, the level of consumption appears to have fallen more rapidly in recent years in males than females. Between 2005 and 2017, the Opinion and Lifestyle survey found males reporting to have drunk alcohol in the past week fell from 72% to 62%, whereas females fell from 57% to 52%.<sup>6</sup>

The population of Leicestershire is older than the population of England as a whole. In Leicestershire in 2016, 33.5% of the population were aged 40-64 and 20.2% were aged 65 and over, higher than the national percentages of 31.8% and 18.0% respectively.<sup>4</sup>

### **2.3. Ethnicity**

The Local Alcohol Consumption Survey piloted by Public Health England in 2017 found variation of alcohol consumption patterns amongst different ethnic groups. Nearly half (48.9%) of non-White people abstain from alcohol, whereas the corresponding proportion amongst their White counterparts was just under a fifth (18.7%)<sup>7</sup>. However it is important to note that grouping ethnic minority groups is likely to risk hiding the variation amongst different minority groups. Further, interlinked variables such as religion may be a larger contributing factor to these figures.

Another survey which provides estimates by ethnicity is the Opinions and Lifestyles Survey. In 2017, it was reported that 61.0% of White people in Great Britain said they drank in the last week, compared to 30.5% of 'other' ethnicities<sup>8</sup>. Notably, the change from the previous year was minimal for White respondents (61.5% to 61.0%), whereas respondents of 'other' ethnicities increased by 4.8 percentage points (25.7% to 30.5%).

In 2017, Public Health England published a Health Equity Report, with a focus on ethnicity, based on the indicators within the Public Health Outcomes Framework. One of the areas examined in this report was alcohol-specific hospital admissions compared to admissions for all causes. This comparison was examined by ethnicity and sex, based on 2014/15 data. It was found that there are variations in the ethnic group distribution of alcohol specific admissions compared with admissions for all causes for both males and females. Where the percentage

of alcohol specific admissions for a given ethnic group is larger than the percentage for all admissions, this means there is a disproportionate number of alcohol specific admissions for this ethnic group (shaded red in chart). For females, these groups included White British and White Irish; and for males these groups included White British, other White, Indian, other and White Irish.<sup>9</sup>

**Figure 3: Alcohol-specific hospital admissions compared to admissions for all causes in England by ethnicity and sex, 2014/15**

	All admissions (%)	Alcohol specific admissions (%)
White British	75.4	79.1
Other White	3.7	4.7
Indian	1.8	2.0
Other	1.6	1.7
White Irish	0.8	1.1
Other Asian	1.1	0.8
Black African	1.0	0.5
Black Caribbean	0.9	0.5
Pakistani	1.8	0.5
Other Black	0.5	0.4
Other Mixed	0.4	0.3
White and Black Caribbean	0.3	0.2
Bangladeshi	0.5	0.1
White and Asian	0.2	0.1
White and Black African	0.1	0.1
Chinese	0.2	0.0
Not given/not stated	9.8	7.9
<b>Total</b>	<b>100.0</b>	<b>100.0</b>

Figure 9d: Males, England, 2014/15.

	All admissions (%)	Alcohol specific admissions (%)
White British	74.6	84.5
Other White	4.4	3.3
Other	1.7	1.1
White Irish	0.7	0.8
Black Caribbean	1.0	0.5
Indian	1.9	0.4
Black African	1.4	0.4
Other Black	0.5	0.4
Other Mixed	0.4	0.4
White and Black Caribbean	0.3	0.3
Other Asian	1.1	0.3
White and Asian	0.2	0.2
Pakistani	2.0	0.1
White and Black African	0.2	0.1
Chinese	0.3	0.1
Bangladeshi	0.6	0.1
Not given/not stated	8.8	7.1
<b>Total</b>	<b>100.0</b>	<b>100.0</b>

Figure 9e: Females, England, 2014/15.

Source: PHE analysis of Hospital Episode Statistics data.

The vast majority of the county population belong to White ethnic groups. The Annual Population Survey (APS) via NOMIS in 2016 found that over 42,000 people (7.8% of the population) in Leicestershire were from ethnic minorities. This percentage is significantly lower than the national and regional percentage of 13.6% and 10.6% respectively.

#### 2.4. Sexual orientation and gender identity

The Health Report of LGBT groups in Britain, published by Stonewall in 2018 found 1 in 16 LGBT people said they drank alcohol almost every day over the last year. Frequency of alcohol consumption increases with age; a third of LGBT people aged 65+ (33%) say they drink almost

every day, compared to just seven per cent of LGBT people aged 18-24. One in five GBT men (20%) drank alcohol almost every day over the last year compared to 13 per cent of LGBT women and 11 per cent of non-binary people.<sup>10</sup>

The Part of the Picture research project is a five year study exploring drug and alcohol use among LGB people in England. The report of the project was published at the end of the third year of the study based on a sample of more than 4,000 responses collected between January 2009 and December 2011; it found that LGB people are approximately twice as likely to binge drink at least once a week, compared with the general population. The report further found significant barriers exist to seeking information, advice or help among LGB people with only third of respondents to their questionnaire had sought information, advice or help about their substance use.<sup>11</sup>

In the East Midlands in 2016, there was an estimated 92,000 residents who identified as gay, lesbian, bisexual, or 'other', which equated to 2.5% of the regional population, compared to 2.4% of the national population.<sup>12</sup>

## **2.5. Childhood**

Guidance from Public Health England notes family history of addiction is a recognised risk factor for alcohol misuse. There is a cyclical relationship between childhood experiences of, and exposure to, adult alcohol misuse, and subsequent misuse of alcohol in adulthood. The study of adverse childhood events (ACE's) in England found that compared to experiencing no childhood ACE's, children who experience four or more adversities are twice as likely to binge drink<sup>13</sup>, and four times as likely to be a higher risk drinker.<sup>14</sup> Parents or carers affected by ACE's are at increased risk of exposing their own children to ACE's, resulting in an intergenerational cycle.<sup>15</sup> With this, misusing alcohol can be a sign that young people are dealing with adversity, trauma and/or experimenting with their identities. Alcohol misuse hence overlaps with a range of other vulnerabilities which can also exacerbate their risk of abuse and exploitation. In England, one in ten adults lived at some point during their childhood with someone misusing, or dependent on, alcohol.

The Smoking, Drinking and Drug Use (SDD) among Young People in England survey questions secondary school pupils, aged 11 to 15 on certain health behaviours in exam conditions. Due to the difference in methodologies, the results of the SDD and What About Youth (WAY) surveys should not be directly compared. The SDD survey shows that substance misuse (including alcohol) amongst young people has been broadly in decline since 2001. The most recent survey in 2016 showed that 46% of girls and 43% of boys aged 11-15 had said they had ever had a drink. Whether a pupil had drunk alcohol was related to their age, increasing from 15% of 11 year olds to 73% of 15 year olds.

The 2014/15 What About Youth (WAY) survey is a home postal survey which questioned 15 year olds on various health behaviours, including drinking. The survey found 7.2% of Leicestershire's 15 year olds drank at least once a week, similar to the national average of 6.2%. When asked whether they had been drunk in the past 4 weeks, 16.7% of Leicestershire's 15 year olds said yes, significantly worse than the national average of 14.6%.<sup>16</sup> When examining results nationally, a significantly higher proportion of males reported being regular drinkers compared to females (6.6% and 5.9% respectively); while a significantly higher proportion of females reported being drunk in the last 4 weeks compared to males (17.7% and 11.6% respectively). Those from white ethnic groups had a significantly higher proportion drinking at least once in the last week, compared to the England average and all other ethnic groups. A significantly higher proportion of Gay/lesbian and Bisexual 15 year olds reported being drunk at least once in the last week compared to their heterosexual counterparts (10.7%, 12.4% and 6.0%)

## **2.6. Population groups**

### **2.6.1. Homeless**

The association between homelessness and drug misuse is complex. Problems with alcohol can be part of a person's spiral into homelessness, but homelessness can also result in alcohol misuse. As such, homelessness can be both a cause and consequence of alcohol misuse, although not everyone who has problems with alcohol becomes homeless, and not every homeless person has problems with alcohol misuse.

Homelessness can be defined in many ways: from statutorily homeless, single homeless people, rough sleepers and those at risk of homelessness. Many people who become homeless do not show up in official figures. This is known as hidden homelessness. This includes people who become homeless but find a temporary solution by staying with family members or friends, living in squats or other insecure accommodation. Research by the charity Crisis indicates that about 62% of single homeless people are hidden and may not show up in official figures. In Leicestershire, the number of rough sleepers has increased from 121 in 2010, to 313 in 2017.

The charity Crisis reports that nationally levels of drug abuse are relatively high amongst the homeless compared to the general population. During 2013-15, 27% of their clients reported problematic drug/alcohol use, with two thirds of homeless people citing drug or alcohol use as a reason for first becoming homeless. It is recognised that a safe, stable home can further enable people to sustain alcohol misuse recovery.

The 2017/18 National Drug Treatment Monitoring System (NDTMS) data shows that of the

450 individuals who had an accommodation status recorded at the start of treatment, 42 individuals reported a housing problem or urgent no fixed abode problem. This is just under one tenth (9.3%) of those with an accommodation status at start of treatment. In the same time period, there were 700 decisions taken by the local authority on homelessness applications, at a rate of 2.5 per 1,000 households. Please note this includes both positive and negative decisions in order to capture the demand on local authority housing provision.

### **2.6.2. Prisoners**

It has been estimated that around three-quarters of those who come into contact with the UK's criminal justice system (those in police custody, probation settings and the prison system) have a problem with alcohol, and over a third are dependent on alcohol. Many prisoners surveyed have indicated they had been drinking at the time of committing their offence. Figures ranging from 41%–70% have been reported.<sup>17</sup>

Nationally in 2016/17, 13% of adults in prison receiving treatment were in treatment for alcohol only, and 19% were in treatment for non-opiate and alcohol.<sup>18</sup>

Substance misuse can further be a problem for those released from prison. Nationally in 2017/18 32.1% of individuals who were transferred to a community treatment provider for structured treatment interventions for substance misuse (either drugs or alcohol) post-release, started treatment intervention within 3 weeks of release. Leicestershire and Rutland (combined) performed significantly better with 63.7% doing so, accounting for 179 individuals.

There are two prisons within Leicester and Leicestershire for males; Leicester prison and the Gartree prison near Market Harborough, Leicestershire. Female prisoners are most commonly sent to Peterborough prison.

### **2.6.3. Military Personnel and Veterans**

Data from a 2016 screening and advice initiative by the Defence Primary Health Care dental centre indicates that alcohol misuse within the UK Armed Forces population is higher than in the UK general population, with estimates of increased risk drinking levels within the Armed Forces ranging from 39% to 67% of the military population.<sup>19</sup> Between 2016/17, 61.2% of regular UK Armed Forces personnel were considered potentially at increasing or higher risk drinking. Alcohol drinking and misuse in the Army has a historical relationship and some evidence highlights that alcohol drinking patterns may be different depending on age and rank, with younger, single men being more at risk of alcohol misuse.<sup>20</sup> More recent evidence highlights that drinking patterns in the Army and drinking cultures have continued to change and alcohol intake is reducing.<sup>21</sup>

As with civilian members of the community, veterans can be vulnerable to substance misuse. Veterans sometimes use alcohol, and/or, drugs to cope with the physical and psychological effects of military service. These risks can be increased if their physical, and/or, mental health reduces their ability to find and hold long-term, fulfilling employment and secure accommodation. However, it is not possible to quantify how many veterans are misusing alcohol within local authority areas.

### **3. Level of need in Leicestershire**

#### **3.1. Prevalence**

Data from the Health Survey for England showed that approximately 8.2% of the population in Leicestershire abstained from drinking alcohol in 2011-2014. This is significantly worse than the national average of 15.5%, and 3<sup>rd</sup> worst when compared to CIPFA neighbours. This data was based on consumption at the point of answering the questionnaire; therefore it is possible that some individuals, who abstained from alcohol at the point of answering, might have drunk at risky levels in the past and hence remain at risk of developing alcohol-related conditions.

For the same time period, the survey also showed that Leicestershire has a significantly higher proportion of adults who drink more than 14 units per week, with 29.8% doing so compared to 25.7% across England. A significantly higher proportion locally also reported binge drinking (women more than 6 units, men more than 8 units) compared to the national average (21% and 16.5% respectively). Leicestershire is in the top two worst performing areas when compared to similar CIPFA neighbours for both these indicators. The Health Survey for England is a household survey - these are known to under-estimate alcohol consumption when compared to administrative sources such as sales data. This also means that people living in institutional settings, such as residential care homes, institutions, prisons, in temporary accommodation or rough sleeping are outside the scope of the survey.

Based on modelled estimates using the 2014 Psychiatric Morbidity Survey, the estimated percentage of adults with alcohol dependence in Leicestershire in 2014/15 was 0.97%, similar to the national average of 1.39%. Leicestershire performs second best when compared to similar CIPFA neighbours for this indicator.

In 2016-17, the estimated rate of alcohol dependent adults in Leicestershire was 1.01 per 100 adult population, compared to England's 1.35 per 100 adults.<sup>22</sup> This translated to 5,488 adults in Leicestershire.

