

A Joint Specific Needs Assessment: Drugs and Alcohol

Final Version 7th June 2012

A Drug and Alcohol Joint Specific Health Needs Assessment for Leicester City

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Executive summary

Introduction

Leicester has a young (and getting younger), diverse population. The Safer Leicester Partnership oversees the implementation of national drugs and alcohol strategies at a local level, with action being implemented through the adult's drug treatment strategy, young person's substance misuse plan and alcohol harm reduction strategy.

Methods

This Joint Specific Needs Assessment systematically reviewed the health issues within Leicester city of those who misuse substances as part of the Leicester Joint Strategic Needs Assessment Programme. It assesses the impact of drug and alcohol misuse across Leicester, maps the current services, reviews effectiveness and summarises these findings. This report uses both quantitative and qualitative analysis of the drugs and alcohol needs in Leicester City.

Key Findings

The self-reported drug use is lower than that nationally; however there are significantly more drug admissions than nationally, although there are differences across the city. Self-reported alcohol consumption is also lower than nationally, however there is a statistically significantly higher rate of hospital admissions, deaths for alcohol specific and related disease, as well as alcohol related crime and sexual crime. This may reflect the high rates of alcohol consumption and admissions in the west of the city and low levels in the east. There is some evidence to suggest that behaviour around alcohol in the South Asian community, who are predominately based in the east of the city, may be changing.

Those that report misusing drugs and alcohol are likely to be male, White and 16-24. Additionally they are more likely to have poor mental health, diets and smoke, highlighting the importance of having more integrated interventions. There is a clear east/west split in substance misuse, with the west being higher than the east. The consequences of this are seen in hospital admissions and those in treatment, however with changing attitudes and behaviours in South Asian communities in relation to drugs and alcohol this picture may change.

There is a clear link between mental health problems and drug and alcohol misuse (dual-diagnosis), with many clients being seen in treatment that have been identified as having mental health problems. The Intercept project has started to identify more people within the criminal justice system, however further work is needed in the mental health and substance misuse treatment services to identify and treat these people.

Local Police data indicates that young people (16-24 years) are much more likely to have an alcohol and drug related offence, Black and other BME groups are more likely to have a alcohol and drug related offences, respectively. Asian groups show much lower lever rates. There is a small number of drug related and alcohol specific deaths each year, with the majority of drug related deaths being caused by opiate use.

Treatment services for adults and children, for both drugs and alcohol have recently been redeveloped and the data presented in this HNA covers the period before the reconfiguration in 2011. However the data does provide some indicators of the health issues relating to drugs and alcohol in Leicester.

For adults there are a relatively high number of referrals that come from the criminal justice system, compared to nationally and our comparator DAAT partnerships. Consequently there are a high proportion of those in treatment that are referred on, rather than exiting from the services.

Successful completions as a proportion of all those in treatment is also lower than nationally, suggesting further work is needed to intervene at an earlier stage rather than when someone is picked up through the criminal justice system. This may reduce the proportion referred on and increase the proportion successfully completing. Some data indicates that health outcomes of those in treatment have improved, although much of the data is incomplete and improvements in initial assessment are required.

The picture is similar for substance misuse treatment for young people. There are a higher proportion of referrals coming from the criminal justice system, those in treatment appear to have a greater complexity of need when in treatment compared to nationally and comparator partnerships and therefore there is a lower proportion of successful exits from treatment. There have recently been an increasing number of young people in treatment, which may be a reflection of the improvement in access,, services meeting the need or an increasing need. This will need further exploration.

Alcohol consumption is reported to be lower than nationally, however Leicester has a higher rate of hospital admissions and deaths related to alcohol, and much greater rate in males. There also appears to be a greater proportion of males being admitted for alcohol specific mental health problems than England and East Midlands. There are longer waiting times for alcohol treatment and a lack of reporting of certain types of interventions compared to the national picture. There are a higher proportion of referrals from health and mental health services compared to nationally, with similar outcomes, although a lower complexity of clients than nationally. With all these services, there were a low proportion of self/family referrals, which in some aspects may reflect how clients can access services i.e. referral through healthcare or another service, or may indicate the lack of knowledge of the services in the local community or the feeling of a lack of access.

Within the Criminal justice system, much work has been undertaken over the past 3 years to fully integrate services to form a cohesive end to end specialist system of drug and alcohol treatment that meets the complex needs of offenders. Within the local prison (HMP Leicester) this has partly been achieved by joining up of what was previously known as the CARAT services within the community contract, yet the Clinical IDTS interventions remain outside of the integrated pathway. This causes a confused picture of treatment within the Prison with both services assessing need differently, having poor data compliance and a lack of co-ordination of interventions.

There are a range of 'wraparound' services providing support for those who misuse drugs and alcohol, with the QoL service pulling together some wraparound services and support families to support recovery; however there is not a coherent systematic process on identification and assessment of drug and alcohol misuse, nor a systematic collection of data from these services. Therefore some needs and opportunities to refer/signpost people into treatment are being missed.

For all services that provide support and treatment, improved data collection, assimilation, analysis and interpretation is needed to provide a comprehensive picture of the needs and emerging needs of those in Leicester with substance misuse problems and provide a strategic overview of the issues.