### 3.1.1. Numbers in treatment

While numbers in treatment does not provide a prevalence estimate within the population, it does give insight into those who drink at levels to cause themselves, or others harm. It is likely that the true prevalence of this population is higher, and not all who could benefit from treatment, access it. The National Drug Treatment Monitoring System (NDTMS) collects regular activity and performance data from all public drug and alcohol treatment services in England and reports information on individuals receiving structured drug or alcohol treatment in each local area. For the purpose of this chapter, the service data presented includes all individuals who cited alcohol as their only substance misuse problem upon entering treatment, unless otherwise stated.

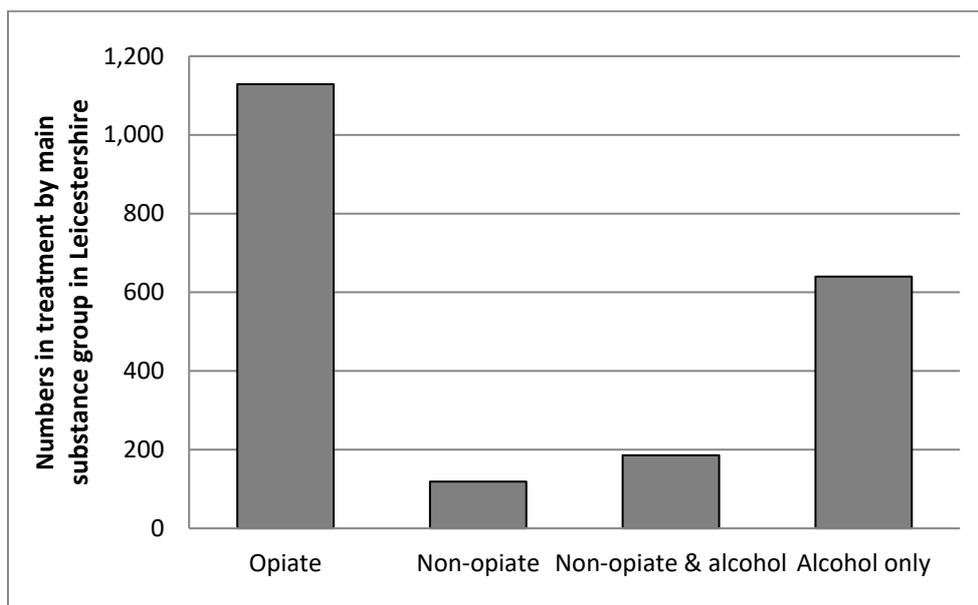
In 2017/18, there were 2,074 individuals in drugs and alcohol substance misuse treatment in Leicestershire. These individuals are segmented by the four substance groups in Table 1. Nationally, just over half the clients in treatment during the year (53%) had presented with problematic use of opiates, a further 19% had presented with problems with other drugs and just under a third (28%) had presented with alcohol as the only problematic substance. The comparative proportions in Leicestershire are 54%, 15% and 28% respectively. 'Alcohol only' was the second most common cited reason for accessing treatment following opiate use. This equates to 640 adults in drug treatment in Leicestershire in 2017/18.<sup>23</sup>

**Table 1: Numbers in treatment by main substance group, in Leicestershire, 2017-18<sup>23</sup>**

	Leicestershire		England
	Numbers	% of total	% of total
<b>Opiate</b>	1,129	54%	53%
<b>Non-opiate</b>	119	6%	9%
<b>Non-opiate &amp; alcohol</b>	186	9%	10%
<b>Alcohol only</b>	640	31%	28%
<b>Total</b>	2,074	100%	100%

Source: NDTMS, Local area trend report, 2017-18

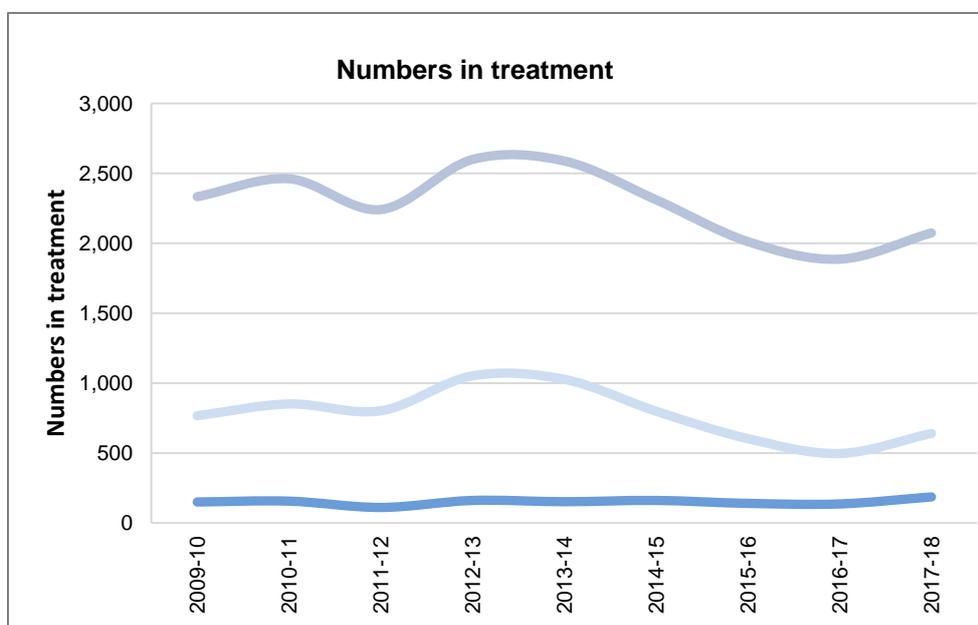
**Figure 4: Numbers in treatment by main substance group, in Leicestershire, 2017-18<sup>23</sup>**

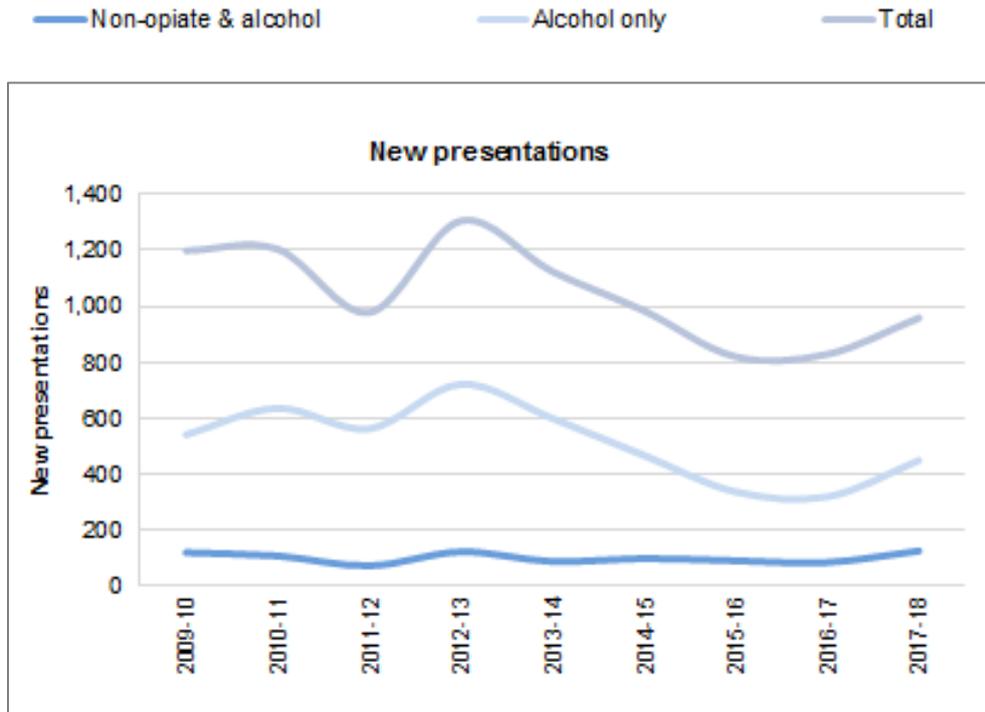


Source: NDTMS, Local area trend report, 2017-18

The numbers in treatment for alcohol misuse in 2017-18 had risen by 29% from the previous year (497 to 640). This increase is shown in Figure 5 and contributes to the overall increase in numbers in treatment. In the same year, there were 450 new presentations to treatment for alcohol misuse, a 41% increase of the previous year (320 new presentations). These new presentations are likely to be a contributing factor to the increase in numbers in treatment.<sup>23</sup>

**Figure 5: Trends in numbers presenting to treatment and new presentations to treatment by main substance group<sup>23</sup>**





Source: NDTMS, Local Area Trend Report 2017-18

For more information on substance misuse or alcohol and non-opiate use, please see the substance misuse JSNA chapter

### 3.1.1.1. In treatment by sex and age

The age-sex ratios of those in treatment in Leicestershire are generally comparable to national proportions, as shown in Table 2. There were more males than females in treatment for alcohol in Leicestershire in 2017-18, with males making up 59% of the alcohol only treatment cohort, and females 41%. This equates to 378 males and 262 females. Nationally there was a 60% and 40% split respectively. For both males and females, locally and nationally, the majority of those in treatment were aged 40-49, with just under a third falling into this age-sex group. The age bracket with the least numbers in treatment was those aged 80+, although these have been suppressed locally for disclosure control.<sup>24</sup>

**Table 2: Age and sex of all adults in treatment, in Leicestershire, 2017-18<sup>24</sup>**

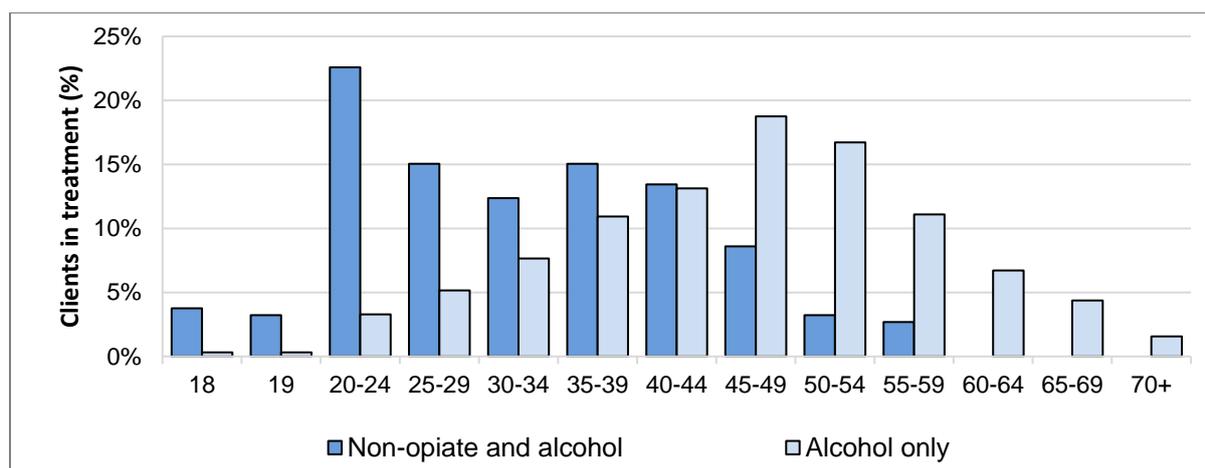
	Leicestershire	England					
	n	Proportion of all clients	Males	Females	Proportion of all clients	Males	Females
<b>18-29</b>	58	9%	8%	10%	9%	8%	10%
<b>30-39</b>	119	19%	18%	19%	22%	22%	22%
<b>40-49</b>	204	32%	31%	33%	31%	31%	31%
<b>50-59</b>	178	28%	29%	26%	26%	27%	26%
<b>60-69</b>	71	11%	12%	10%	10%	10%	9%
<b>70-79</b>	*	*	*	*	2%	2%	2%
<b>80+</b>	*	*	*	*	0%	*	*

\*suppressed for disclosure control purposes

Source: NDTMS, Alcohol commissioning support pack, 2019-20

Nationally, alcohol only clients have the oldest age distribution in drug and alcohol treatment services, followed by opiate clients. For Leicestershire, Figure 6 shows the alcohol only treatment group have an older age distribution than the non-opiate and alcohol group.

**Figure 6: Age distribution of all clients in treatment in Leicestershire, 2017/18<sup>23</sup>**



Source: NDTMS, Local Area Trend Report 2017-18

### **3.1.1.2. In treatment by ethnicity, sexual orientation and disability**

Of all people in treatment in Leicestershire in 2017/18 for alcohol misuse, 450 were new presentations who were starting treatment within that year. This equates to 70% of all alcohol clients, compared to 67% nationally. When splitting by ethnicity, 90% of new presentations identified as White British, accounting for 407 individuals. This is in line with the ethnic

breakdown in the Leicestershire population. The second most common ethnic group was Indian and 'other white', with 13 individuals each, accounting for 3% of new presentations. All other ethnic groups had counts of five or under. Of all new presentations, 91% identified as heterosexual, accounting for 408 individuals, with 3% identifying as bisexual, accounting for 15 individuals. 14% of new presentations reported at least one disability.

### **3.1.2. Hospital admissions:**

Alcohol-related hospital admissions can be due to regular alcohol use that is above lower risk levels and are most likely to involve increasing risk drinkers, higher risk drinkers, dependent drinkers and binge drinkers. Admissions can be categorised as 'alcohol-related' or 'alcohol-specific'. Alcohol-related conditions refer to those where alcohol is causally implicated in some, but not all cases, for example high blood pressure, various cancers and falls. Alcohol-specific conditions refer to those where alcohol is causally implicated in all cases e.g. alcohol poisoning or alcoholic liver disease.

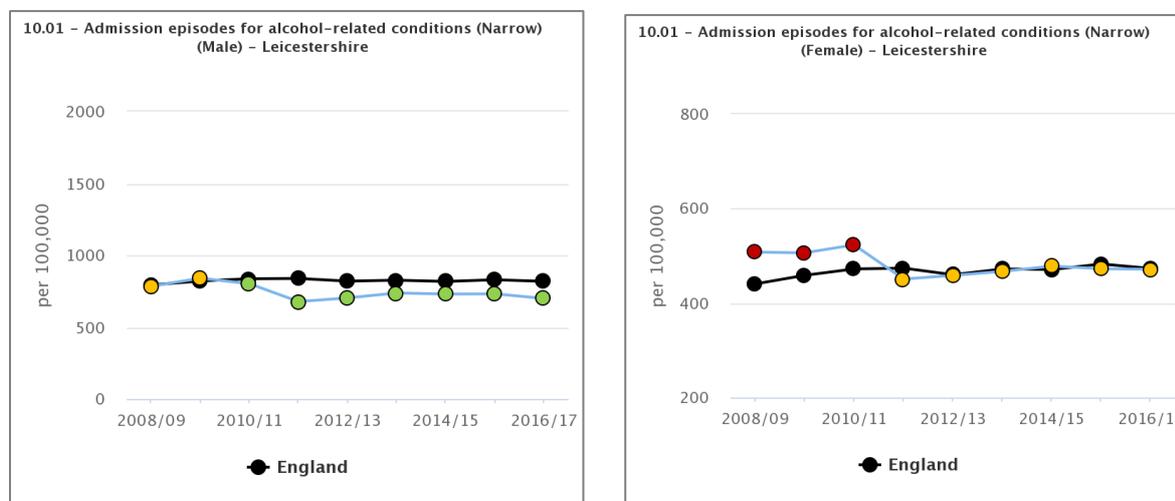
Admission episodes for alcohol-related conditions give an idea of the pressures from alcohol on health systems. Here, alcohol-attributable fractions are applied in order to estimate the number of admissions, rather than the number of people. Within this, there are two types of measure; broad and narrow. 'Broad' is an indication of the totality of alcohol harm in the local adult population, it includes admissions to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable code. 'Narrow' shows the number of admissions where an alcohol-related illness was the primary diagnosis or one of the secondary codes was identified as an external alcohol-attributable cause code. The narrow measure is more responsive to change resulting from local action on alcohol.

#### **3.1.2.1. Hospital admissions for alcohol related conditions**

In Leicestershire in 2016/17 there were 3,942 admissions to hospital due to alcohol related causes. This is based on the narrow definition for admissions. This equates to a rate of 578 per 100,000 population, significantly better than the England average of 636 per 100,000 population. Rates have stayed stable since 2011/12, and the latest data shows Leicestershire performs third best when compared to CIPFA nearest neighbours. The rate in males is higher than the rate in females, at 700 per 100,000 males and 472 per 100,000 females respectively. While Leicestershire males perform significantly better than the national average for males (818 per 100,000 males), Leicestershire females perform similar to the national average for females (473 per 100,000 females) and have done so since 2011/12. When analysing admission episodes for alcohol-related conditions by district, Blaby and Oadby and Wigston perform similar to national for males, while all other districts perform significantly better. In contrast, Hinckley and Bosworth was the only district to perform significantly better than

national for females, with all other districts performing similar to the national average.<sup>3</sup>

**Figure 7: Admission episodes for alcohol-related conditions (by narrow definition), for males and for females in Leicestershire compared to England, 2016/17<sup>3</sup>**



*Source: Local Alcohol Profiles for England, Public Health England Fingertips*

When examining by age and gender, the rate of alcohol-related hospital admission episodes amongst females aged under 40 years increased year-on-year from 2012/13 to becoming similar to the national average in 2016/17, and the rate amongst females aged 40-64 years was similar to England between 2011/12 to 2016/17. In males aged under 40 years, the rate of alcohol related conditions has performed significantly better than the national average since 2011/12. The rate amongst males aged 40-64 years has also been significantly better to England from 2010/11. The rate amongst males, females and persons aged over 65 has been similar to England for the last two years (2015/16 and 2016/17).<sup>3</sup>

When considering the broad definition for admissions, Leicestershire has consistently performed significantly better than England, for all individuals and both males and females, since recording began in 2008/09. There has been a gradual increase over this time with some fluctuations, largely in line with national trends. In 2016/17, there were 1,761 admissions per 100,000 population in Leicestershire, significantly better than the national rate of 2,185 per 100,000 population. All districts perform significantly better than the national average, with Oadby and Wigston having the smallest difference from the national average compared to all other districts, and Harborough the largest.<sup>3</sup>

### **3.1.2.2. Hospital admissions for alcohol specific conditions**

Leicestershire's admission rate for alcohol specific admissions in 2016/17 was 363 per 100,000 population, significantly better than the national rate of 563 per 100,000 population. This equates to 2,468 admissions, 1608 which are attributed to males and 860 which are attributed to females. All individuals, including males and females when individually analysed have performed significantly better than national since reporting began in 2008/09, showing small fluctuations over the years. Leicestershire performs in the top three for persons, males and females when compared to similar CIPFA neighbours in 2016/17. All districts also perform significantly better than the national average, with Oadby and Wigston showing the most fluctuation over the years.<sup>3</sup>

### **3.1.2.3. Frequent hospital admissions**

Data on individuals who are admitted to hospital frequently for alcohol-specific conditions have been included to give an indication of the number of drinkers who place a heavy burden on health services and, very often, on social, housing and criminal justice services. The fact that these people are suffering ongoing alcohol-specific ill health suggests that they may not have had contact with treatment services, or if they have, it is likely that they have not engaged with services for long enough for them to achieve sustained abstinence. In 2015/16 in Leicestershire, 173 individuals had been admitted into hospital for an alcohol-specific condition who had previously been admitted on one occasion; this equates to a rate of 26 per 100,000 population, significantly lower than the national rate of 45 per 100,000 population.

## **3.2. Dependent drinkers who may benefit from treatment**

In 2016/17, it is estimated that there were 5,488 individuals who were dependent drinkers who may benefit from treatment for alcohol, or alcohol and non-opiate misuse. This gives a rate of 10.1 per 1,000 population. In this time, there were 826 people in treatment, equating to 85% of those who may benefit from specialist alcohol treatment not receiving it. This is also termed 'unmet need'. The local rate of 85% is statistically similar to the national estimate of 82% unmet needs.<sup>24</sup>

## **3.3. Comorbidities/Co-occurrence**

### **3.3.1. Tobacco**

Smoking in people who use drugs and alcohol is highly prevalent and a major cause of illness and death.

The 2017 Annual Population Survey showed that 12.1% of Leicestershire's population were

self-reported smokers, significantly better than the England average of 14.9%. Of those Leicestershire residents accessing substance misuse services, 60% were smoking tobacco at the start of treatment. This suggests that smoking prevalence is higher for those in treatment for substance misuse compared to the general population.

The proportion of those accessing treatment services for alcohol misuse in 2017/18, who were identified as smoking tobacco at the start of treatment was 40% in Leicestershire, while the national average was 42%. When considering those who were in treatment for non-opiates and alcohol, 61% were identified as smoking tobacco at the start of treatment, both locally and nationally.

### **3.3.2. Drugs**

In 2017/18 in Leicestershire, there were 196 individuals in treatment for non-opiate and alcohol use, accounting for 9% of all those in treatment. While this is a small proportion of the total, this group saw the largest increase for numbers in treatment compared to the previous year (37%) and the largest increase of new presentations compared to the previous year (48%). Over a third (38.2%) of those in treatment for non-opiate and alcohol use successfully completed treatment.

For further information on drugs misuse, please refer to the substance misuse JSNA chapter available here: <http://www.lsr-online.org/leicestershire-2018-2021-jsna.html>

### **3.3.3. Mental Health**

Direct indicators of dual diagnosis are currently largely unavailable. However, mental health problems are common in those in treatment for alcohol use.

The proportion of people in concurrent contact with mental health services and alcohol misuse services in Leicestershire (and Rutland) (21.5%) was similar to England (22.7%) in 2016/17. This represents an increase from 2015/16 (15.0%) when Leicestershire's proportion was significantly lower than the national average.<sup>25</sup>

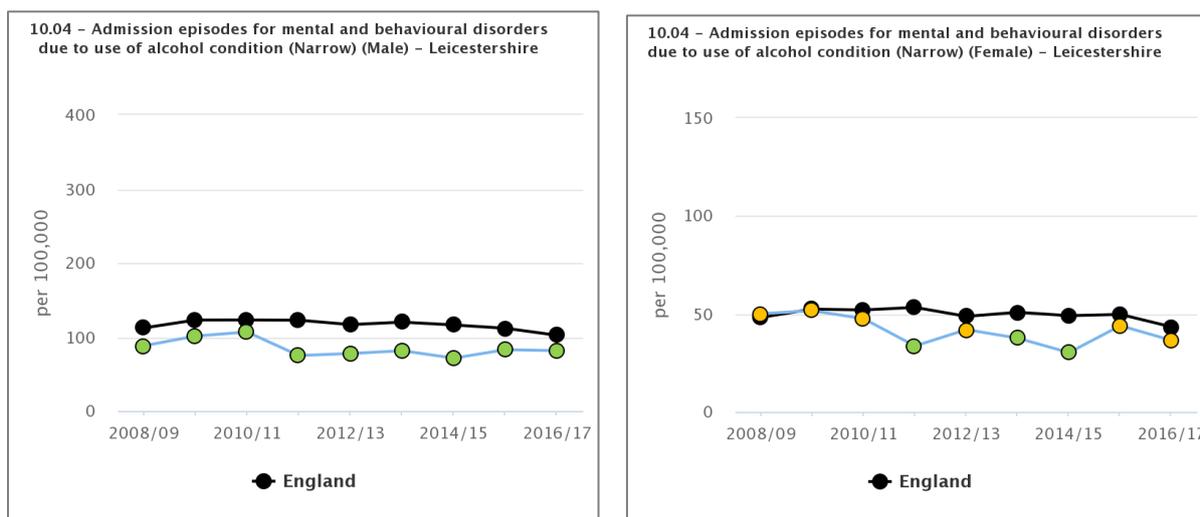
The NDTMS also reports on alcohol clients who started treatment in 2017-18 who were identified as having a mental health treatment need for reasons other than their alcohol misuse. In 2017/18, this equated to 221 individuals in Leicestershire, 49% of new presentations. This is higher than the national average of 41%. Although a lower number of females entered treatment compared to males, a higher proportion of them were identified as having a mental health need with 60% of new female presentations doing so. This is also higher than the national average for females of 46%. For males, figures were 41% and 38% respectively.<sup>24</sup>

In 2017/18, 203 individuals in treatment for their alcohol misuse problem were also receiving mental health treatment in Leicestershire – this accounts for 92% of those with a mental health need within that year, compared to 79% nationally. The majority of identified clients (75%) of those identified with a mental health need were receiving mental health treatment from their GP, compared to 53% nationally.

The rate of admission to hospital for mental and behavioural disorders due to alcohol by narrow definition has been significantly better (lower) in Leicestershire than national since recording began in 2008/09. In 2016/17, there were 58.7 admissions per 100,000 population, equating to 393 admissions. This compares to 72.3 admissions per 100,000 nationally.<sup>3</sup>

The rate of admissions in Leicestershire males is more than double that in females, with 81.4 admissions per 100,000 males compared to 36.5 admissions per 100,000 females. This accounted for 269 and 124 admissions respectively. Figure 8 shows that while males have continually performed significantly better (lower) than national since recording began in 2008/09, the rate in females has fluctuated between performing similar to national and better than national. For the past two years, Leicestershire females have performed similar to the national average.<sup>3</sup>

**Figure 8: Admission episodes for mental and behavioural disorders due to use of alcohol condition (by narrow definition), for males and females in Leicestershire, compared to England, 2016/17<sup>3</sup>**

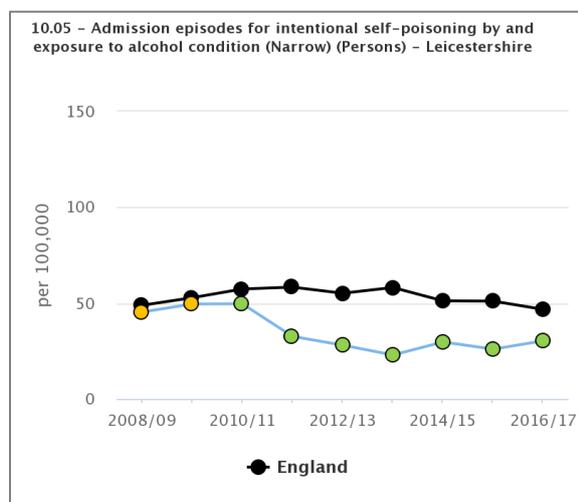


Source: Local Alcohol Profiles for England, Public Health England Fingertips

The rate of admissions for self-poisoning by and exposure to alcohol (by narrow definition) in Leicestershire in 2016/17 is 30.3 per 100,000 population, significantly better than the national average of 46.7 per 100,000 population. Leicestershire’s admission rate has been significantly better (lower) than national since 2010/11. The rate in females is significantly higher than the rate in males at 36.9 admissions per 100,000 females compared to 24.2 per 100,000 males.

However, both males and females admissions are lower than the national rates (29.7 per 100,000 males and 53.7 per 100,000 females respectively) and have been so since 2011/12.<sup>3</sup>

**Figure 9: Admission episodes for intentional self-poisoning by and exposure to alcohol condition (by narrow definition) in Leicestershire, 2016/17<sup>3</sup>**



Source: *Local Alcohol Profiles for England, Public Health England Fingertips*

### 3.4. Harm reduction interventions

#### 3.4.1. Identification and brief advice

Not all people estimated to have some level of alcohol dependence will need specialist alcohol treatment. Some will benefit from a brief intervention consisting of a short alcohol health risk check in a range of health and social care settings. In some cases simple feedback of the risk with a leaflet maybe all that is required.

#### 3.4.2. Alcohol brief interventions

The Alcohol Brief Intervention (ABI) Service is a short, evidence-based, structured and non-confrontational conversation about alcohol consumption. The service seeks to motivate and support an individual to think about and plan changes in their drinking behaviour in order to reduce their consumption and their risk of harm. The alcohol brief intervention service comprises four different components:

- Patients (16+) screened using the shortened AUDIT-C questionnaire
- Patients (16+) screened positive using the AUDIT-C questionnaire, further assessed using the full ten-question AUDIT questionnaire to determine increasing, higher risk or likely

dependent drinking.

- Patients (16+) identified as drinking at increasing risk or higher risk levels who have received a brief intervention to help them reduce their alcohol-related risk.
- Registered patients (16+) identified as likely dependent drinking who have been referred for specialist advice for dependent drinking.

The service is cumulative and all clients will be offered the AUDIT-C screening, with clients only being offered the next level of the service if assessed as necessary. As of 2017/18, the service is now open to any provider based in a clinical setting, including GPs and community pharmacies as well as other suitable providers. There are 19 pharmacies in Leicestershire that provide an alcohol brief intervention as of 31st March 2017: six in Charnwood, four each in Hinckley and Bosworth and in Oadby and Wigston, three in Harborough, and one each in Blaby and North West Leicestershire. Three of these are 100 hour pharmacies, with one each located in Harborough, Charnwood and Hinckley and Bosworth. Throughout Leicestershire and Rutland between Q4 2017/18- Q3 2018/19, nearly 60,000 patients aged 16 years or over were screened using the shortened AUDIT-C questionnaire in General Practices. The screening identified 1,670 existing patients and 792 new patients as drinking at levels of increasing risk. These patients received a brief intervention to help them reduce their alcohol-related risk. A further 231 patients (0.4%) were referred by the provider for specialist advice for dependent drinking from undertaking this AUDIT-C questionnaire.

### **3.5. Treatment pathway measures**

#### **3.5.1. Routes into treatment**

Routes into treatment are also known as source of referral i.e. the routes by which people accessed treatment. There are many possible sources of referral an individual can provide, these have been grouped by self, family & friends; health services and social care; criminal justice system (CJS); substance misuse service and other. The CJS is mainly made up of prison referrals, probation and arrest referrals, or court based referral scheme.

Table 3 shows the number of clients who were referred into treatment for alcohol broken down by their referral source in 2017/18. The most common route of referral locally and nationally was self-referral, accounting for 52% and 59% of all referrals respectively.<sup>24</sup>

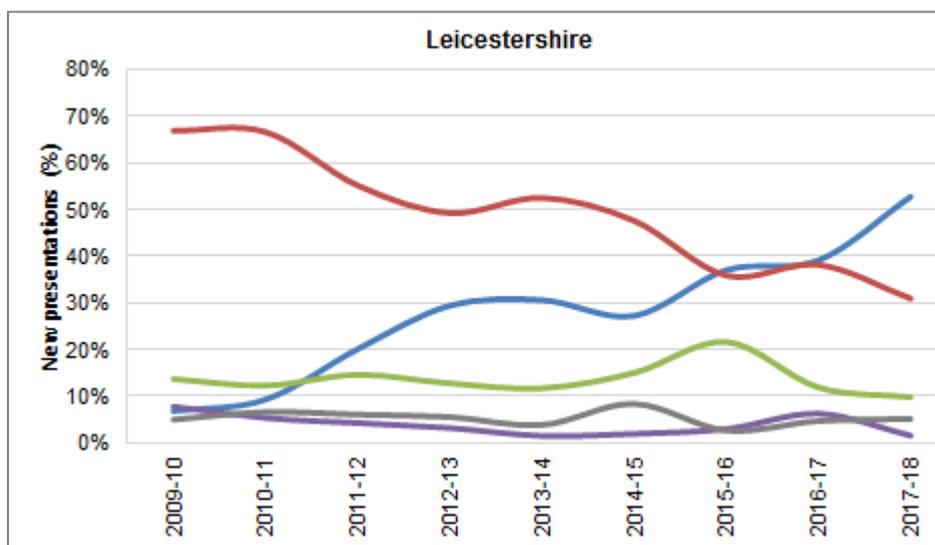
**Table 3: Routes into treatment, Leicestershire, 2017/18<sup>24</sup>**

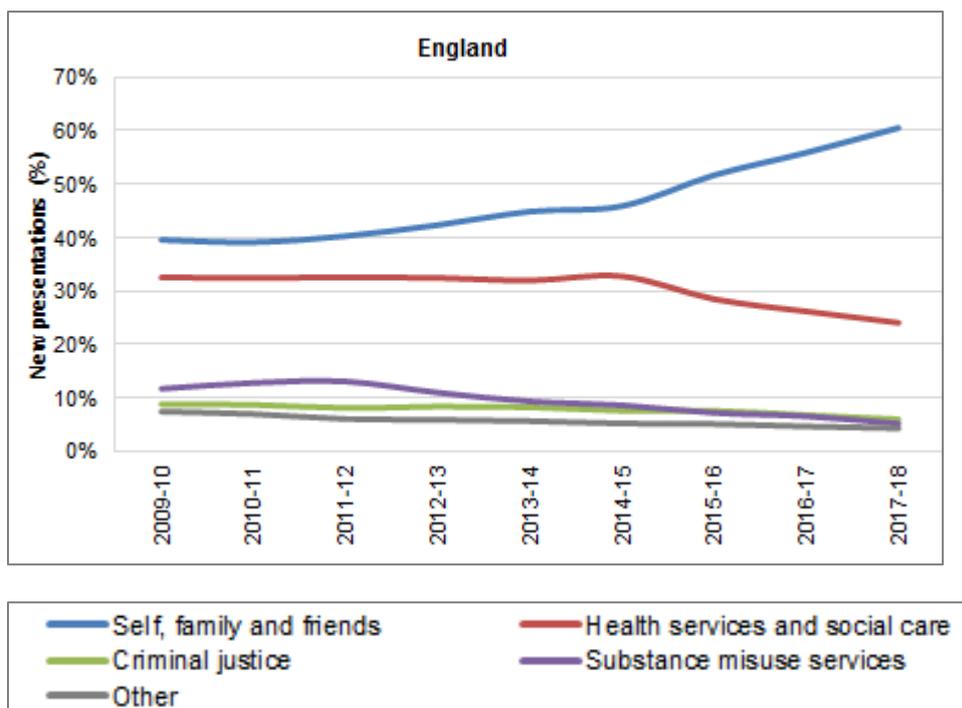
	Leicestershire		National
	n	Proportion of referrals	Proportion of referrals
<b>Self-referral</b>	233	52%	59%
<b>Referred through CJS</b>	44	10%	6%
<b>Referred by GP</b>	92	20%	14%
<b>Hospital/A&amp;E</b>	31	7%	5%
<b>Social Services</b>	11	2%	2%
<b>All other referral sources</b>	39	9%	14%

Source: NDTMS, Alcohol commissioning support pack, 2019-20

Figure 10 shows that when examining source of referral for alcohol misuse, the most common route is self, family and friends in 2017/18. This follows a long-term increase since 2009/10 equating to a 46 percentage point increase locally, over double the increase nationally (21 percentage points). During the same time period, the proportion of referrals from health services and social care has decreased, from 362 in 2009-10 to 139 in 2017-18. Locally this equates to a 35 percentage point decrease, compared to a 9 percentage point decrease nationally.<sup>23</sup>

**Figure 10: Trends in source of routes into treatment for Leicestershire and England**



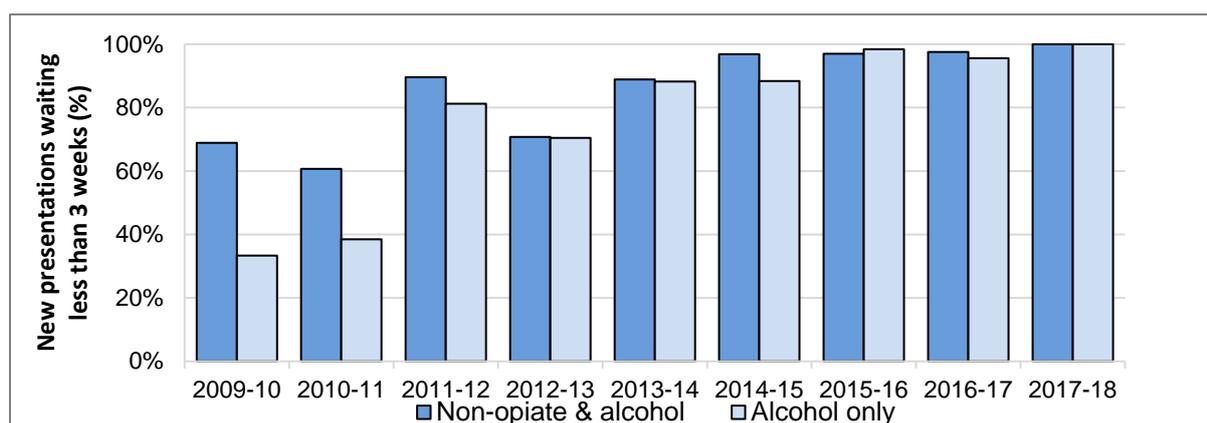


Source: NDTMS, Local Area Trend Report 2017-18

### 3.5.2. Waiting times

People who need alcohol treatment need prompt help if they are to recover from dependence. Waiting times refer to the number of first interventions that took less than three weeks from intervention referral to first offered appointment. Local efforts to keep waiting times low mean that the national average waiting time is less than one week. Nationally, 98% of initial waits to start treatment were under three weeks in 2017/18.<sup>24</sup> In Leicestershire 100% of all initial waits for the start of treatment were less than three weeks. For the past three years, 95% or more of those waiting for first their first treatment intervention were seen in less than three weeks as shown in Figure 11.<sup>23</sup>

**Figure 11: Trends in waiting times of three weeks and under for first intervention<sup>23</sup>**



Source: NDTMS, Local Area Trend Report 2017-18

### **3.5.3. Treatment Engagement**

When engaged in treatment, people use alcohol less, commit less crime, improve their health, and manage their lives better. Preventing early drop out and keeping people in treatment long enough to benefit contributes to these improved outcomes. As people progress through treatment, the benefits to them, their families and their community start to accrue. For those leaving treatment in an unplanned way/dropping out, the positive outcomes/benefits are reduced.

In 2017/18, 9% of new presentations in Leicestershire left treatment in an unplanned way, without being discharged as completed treatment, before 12 weeks. This equates to 40 people who were in treatment for alcohol. The Leicestershire proportion is lower (better) than the national average of 14%.<sup>24</sup>

### **3.5.4. Length of time in treatment**

NICE Clinical Guidelines CG115 recommends harmful and mildly dependent drinkers receive a treatment intervention lasting three months, those with moderate and severe dependence should receive treatment for a minimum of six months, while those with higher or complex needs may need longer in specialist treatment.

The length of a typical treatment period is just over six months, although nationally 12% of clients remained in treatment for at least a year. Retaining clients for their full course of treatment is important in order to increase the chances of long-term recovery. Conversely, having a high proportion of clients in treatment for more than a year may indicate that they are not moving effectively through and out of the treatment system.

Of all clients who exited treatment in 2017-18, the average time in treatment was 200 days; the national average over the same time was 190 days. With this, Table 4 shows the majority of clients both locally and nationally, were in treatment for three to six months.<sup>24</sup>

**Table 4: Length of time in treatment as a percentage of all exits, 2017/18<sup>24</sup>**

	Leicestershire		England
	n	% of all exits	% of all exits
<b>&lt; 1 month</b>	16	4%	9%
<b>1 to &lt; 3 months</b>	80	21%	26%
<b>3 to &lt; 6 months</b>	121	32%	31%
<b>6 to &lt; 9 months</b>	75	20%	15%
<b>9 to &lt; 12 months</b>	43	11%	8%
<b>12 months and over</b>	41	11%	12%

*Source: NDTMS, Alcohol commissioning support pack, 2019-20*

### **3.5.5. Residential rehabilitation**

Alcohol treatment mostly takes place in the community, near to users' families and support networks. Residential rehabilitation may be cost effective for someone who is ready for active change and a higher intensity treatment at any stage of their treatment. In 2017/18 in Leicestershire, 20 individuals attended residential rehabilitation for alcohol only treatment. This makes up 3% of the treatment population; nationally 3% of the treatment population attended residential rehabilitation.

### **3.5.6. In-treatment outcomes**

In-treatment outcomes are useful as predictors of continued recovery. In Leicestershire in 2017-18, 93 individuals who reported drinking at the start of treatment, reported no drinking in the 28 days before planned exit. This accounts for 40% of those who exited who reported drinking at the start of treatment, compared to 51% nationally. When splitting by gender, this proportion was higher in males than females (43% of all males and 35% of all females), and both were lower than national averages (50% and 52% respectively).

NDTMS also reports on the change in the average number of drinking days between the start of treatment and planned exits. The local averages (20.1 days and 12.0 days respectively) for 2017-18 are in line with national averages (20.7 days and 11.7 days respectively).

### **3.5.7. Completion of treatment**

The alcohol evidence review indicates that treatment is effective and cost-effective and is a

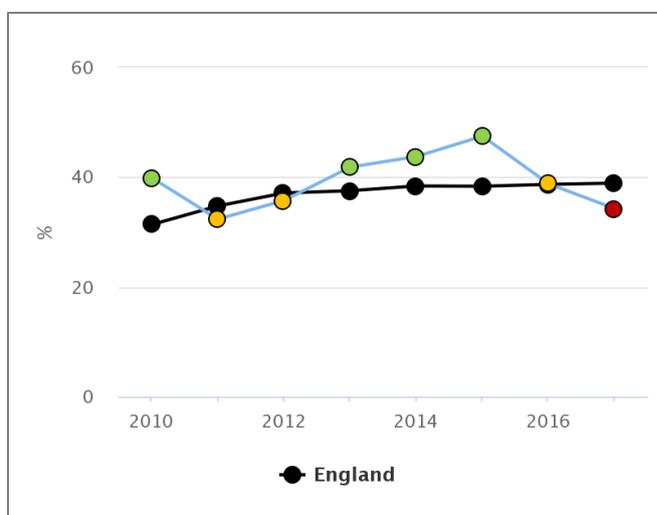
necessary part of any overall approach to reduce alcohol-related harm. Although there is no single measure of effective treatment for alcohol dependence, completion of treatment indicators can give an indication of how well the current system is working treating those who are receiving structured treatment. A high proportion of successful completions and a low number of re-presentations to treatment indicate that treatment services are responding well to the needs of those in treatment.

The proportion of clients whose latest treatment journey ended during 2017-18 and whose reason for discharge was 'treatment completed', as a proportion of all clients in treatment during 2017-18 was 69%, higher than the national proportion of 61%. Local percentages for males (70%) and females (67%) were higher than national averages (59% and 63% respectively).

Another definition of successful treatment is those who leave treatment free of alcohol dependence and do not re-present to treatment within six months. Since 2010, the national average has been gradually increasing as shown in Figure 12.

Over the same time period, Leicestershire and Rutland has no significant change in trend. Values have however fluctuated when compared to the national average, with the past three years showing a change from being significantly better (higher) than England in 2015, to similar to England in 2016 to significantly worse (lower) in 2017. In 2017, in Leicestershire and Rutland, just over one third (34.3%) of alcohol misuse clients successfully completed drug treatment without representing in six months, significantly worse than the national average of 38.9%.<sup>9</sup>

**Figure 12: Trends in successful completion of treatment, Leicestershire**



Source: *Public Health Outcomes Framework, Public Health England*

More recent local data from Turning Point shows for Q2 and Q3 2018, the percentage of successful completion of alcohol treatment with no representation in 6 months was 47.7% and 44.7% respectively. This is encouraging as it infers the successful completion percentage for the annual figure in 2018 is likely to be much higher than the annual figure published for 2017.

### **3.6. Harmful effects of Alcohol – Morbidity and Mortality**

Excessive alcohol consumption is a cause of preventable, premature death.<sup>26</sup> Harm from alcohol can be short-term and instantaneous, due to intoxication or long-term, from continued exposure to the toxic effect of alcohol or from developing dependence. Alcohol-related harm is largely determined by the volume of alcohol consumed and the frequency of drinking occasions. As such, the risk of harm is directly related to levels and patterns of consumption. However there can be a considerable lag between alcohol consumption and alcohol-related harms, particularly for chronic conditions where the lag can be many years.<sup>24</sup>

Alcohol is a causal factor in more than 200 medical conditions, including circulatory and digestive diseases, liver disease, a number of cancers and depression.<sup>27</sup> The increase in risk for these conditions is greatest among the 1.9 million adults in England drinking at harmful levels (in excess of 35 units per week for women and 50 units per week for men). However, even increasing-risk drinkers (those regularly exceeding the lower risk guidelines) are at significantly increased risk of developing long-term conditions.<sup>27</sup> The health harms from regular drinking of alcohol can develop over many years. This occurs either from the repeated risk of acute harms (e.g. alcohol-related accidents) or from long term diseases caused by alcohol, which may take ten to twenty years to develop. These illnesses, including various cancers, strokes, heart disease, liver disease, and damage to the brain and nervous system, can develop despite drinking for years without any apparent harm.<sup>1</sup>

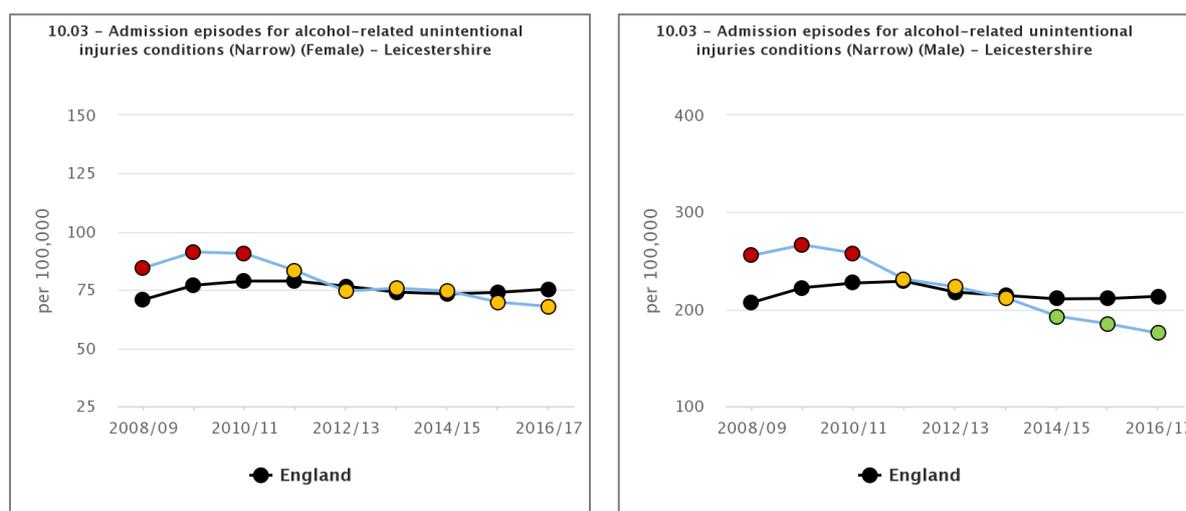
#### **3.6.1. Unintentional injuries**

‘Short term’ risks are the immediate risks of harm, injury and accident (sometimes fatal) linked to drinking a large amount of alcohol on one occasion, which often leads to drunkenness. They include: head injuries, fractures, facial injuries, scarring and alcohol poisoning.<sup>1</sup>

The directly standardised rate for hospital admissions for alcohol-related unintentional injuries by narrow definition in 2016/17 is 119.4 per 100,000 population, significantly better than the England average of 141.6 per 100,000 population. The rate in males is more than double the rate in females. The local males rate of 175.2 per 100,000 population is

significantly better than the England average of 213.4 per 100,000 population, while the local female rate of 67.8 per 100,000 population is similar to the national rate of 75.3 per 100,000 population. For both genders, Figure 13 shows the rate has gradually decreased over time, although the incremental decrease in females is smaller than the incremental decrease in males.<sup>3</sup>

**Figure 13: Trends in admission episodes for alcohol-related unintentional injuries conditions (by narrow definition) for males and females in Leicestershire<sup>3</sup>**



Source: *Local Alcohol Profiles for England, Public Health England Fingertips*

District level data for females was suppressed for Oadby and Wigston and Melton due to the number of cases being too small; all other districts were similar to the national average. For males, Charnwood and Hinckley and Bosworth are significantly better than the national average with all other districts being similar to the national average.<sup>3</sup>

### 3.6.2. Liver disease

In 2016/17 in Leicestershire the directly standardised rate for admission episodes for alcoholic liver disease, by broad definition, was 66.0 per 100,000 population, significantly better than the national average of 120.6 per 100,000 population. Leicestershire's rate has remained significantly better than the national average since reporting first began in 2008/09. All districts perform significantly better than the national average, other than Oadby and Wigston and Melton with rates of 107.0 per 100,000 population and 98.3 per 100,000 population respectively (please note there may be a data quality issue with Melton's value). Oadby and Wigston, Melton and North West Leicestershire have seen the greatest fluctuation in admission episodes over the years.

When considering admission by sex, the rate for males in 2016/17 is significantly higher than females (89.7 per 100,000 males and 57.5 per 100,000 females) and has remained so since reporting began in 2008/09. However, the increase in the local female rate over the years is higher than the increase in the male rate with the 2016/17 figure for females being 51.3% higher than the 2008/09 figure, whilst for males the 2016/17 rate is 12.9% higher than the 2008/09 rate. In 2016/17 all districts perform significantly better than the national average for males, other than Oadby and Wigston which is similar to the national average with 158.6 admission episodes for alcohol liver disease per 100,000 males. Please note, Melton has a data quality issue with this indicator. For females, Harborough, Melton, North West Leicestershire and Oadby and Wigston all perform similar to national in 2016/17, although, please note there is a data quality issue with the value for Melton. Blaby, Charnwood and Hinckley and Bosworth all perform significantly better than the national average for admission episodes for alcoholic liver disease per 100,000 females in the same time period.<sup>3</sup>

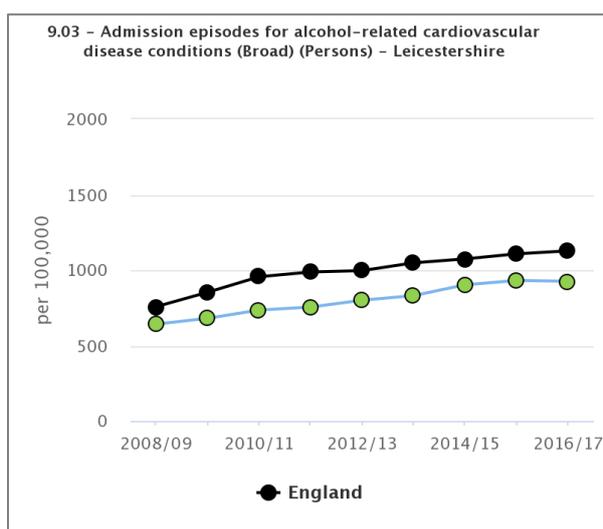
High rates of mortality from chronic liver disease may indicate a population who have been drinking heavily and persistently over the past 10-30 years (it is recognised that obesity is also a key factor in liver disease). In 2015-17 in Leicestershire, the directly age-standardised rate for mortality from chronic liver disease was 9.9 per 100,000 population. This is significantly better than the England average of 12.2 deaths per 100,000 population. When analysing by district, Hinckley and Bosworth is the only district to be significantly better than England, with a rate of 7.8 deaths per 100,000 population, with all others similar to national. The rate for Leicestershire males is almost double the rate in Leicestershire females (13.4 deaths per 100,000 males and 6.8 deaths per 100,000 females), although both rates are significantly better than national averages (16.0 per 100,000 males and 8.6 per 100,000 females respectively). This is the first time period since reporting began that females have performed significantly better than national, having previously always been similar to national. When considering districts, all perform similar to national for males and females, although for females data is not available for Blaby, Hinckley and Bosworth, Melton and Oadby and Wigston as the number of cases is too small.<sup>3</sup>

### **3.6.3. Cardiovascular disease**

In 2016/17 in Leicestershire the directly standardised rate for admission episodes for alcohol-related cardiovascular disease, by broad definition, was 925 per 100,000 population, significantly better than the national average of 1,127 per 100,000 population. Figure 14 shows the number and rate of admissions has gradually increased since reporting began in 2008/09 when Leicestershire's rate was 642 per 100,000 population, although the increase is in line with national trends. All districts perform significantly better than the national average, although for Oadby and Wigston this is after four years of performing similar to the national

average. When analysing admission episodes by sex, admission episodes in males are more than twice as high than with females (1,387 per 100,000 males and 549 per 100,000 females). This also follows national patterns. When examining by district, Oadby and Wigston is the only district to perform similar to the national average for both males and females, with all other districts being significantly better.<sup>3</sup>

**Figure 14: Trends in admission episodes for alcohol-related cardiovascular disease conditions (by broad definition), Leicestershire<sup>3</sup>**



Source: Local Alcohol Profiles for England, Public Health England Fingertips

### 3.6.4. Cancer

Drinking alcohol increases the risk of developing a range of cancers. The Committee on Carcinogenicity recently concluded that ‘drinking alcohol increased the risk of getting cancers of the mouth and throat, voice box, gullet, large bowel, liver, of breast cancer in women and probably also cancer of the pancreas’. These risks start from any level of regular drinking and then rise with the amounts of alcohol being drunk.<sup>28</sup>

The incidence rate is a measure of the frequency with which a disease occurs in a population. In other words, it is the rate of new (or newly diagnosed) cases of a disease or illness, in this case cancer. The directly standardised incidence rate for alcohol-related cancer in Leicestershire in 2014-16 was 37.24 per 100,000 population, similar to the national average of 37.98 per 100,000 population. This includes cancer of the mouth, oesophagus, colorectal, liver, larynx and breast cancer. The incidence rate in males (37.07 per 100,000 males) is not significantly different than the incident rate in females (37.89 per 100,000 females), and both are similar to their respective national averages (39.30 per 100,000 males and 37.15 per

100,000 females).<sup>3</sup>

Although there is a proven link between alcohol consumption and certain cancer types, the effect is lagged i.e. development of cancer would generally occur several years after consumption. The effect is also cumulative over time. The alcohol attributable fraction methodology uses current population consumption in different age groups applied to known dose/response relationships. This does not take into account the fact that alcohol consumption patterns change over an individual's life course. Fractions are applied by age and gender. However, there is no differentiation by region or deprivation group i.e. the same fraction, split by age and gender is applied across the whole country. Please note that some of the cancers related to alcohol are also smoking-related (so smoking could also be a contributory factor). In addition, this indicator is not sensitive enough to measure significant change in areas over time.

### ***3.6.5. Mortality and years of life lost***

Mortality and years of life lost reflects the level of chronic heavy drinking in the population, and is most likely to be found in higher risk drinkers and dependent drinkers. Broadly speaking, alcohol-related deaths make up around 5% of all deaths nationally. Of these, a third are alcohol-specific deaths e.g. from alcohol poisoning, alcoholic liver disease, alcoholic pancreatitis. The remaining alcohol-related deaths are from conditions partly related to alcohol, roughly two thirds of which are from chronic conditions e.g. cardiovascular disease and cancers, with the remainder caused by acute consequences such as road traffic accidents or intentional self-harm.<sup>24</sup>

Alcohol related mortality is defined as those deaths where alcohol has contributed to, but not wholly caused the death. In 2017, the rate of alcohol related mortality in Leicestershire was 40.5 per 100,000 population, significantly better than the England rate of 46.2 per 100,000 population. All districts perform similar to the national average. The male rate is more than double the female rate (59.5 per 100,000 males and 24.9 per 100,000 females) accounting for 189 and 49 deaths respectively. Both genders performed similar to national averages (66.5 per 100,000 population and 28.8 per 100,000 populations). Since data has first been reported in 2006-08, Leicestershire has never performed significantly worse than the national average.<sup>3</sup>

High rates of alcohol-specific mortality are likely to indicate a population who has been drinking heavily and persistently over the past 10-30 years. Alcohol specific mortality is defined as those deaths where the primary diagnosis or any of the secondary diagnoses are wholly attributable to an alcohol condition. In 2015-17, the directly standardised rate for alcohol-specific mortality per 100,000 population in Leicestershire was 8.9 per 100,000 population, accounting for 186 deaths. This is significantly better than the national rate of

10.6 per 100,000 population. Since data has first been reported in 2006-08, Leicestershire has always performed similar or significantly better than the national average. However, when examining mortality by district, in Table 5, Hinckley and Bosworth was the only area to perform significantly better than national, while North West Leicestershire performed significantly worse. North West Leicestershire's alcohol specific mortality rate has increased year on year for the past five time periods with the rate changing from 8.5 per 100,000 in 2011-13 to 15.1 per 100,000 in 2015-17, representing an increase of 24 deaths.<sup>3</sup>

**Table 5: Alcohol specific mortality rates by Leicestershire Districts**

Area	2006-08	2007-09	2008-10	2009-11	2010-12	2011-13	2012-14	2013-15	2014-16	2015-17
Blaby	6.5	6.8	8.9	10	8.8	8	6.3	5.9	6.9	7.7
Charnwood	9	10	10.7	12.4	11.1	12.7	9.6	9.5	7.3	8.5
Harborough	5.1	*	5.8	6.2	9	8.9	10.7	10.9	9.6	7.1
Hinckley and Bosworth	7.8	8	9.1	9.4	6.4	6.2	7.8	9.9	7.5	7.2
Melton	8.9	8.6	*	*	6.1	10.4	11.8	11	8.3	9.9
North West Leicestershire	13	11	10	8.4	9.3	8.5	10.5	13.4	14.6	15.1
Oadby and Wigston	8.9	10.6	13.2	16	10.5	7.9	6	7.5	8.9	7.7
Leicestershire	8.5	8.3	9	9.6	9	9.2	9	9.8	8.9	8.9
England	10.9	10.9	10.9	10.7	10.6	10.4	10.3	10.3	10.4	10.6

\*value cannot be disclosed/calculated as number of cases is too small

*Source: Local Alcohol Profiles for England, Public Health England Fingertips*

The 2015-17 the directly standardised alcohol-specific mortality rate for males is significantly higher than females in Leicestershire (11.9 per 100,000 males and 6.1 per 100,000 females, accounting for 121 and 65 deaths respectively) – this follows national patterns. When comparing to the national average, males perform significantly better, while females perform similar to the national average, with national rates being 14.5 per 100,000 males and 7.0 per 100,000 females respectively. When considering males, all districts in Leicestershire perform similar to the national average, other than Harborough which performs significantly better. Rates for females cannot be calculated for Blaby, Harborough, Hinckley and Bosworth and Oadby and Wigston due to the number of cases being too small. While Charnwood and Harborough perform similar to national (5.5 per 100,000 females and 6.7 per 100,000 females respectively), North West Leicestershire performs significantly worse than the national average with 13.7 deaths per 100,000 females.<sup>3</sup>

**Table 6: Alcohol specific mortality in Leicestershire 2015-17, Males and females<sup>3</sup>**

Area	Females		Males	
	Count	DSR per 100,000	Count	DSR per 100,000
Blaby	6	*	17	11.5
Charnwood	14	5.5	28	11.6
Harborough	10	6.7	11	7.5
Hinckley and Bosworth	7	*	18	10.2
Melton	5	*	11	14.4
North West Leicestershire	22	13.7	25	16.4
Oadby and Wigston	1	*	11	14.5
Leicestershire	65	6.1	121	11.9
England	5,608	7	11,048	14.5

\*value cannot be disclosed/calculated as number of cases is too small

*Source: Local Alcohol Profiles for England, Public Health England Fingertips*

Years of life lost indicate the contribution of alcohol misuse to premature death. The directly age standardised rate of potential years of life lost due to alcohol-related conditions in adults aged under 75, was 516 per 100,000 population in 2017 in Leicestershire. This is significantly better than the England rate of 626 per 100,000 population although still represents a total of 3,179 years of life lost in Leicestershire due to alcohol-related conditions. All districts in Leicestershire were similar to the national average. As seen nationally, the rate in males is more than double the rate in females (761 per 100,000 males and 277 per 100,000 females respectively). With that, 72.7% of these years of life lost are attributed to Leicestershire males with 27.2% attributed to Leicestershire females. Care should be taken in the interpretation of this indicator as this may well be an under-reporting of the actual years of life lost. This is due to the fact that although the age of 75 is the cut off for what is deemed an "early" or "premature" death, the life expectancy in England is actually 4.5 years higher for males and about 8 years higher for females.<sup>3</sup>

### **3.7. Data Summary**

The data in the above intelligence sections highlights that several groups are identified in the literature as being at increased risk of misusing alcohol, or alcohol related harm. This includes, although is not limited to, those living in the most deprived deciles compared to those in living in the least deprived deciles, males compared to females, LGBT+ groups compared to their heterosexual counterparts, those who have had childhood experiences of and exposure to

alcohol misuse, and the homeless.

Data from the Health Survey for England shows that generally, levels of drinking in Leicestershire are higher than national averages. Approximately, 8.2% of Leicestershire's population abstained from drinking alcohol in 2011-2014, significantly worse than the national average of 15.5%, and 3<sup>rd</sup> worst when compared to CIPFA neighbours. Furthermore, Leicestershire has a significantly higher proportion of adults who drink more than 14 units per week, with 29.8% doing so compared to 25.7% across England. A significantly higher proportion locally also reported binge drinking (women more than 6 units, men more than 8 units) compared to the national average (21% and 16.5% respectively). Leicestershire is in the top two worst performing areas when compared to similar CIPFA neighbours for both these indicators. Alcohol dependency in Leicestershire is estimated to be similar to national averages, although the most recent 2016/17 estimate suggests this affects 5,488 adults in Leicestershire. In this time, there were 826 people in treatment, equating to 85% of those who may benefit from specialist alcohol treatment not receiving it. This is also termed 'unmet need'. The local rate of 85% is statistically similar to the national estimate of 82% unmet needs.

Numbers in treatment give an insight into those who drink at levels to cause themselves, or others harm, although it is recognised that not all who could benefit from treatment, access it. In 2017/18, just under a third of adults (31%) in substance misuse treatment in Leicestershire cited alcohol as their reason for accessing treatment - the comparative proportion nationally was 28%. The numbers in treatment for alcohol misuse in has risen by 29% from the previous year (497 to 640). An increase in new presentations to treatment for alcohol misuse is likely to be a contributing factor to the increase in numbers in treatment.

The age-sex ratios of those in treatment in Leicestershire are generally comparable to national proportions. There were more males than females in treatment for alcohol in Leicestershire in 2017-18, with males making up 59% of the alcohol only treatment cohort, and females 41%. Nationally, the split was similar at 60%: 40% respectively. For both males and females, at a local and national level, the majority of those in treatment were aged 40-49, with just under a third falling into this age-sex group.

Data shows that drugs misuse is often concurrent with alcohol misuse, tobacco use, and mental health and wellbeing problems. In Leicestershire, and nationally, smoking prevalence is higher for those in treatment for substance misuse compared to the general population. In 2017/18, 9% of those in treatment were there for non-opiate and alcohol misuse. While this is a small proportion of the total, this group saw the largest increase for numbers in treatment compared to the previous year (37%) and the largest increase of new presentations compared to the previous year (48%). In the same time period, almost half (49%) of new presentations

were identified as having a mental health treatment need, for reasons other than their alcohol misuse. This is higher than the national average of 41%. Although a lower number of females entered treatment compared to males, a higher proportion of them were identified as having a mental health need in Leicestershire with 60% of new female presentations doing so. This is also higher than the national average for females of 46%. For males, figures were 41% and 38% respectively.

In Leicestershire, the rate of alcohol-related hospital admissions in females aged 40-64 years has performed similar to the national average for the past six years. The rate for males has performed significantly better throughout this time. While admission episodes for alcohol liver disease have remained lower than national since reporting began in 2008/09, the rate in males is significantly higher than the rate in females in Leicestershire (89.7 per 100,000 males and 57.5 per 100,000 females in 2016/17). High rates of mortality from chronic liver disease may indicate a population who have been drinking heavily and persistently over the past 10 to 30 years. The rates of mortality from chronic liver disease in males is almost double the rate in Leicestershire females (13.4 deaths per 100,000 males and 6.8 deaths per 100,000 females in 2015-17). Alcohol related mortality and alcohol-specific mortality are also both significantly higher in males compared with females, both nationally and in Leicestershire.

#### **4. How does this impact?**

There are currently over 10 million people in England drinking at levels that increase their risk of health harm. Of these, 595,000 adults potentially need specialist treatment for alcohol dependence. Alcohol is the leading risk factor for ill-health, early mortality and disability among men and women aged 15-49 years in the UK and the harm from alcohol affects a range of other public health outcomes.

Alcohol is a causal factor in more than 200 medical conditions, including circulatory and digestive diseases, liver disease, a number of cancers and depression. Alcohol-related harm disproportionately affects the poorest people in society.

##### **4.1. Employment**

Drinking in excess can lead to injuries, anti-social behaviour and other societal harm. Alcohol misuse also causes losses to business and the local economy through absenteeism, poor performance and work-place accidents.<sup>27</sup>

In Leicestershire in 2016 there were 280 claimants from working age population of incapacity benefit/severe disablement allowance or Employment and Support Allowance (ESA) with alcohol misuse as the main disabling condition. The rate of claimants benefits due to

alcoholism in the county has remained significantly better (lower) than the national rate for two years that the indicator has been published (2015, 2016).

## **4.2. Impact of children and families**

Alcohol misuse impacts not just on the drinker but also those around them. Children affected by parental alcohol misuse are more likely to have physical, psychological and behavioural problems. Parental alcohol misuse is strongly correlated with family conflict and with domestic violence and abuse. This poses a risk to children of immediate significant harm and of longer-term negative consequences. Alcohol plays a part in 25 to 33% of known cases of child abuse.<sup>26</sup>

Alcohol causes harm to others. It is associated with family and relationship problems, and was a component in 18% of the assessments of children in need by children's social care in England during 2016 to 2017.<sup>27</sup>

## **4.3. Crime**

Alcohol is a significant contributory factor in offences of violence and disorder including domestic abuse.<sup>27</sup> The Crime Survey (year ending March 2017) found 28% of domestic violence incidents were carried out by offenders perceived to be under the influence of alcohol<sup>29</sup> In addition the latest Crime Survey (year ending March 2018) found that, of those that had experienced partner abuse in the last year, over half (56.9-62.0%) drank once a week or more.

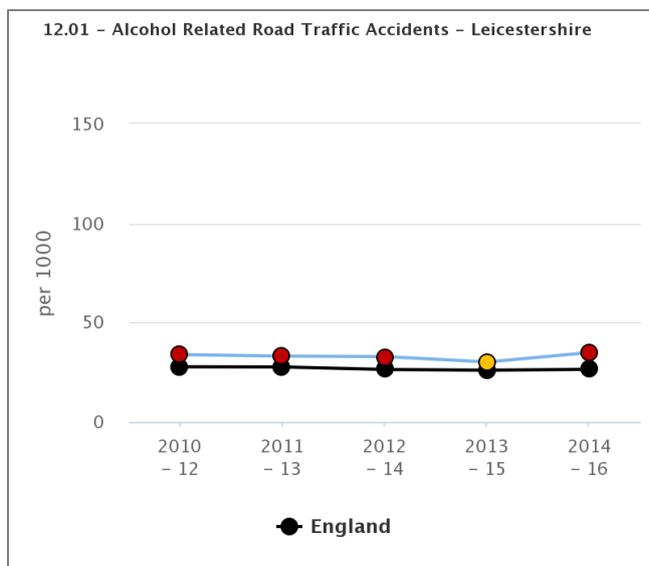
### ***4.3.1. Alcohol Related Road Traffic Accidents***

Alcohol consumption is responsible for around one in every seven deaths in reported road traffic accidents in Great Britain. Final estimates for 2013 show that between 220 and 260 people were killed in accidents where at least one driver was over the drink drive limit, around 1,100 were seriously injured and the total number of casualties of all severities was 8,270.

The legal limit in the UK is 35 micrograms of alcohol per 100ml of breath. However, any amount of alcohol affects your ability to drive safely. The effects can include slower reactions, increased stopping distance, poorer judgement of speed and distance and reduced field of vision, all increasing the risk of having an accident or fatality.

The latest data in 2014-16 shows there were 140 alcohol related road traffic accidents in Leicestershire. This represents a significantly worse rate compared to the national average. As shown by Figure 15, over the past five time periods, four out of five time points have performed significantly worse than the national average.<sup>3</sup>

**Figure 15: Trend in alcohol related road traffic accidents in Leicestershire<sup>3</sup>**



#### 4.4. Return on investment

Decision-makers have been enabled to understand the potential return on investment from alcohol and drug interventions and the possible cost of under-investment. Tools like the Value for Money Commissioning Support Tool (<https://www.ndtms.net/VFM>) can help commissioners demonstrate the benefits derived from local investment.<sup>27</sup>

## 5. Policy and Guidance

### 5.1. NICE Guidance

- NICE (National Institute for Health and Care Excellence) has published a number of clinical guidelines, guidance and quality standard documents relating specifically to alcohol including;
- CG 100 (2010) Alcohol Use Disorders: diagnosis and management of physical complications
- CG 115 (2011) Alcohol Use Disorders: Diagnosis, Assessment and Management
- PH24 (2010) Alcohol Use Disorders: Prevention of Harmful Drinking and Alcohol Dependence
- QS 11 (2011) Alcohol Use Disorders: Diagnosis and Management

- QS83 (2015) Alcohol: Preventing Harmful Use in the Community

## **5.2. The Governments Alcohol Strategy 2012**

The strategy was published under the 2010-15 Coalition Government and has since been archived.

The strategy focused on reducing availability of cheap alcohol, local action to tackle local alcohol related issues and local enforcement, responsibility of the alcohol industry to change behaviour, and supporting individuals to change behaviour.

A new alcohol strategy is expected to be published early in 2019.

## **5.3. NHS Long Term Plan 2019**

The NHS Long Term Plan was published in January 2019 and sets out how the NHS will be redesigned to ensure it is fit for the future.

An element of the NHS Long Term Plan focuses on action the NHS will take to strengthen its contribution to prevention and health inequalities. Within this section there is a specific focus on evidence-based NHS prevention programmes to limit alcohol-related A+E admissions.

## **6. Current Services**

The responsibility for providing alcohol related services does not fall to any one organisation or authority. Clinical Commissioning Groups (CCGs), the NHS, local authorities and the voluntary sector all have a role to play. The provision of alcohol services needs to include prevention and early intervention, treatment, and recovery services.

Many people who drink alcohol to excess will not require specialist treatment services and can be successfully managed within other health and social care services such as general practice.

### **6.1. Alcohol Risk Reduction Scheme – Community Based Service**

This service is commissioned by Leicestershire County Council Public Health and delivered across the county by individual GP practices, often grouped into Federations, and individual pharmacies. Currently the service is delivered by over 70 GP practices and 35 pharmacies.

Contracted GP practices and pharmacies deliver Alcohol Identification and Brief Advice (Alcohol IBA) to their patients and customers. Alcohol IBA is a simple structured intervention based on assessment using a validated alcohol screening tool, followed by brief advice including feedback on the individual's score, information on the harm of alcohol, and written

information on reducing the risk from drinking alcohol. It is a preventative approach aimed at people drinking alcohol at increasing risk and higher risk, and is not aimed at dependent drinkers who should be referred to specialist substance misuse treatment services.

## **6.2. First Contact Plus**

The service is provided by Leicestershire County Council Public Health Department and offers access to a range of low level preventative services through a single point of contact. This is an online service ensuring that people can access information, advice and support across a range of issues. This includes a range of health and wellbeing topics including alcohol, drugs and mental health, and advice and support on topics that have the potential to impact on mental wellbeing, such as debt and welfare benefits, housing support, and families and relationships. The service provides early identification of needs and brief opportunistic interventions, support for self-help, or referral to a service provider. As well as providing advice pages, and signposting to useful resources, there is an option to self-refer for further contact.

Whilst the service does not receive a high number of contacts/referrals relating to alcohol the service does signpost and/or refer to specialist treatment services (Turning Point) where appropriate, and to peer support services such as Dear Albert and Alcoholics Anonymous (AA).

## **6.3. Local Area Co-ordination**

This is a community based intervention delivered in specific areas by Local Area Co-ordinators (LACs) and is delivered by Leicestershire County Council Public Health Department. Local Area Co-ordination is focused on helping isolated, excluded and vulnerable people. Local Area Co-ordinators build the resources, networks and resilience of those who need help before they hit crisis, with the aim of diverting people from formal services and supporting people to have a good life as part of their community. Local Area Co-ordinators work with a whole community including those who have a low level of substance misuse and will work collaboratively with specialist substance misuse treatment services (Turning Point) to secure positive engagement with an individual. The team regularly work and refer into specialist substance misuse treatment services and support that introduction and engagement.

## **6.4 Public Health Programme Delivery Team**

The Leicestershire County Council Public Health Programme Delivery Team focus on health improvement and promoting better health and wellbeing, including substance misuse and alcohol. The Health Improvement Practitioners use a range of health promotional resources, communications and campaigns to deliver initiatives in a variety of settings including workplaces, communities, pharmacies, schools, nurseries and the media.

The team are involved in delivering specific initiatives to address alcohol misuse including;

Workplace – To increase awareness of safer use of alcohol to all county council employees through use of effective and appropriate marketing and communication and to raise awareness of services that can support employees i.e. Turning Point, Dear Albert. The Health Improvement Practitioners also support national campaigns such as Alcohol Awareness week.

Communities & Workplace – the Health Improvement Practitioners use a resource called the Mock Bar to promote responsible drinking at health events across Leicestershire. The Mock Bar is a large stand-alone display unit, asking the question ‘What’s in your drink?’ and prompting individuals to ‘Rethink your drink’. Partner organisations are able to use the resource in their own awareness raising campaigns.

Schools: Through the Leicestershire Healthy Schools Programme, school staff are offered the opportunity to attend various health & wellbeing training courses to help them support children and young people to develop healthy behaviours for life. One of the courses on offer is Teaching Drugs, Alcohol, Tobacco Education with confidence in both Primary & Secondary Schools.

## **6.5 Integrated Substance Misuse Treatment Service – Turning Point**

The Integrated Substance Misuse Treatment Service is provided by Turning Point and commissioned jointly by Leicestershire County Council Public Health Department and Leicester City Council with additional funding contribution from the Office of the Police and Crime Commissioner.

Turning Point provides a community based drug and alcohol misuse treatment service for adults and young people with the purpose of achieving freedom from dependence on alcohol and/or drugs, reducing the harm arising from dependence, and sustaining recovery.

The service is provided from four main hubs: Leicester City hub (Eldon Street), Coalville hub, Loughborough hub and Young People’s hub (based in Leicester City). The service also operates from approximately 30 outreach venues across Leicestershire and Leicester City including GP surgeries, health centres, council offices and community venues. Turning Point operates a single point of access through a single telephone number, email address and website to facilitate ease of access. A single engagement team operates across the city and county, triaging all referrals within 48 hours and ensuring all referrals are seen within 21 days, with priority appointments available within a matter of days for those with the highest risks. In addition to referrals through phone and email, self-referrals can be taken at any of the hubs mentioned above.

### **6.5.1 *Community prescribing and Psychosocial interventions***

Turning Point provides a holistic medical screening and specialist prescribing service as part of a wider treatment programme that addresses the co-existing physical, psychological, and social problems. This is delivered by a clinical team including specialist addictions psychiatrist, psychologists, substance misuse GPwSIs (GPs with a Special Interest), and nurses. There are two alcohol specific treatment pathways – Dependent Alcohol Pathway and Non Dependent Alcohol Pathway, and also three additional pathways (opiate and complex drugs pathway, non-opiate drugs pathway, risk vulnerability and complex safeguarding pathway). The clinical team are supported by skilled Recovery Workers and Support Workers who provide a range of evidence-based psychosocial therapeutic interventions.

### **6.5.2 *Liaison with primary and secondary healthcare***

Turning Point provides a shared care scheme with 10 GP surgeries across the city and county to enhance access in rural communities. The scheme primarily works with drug users (opiate users). Within these surgeries the GP undertakes prescribing for substance misuse alongside addressing mainstream health issues. Turning Point provides recovery workers who work collaboratively from the GP surgery. In addition, a dedicated GP with a Special Interest (GPwSI) from Turning Point provides supervision and governance to ensure the quality of clinical interventions delivered. Whilst Turning Point are not responsible for providing a drug and alcohol service within local hospitals, Turning Point do provide hospital liaison recovery workers based within UHL, and available to work from other hospital sites. They see all alcohol and drug related hospital admissions to assess and provide appropriate support (brief interventions to reduce the risk of alcohol and drug related harm, or referral into community treatment). The hospital liaison recovery workers also train staff from across hospital and urgent care settings to provide brief interventions to patients on reducing the risk of alcohol and drug related harm.

In recognition of the link between mental health and substance misuse, Turning Point has a specialist dual diagnosis senior recovery worker who undertakes weekly outreach clinics at the Bradgate Mental Health unit on the Glenfield Hospital site to support service users with alcohol and drug issues. In addition, Turning Point has developed referral pathways with a range of mental health partners including Community Mental Health Teams and Improving Access to Psychological Therapies (IAPT) services.

### **6.5.3 *Harm reduction***

Alcohol users on the dependent pathway are all offered appointments with a Wellbeing Nurse, and where appropriate are offered medications to address vitamin deficiencies. In

in addition Turning Point provide a number of interventions and services for people using drugs including a Needle and Syringe Programme (NSP) and in collaboration with pharmacies, a supervised consumption of medication scheme. For more information, please see the Adults Substance Misuse Chapter: <http://www.lsr-online.org/leicestershire-2018-2021-jsna.html>

#### **6.5.4 Criminal Justice services**

Turning Point provides an arrest referral service within local custody suites whereby individuals who test positive for alcohol and/or drugs are seen by a criminal justice engagement recovery worker who provides brief advice on reducing the risk of alcohol and drug related harm and supports engagement into treatment for those who require it. In addition, Turning Point employs workers (criminal justice recovery workers) who work specifically with criminal justice clients with enforceable treatment requirements in providing treatment and recovery support. The workers have lower caseloads to enable more intensive working with this cohort. This team co-delivers with probation services (within probation offices) wherever possible to enable regular three-way working.

Turning Point also has a team based within HMP Leicester (funded by NHS England) comprising nurses, doctors, healthcare assistants, a pharmacist and recovery workers. The team delivers all the clinical and psychosocial interventions to any prisoner at HMP Leicester including first night prescribing if required, dispensing of alcohol related medications and delivery of group and 1-2-1 interventions to address alcohol and drug misuse. Having Turning Point deliver both the prison based service and the community based service enables effective transfers and continuity of care for clients.

#### **6.5.5 Vulnerable groups**

Turning Point has a dedicated Young People and Young Adults Service for both alcohol and drugs which works with individuals under 18 and up to the age of 25 where a young adults approach would be beneficial. The team delivers via outreach to whichever location suits the young person across the county.

Turning Point has a subcontract with Age UK to deliver the 'last orders project'. This comprises of a dedicated worker who delivers awareness sessions and brief interventions to those aged over 50 across the county to raise awareness of the problems associated with alcohol (and other drug misuse). The worker also refers appropriate individuals into treatment.

Turning Point also has a Communities Development Recovery Worker to provide enhanced outreach to BME communities.

For more information on image and performance enhancing drugs, and addiction to prescription drugs refer to the Adult Substance Misuse JSNA chapter: <http://www.lsr-online.org/leicestershire-2018-2021-jsna.html>

#### **6.5.6 Recovery**

Turning Point works closely with a range of employability providers, and housing authorities to support service users maximise their opportunity for sustained recovery. Turning Point has a team of approximately 25 peer mentors who are linked to all teams across the service and deliver a range of interventions including running drop-ins, co-facilitating groups and supporting with practical matters such as benefits and food parcels. In addition Turning Point also sub-contracts to local social enterprise 'Dear Albert' which delivers aftercare services across the city and county for individuals who have completed treatment and require ongoing support to maintain recovery.

#### **6.6 Inpatient Drug and Alcohol Detoxification Service – Framework Housing Association**

Detoxification from dependent alcohol use is a risky intervention with a high rate of relapse. For some people with alcohol problems who are in treatment, their recovery requires a short hospital stay in a specialist inpatient service to complete a clinically safe detoxification.

Inpatient drug and alcohol services are commissioned by Leicestershire County Council Public Health Department and are currently provided by Framework Housing Trust at a purpose built unit, known as Edwin House, in Nottingham. The authority commissions a number of bed days annually, sufficient for the needs of county residents.

The inpatient service is for both men and women and accessed via referral from the integrated substance misuse treatment service (Turning Point). Edwin House provides specialist assessment, and medically assisted withdrawal from alcohol (and/or drugs) for adults. The service is provided by a multidisciplinary team including addictions consultants/doctors, nursing staff, occupational therapist, and support staff, and provides care and support 24 hours a day, 7 days a week. In addition to medical/clinical treatment all service users have a recovery plan that includes harm reduction and relapse prevention, alongside structured group work, access to mutual aid and leisure and social activities.

The service works closely with the integrated substance misuse treatment service (Turning Point), and Dear Albert to ensure service users have the appropriate support both prior to inpatient treatment and on leaving inpatient treatment.

## **6.7 Dear Albert - The Stairway Project**

Dear Albert is a local social enterprise providing peer led recovery focused community rehabilitation. The service is delivered by peers who are in recovery who have a variety of experience and skills and qualified professional counsellors and therapists. Dear Albert is open to anyone who wants help with their alcohol (and/or drug) use, and does not require referral from a GP or other professional. The service provides a range of groups and activities within a city centre base (The Stairway Project) available to county and city residents. In addition to the drop-in Dear Albert provides a menu of recovery focused activities and holistic treatments, both in groups and one-to-ones. In particular the service delivers evidence – based, abstinence focused, peer-led recovery programmes ‘You do the MAFs (Mutual Aid Facilitation), and ACT Peer recovery (Acceptance and Commitment Training).

Dear Albert is sub-contracted by Turning Point to provide aftercare support to people who have completed treatment to maintain recovery, and also delivers individual and group sessions at the inpatient service (Edwin House) for county and city residents. In addition the You do the MAFs and ACT training sessions are sometimes delivered across the county funded by grants.

## **6.8 Residential Rehabilitation**

Following community treatment and inpatient detoxification a small number of people may need to have longer term support to maintain an alcohol free lifestyle. There are many substance misuse residential rehabilitation facilities across the country, all providing longer term (3-9 months usually) support and care. Whilst the Leicestershire County Council does not directly commission any particular residential rehabilitation facilities it does provide a list of facilities that have been assessed to ensure they provide clinically safe and effective services to a high standard of care. Referral to a substance misuse residential rehabilitation centre would usually come from the integrated substance misuse treatment service (Turning Point) and be a part of an overall recovery care plan.

Whilst living at a substance misuse residential rehabilitation centre residents will take part in an intensive therapeutic programme, alongside life skills, community activities and usually the day-to-day running of the house/centre.

## **6.9 Mutual Aid**

In addition to commissioned substance misuse treatment services there is a network of local mutual aid support available across the county and city. Mutual aid refers to the social, emotional and informational support provided by, and to, members of a group at every stage of their recovery. These include Narcotics Anonymous (NA), SMART Recovery, ACT Peer-led

Recovery, and Alcoholics Anonymous (AA). Some are based on a 12-step fellowship approach and some on cognitive behavioural techniques. The groups are available in a number of venues across the county (although times and venues may change), including Loughborough, Market Harborough, Wigston, Coalville, Melton, Hinckley, Syston, and Oadby.

### **6.10 Mental Health Wellbeing & Recovery Service**

The mental health wellbeing and recovery service is commissioned jointly between, Leicestershire County Council, Leicester City Council, Rutland County Council, and the three CCGs. The service is currently provided by three different providers, providing coverage across all districts in the county (and Leicester City and Rutland); Richmond Fellowship (operating as Life Links), Mental Health Matters, and Voluntary Action South Leicestershire (VASL).

Whilst not a service aimed at providing support specifically for people who use alcohol dependently or illicit drugs, it is not uncommon for people accessing the service to have issues with alcohol and/or drugs in addition to mental health/wellness concerns. The service offers support networks focused on wellness and recovery, encouraging independence and developing own personal support networks. It offers flexibility to choose support based on own personal need. This can be face to face, providing information, advice and navigation services, one to one sessions, and group support sessions; online support including a directory of services, and a 24/7 chat feature allowing questions to be asked/answered; and community recovery support.

### **6.11 PAVE Team (Pro-Active Vulnerability Engagement)**

The service is funded by the Office of the Police and Crime Commissioner for Leicestershire. It is a partnership between police, mental health practitioners, and substance misuse practitioners providing targeted support for people who intensively use health and police services. A majority of the service users have entrenched alcohol dependency and/or drug problems. Dedicated recovery workers from Turning Point work alongside police and mental health services to support individuals who are placing a high demand on resources, have complex needs, are difficult to engage, and who pose a risk to themselves or others. In addition clinical support is available as required from a Consultant Psychiatrist. The team work intensively with each individual with the aim of improving their health and wellbeing, reducing crime and reducing the demand placed on public services.

### **6.12 Mental Health Recovery and Rehabilitation Service – Bridge Street**

Commissioned by the local authority Adults and Communities Department, the service provides supported accommodation with on-site 24 hour support for people with diagnosed serious mental health conditions. Whilst not providing services specifically for people with

alcohol and/or drug problems it is not uncommon for residents to also have alcohol and/or drug problems in addition to serious mental health conditions. The service is provided from 11 self-contained apartments in the Shepshed area of Leicestershire. This service enables adults with diagnosed serious mental health conditions recover and develop or regain skills to maximise their independence, reduce their support needs and live in their own homes and consequently also avoids unnecessary moves to residential care. People are resident for a maximum of two years.

### **6.13 District Councils**

Whilst the individual district councils do not directly commission or provide treatment and support services for alcohol and substance misuse, many do include tackling alcohol and/or drug misuse within their individual district plans, whether that be Community Safety Plans, Health and Wellbeing plans or Prevention plans/strategies.

Examples of the interventions and services provided by district and borough councils include;

- Providing meeting rooms for mutual aid and Dear Albert meetings
- Providing funding for specific local initiatives including educational theatre company developing productions covering issues such as homelessness, drug and alcohol issues, relationship breakdown, and funding for local charitable organisations to deliver drug and alcohol outreach support.

## **7 Unmet needs/Gaps**

### **7.1 Dependent drinkers not in treatment**

85% of individuals who may benefit from specialist treatment for alcohol misuse are not in treatment. This indicates a gap in identifying individuals with alcohol dependency and a gap in referring these individuals into treatment services.

### **7.2 Delivery of alcohol brief interventions**

Leicestershire has a significantly higher proportion of adults who drink more than 14 units per week, compared to England (29.8% and 25.7% respectively). A significantly higher proportion locally also reported binge drinking compared to the national average (21% and 16.5% respectively). Currently the only formal setup for assessment of alcohol intake and delivery of alcohol brief interventions is through GPs and pharmacies. This limits the reach of an

evidence-based prevention intervention.

### **7.3 Delivery of alcohol misuse treatment services within a hospital setting**

In Leicestershire, the rate of alcohol-related hospital admissions in females aged 40-64 years has performed similar to the national average for the past six years. The rate for males has performed significantly better throughout this time. In addition, admission episodes for alcohol related cardiovascular disease conditions has gradually increased since 2008. Also, the proportion of referrals into community treatment services from health services has seen a decline since 2009. There is an opportunity to engage individuals into treatment while they are an inpatient rather than referring into community treatment services upon discharge.

### **7.4 Alcohol related deaths**

Mortality rate from chronic liver disease (which usually indicates that an individual has been drinking heavily and persistently over decades), alcohol related mortality and alcohol-specific mortality are all significantly higher in males compared with females.

### **7.5 Smoking cessation support within treatment services**

Smoking prevalence among Leicestershire residents accessing substance misuse treatment services is higher than that of the general population.

### **7.6 Dual diagnosis (substance misuse and mental health difficulties)**

There are pathways and protocols in place between substance misuse services and inpatient psychiatric services. However separate systems, processes and thresholds across services result in potential gaps in provision. One such gap is support for individuals who have difficulties maintaining engagement with treatment services. Also, whilst there a high numbers of individuals in substance misuse treatment services who also have mental health problems (which puts a significant demand and expectation on the substance misuse treatment service), indicators relating to dual diagnosis individuals are largely unavailable from other services therefore the true demand is unknown.

### **7.7. Health and wellbeing outcomes of those completing treatment**

The treatment service collects a broad range of outcome information (e.g. housing need, employment, self-reported health etc.) from those in treatment to enable a comparison with the information collected on entry into the service. However, information on specific short-term and long-term health outcomes following treatment completion e.g. development of alcoholic hepatitis is not routinely collected. This information would be useful to review health outcomes and to ensure timely access to clinical support for those who require it.

## 8 Recommendations

- i. Consider a review of the delivery of alcohol brief advice to include settings other than primary care. This has the potential to improve the reach of this preventative approach to help identify and support people drinking alcohol at increasing risk or higher risk.
- ii. Explore an approach to enable the delivery of substance misuse treatment services within a hospital setting.
- iii. Explore an approach to strengthen pathways and referrals from primary and secondary care services into substance misuse treatment services and vice versa. For example, a large number of individuals referred to hepatology services from primary care where alcohol is a contributing factor, are not concurrently referred into substance misuse treatment services. Early identification and referral into treatment could lead to improved outcomes for the individual.
- iv. Consider targeted interventions to tackle potential causes of alcohol misuse e.g. homelessness, social isolation, unemployment, debt etc. and to address lifestyle factors including smoking and mental health.
- v. Consider a partnership approach that focuses on targeted interventions for those individuals placing the most demand on services e.g. frequent A&E attendances etc.
- vi. Take action to better understand (locally) the demand placed on services by individuals with concurrent mental health and substance misuse issues.
- vii. Explore an approach to monitoring short and long-term health outcomes of individuals completing treatment.

## GLOSSARY OF TERMS

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CCG	Clinical Commissioning Group
ELRCCG	East Leicestershire and Rutland Clinical Commissioning Group
GP	General Practitioner
HWB	Health and Wellbeing Board
IDACI	Income Deprivation Affecting Children
IDAOP	Income Deprivation Affecting Older People
IMD	Index of Multiple Deprivation
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LPT	Leicestershire Partnership Trust
LSOA	Lower Super Output Area
MSOA	Middle Super Output Area
NHS	National Health Service
ONS	Office of National Statistics
PHE	Public Health England
WLCCG	West Leicestershire Clinical Commissioning Group

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