Many of the issues identified within the quantitative aspect of the report were echoed in the qualitative findings. The strengths included; that there were links across services and a range of interventions offered to clients, however engaging with specific groups e.g. South Asian populations, funding for dual-diagnosis and access to residential rehabilitation were seen as weaknesses. Proposed opportunities included better joint working across Leicester, involvement of families and targeted work in specific groups/communities.

There are a range of effective and cost effective prevention and treatment options for drug and alcohol misuse. To increase the chances of recovery for someone who is receiving treatment, a model that focuses on support from the community and the family and assesses the wider context should be implemented. This would include care coordination for the individual and support from 'wraparound' services to aid recovery. The majority of young people do not need prescribed substitute drugs, and as with adults, a holistic approach to the individual is needed to support them in their recovery. This should be implemented in a partnership way across the city.

There are some areas of substance misuse which this report does not cover, these include; families with multiple problems, the needs of children whose parents misuse substances, offending and substance misuse, the role of substance misuse and domestic violence, novel drugs, mapping strengths and services location of services in relation to need, the needs of the student population, homeless population and comparative spend on treatment services. These areas would need further investigation in the future to understand their needs.

Recommendations

Leicester wide recommendations

1. A clear systematic approach to collating, analysing and interpreting data (and softer intelligence) for all tiers of treatment and broader action on drugs and alcohol misuse on a regular basis in one location locally is required to better understand the issues relating the substance misuse. For example from 'wraparound' services (inc. 3rd sector), hospital, treatment services, police, social care, other LA, UHL (including; A&E assessment, and midwifery) and other healthcare data i.e. ASSIST. It is recommended to implement a system which reports into the appropriate structures i.e. the Safer Leicester Partnership.
2. Ensure that partnership working between health services, drug and alcohol treatment services and wider 'wraparound' services for both adults and young people is developed to better meet the needs of drug and alcohol users, which can include multi-disciplinary treatment and greater understanding of different pathways. Improved coordination, assessment/screening, referral between teams and flexible delivery of services i.e. the development of a care pathway (including support post treatment), improved data collection and collation with shared data agreements and training/development of staff is required to ensure there is efficient use of resources and increase successful completions/recovery.
3. There are some signs of changing behaviour in South Asian communities around substances., There is also an overall change in the type of drug misuse i.e. poly-misuse and use of legal highs. Local services need to be able to understand (i.e. undertake specific research in communities such as South Asian and Somalis, the use of legal highs and Khat), be compliant with diversity requirements, adapt to changing demand, and engage with those groups not readily accessing services to ensure needs are being met. Additionally we need to further understand if we are providing services to the right people, at the right place, at the right time i.e. through health equity audits.
4. The relatively low proportion of those with dual-diagnosis in the treatment system (compared to national figures) and low proportion of referrals from mental health teams across the city for drugs indicates that there may be a number of clients in the mental health system and/or the drug/alcohol treatment system and wraparound services that are not being picked up with dual-diagnosis. Building on current practice, further screening,

assessment, and collaborative working for dual-diagnosis with further exploration of the issue is required.

5. There are a low proportion of referrals into services from self or family and friends, which may be a reflection on the current treatment system set up. However there appears to be a lack of knowledge of services in the community. A clear communications strategy across the whole of Leicester will help partnership working between services, improve education across the community, discourage substance uptake, aid access and encourage uptake of services to those in need.
6. Of those in the drug treatment system, 23% had a child living with them. Further work is needed to explore the needs of the children whose parents misuse substances (alcohol and drugs) to enable holistic support for the family i.e. further exploration of the whole family needs and families with multiple problems.
7. Access to support and information at times of crises was expressed as a concern within the service user and parent/carer groups, as well some CJS services. This needs further exploration. It may be that extension of peer-mentoring across family groups and services users, as well as raising awareness of national or local support helplines, could help to address some of this need rather than opening local services out of hours.
8. It is important for clients to be seen quickly for treatment as it improves their chances of recovery. From the 2010-11 data, Leicester has a relatively lower proportion seen within three weeks of referral (compared to nationally) and there have been long waits for psychosocial treatment and residential rehabilitation. Having low waiting times is important to aid recovery and should be a priority.
9. Coding of services in the NDTMS and NATMS do not reflect the work that the treatment agencies are currently delivering both in adult and young people's services i.e. community detoxification and tier 2 work. Proposed changes in the national systems provide an opportunity for greater insight into treatment regimes, completeness and reporting of data from services across the city so a better understanding of the need and therefore action is provided.
10. Substance misuse treatment services for offenders have undergone much development over the past few years. There is a robust treatment pathway for both drug and alcohol misusing offenders that spans first Criminal justice contact through to community reengagement following sentence finishing. However there is still a mixed picture of provision within HMP Leicester with psychosocial and clinical interventions being delivered separately. There appears to be a duplication of effort, poor data quality and an unclear care coordination process. To ensure that substance misusing offenders receive the best available chance at recovery a fully integrated pathway within the prison should be developed with clear leadership, defined roles and responsibilities and data capture.
11. There was a reported lack of housing support for those leaving custody, and lack of detailed information of no formal abode cases, although the QoL services provides some support. This should be considered a priority area in terms of helping to facilitate a stable and secure environment. To aid this, links between the CJS and specialist housing support should be strengthened.

12. Raised in the qualitative interviews, when commissioning services the DAAT team should strive to mitigate any negative effects of the commissioning cycle, by working with services across the city to ensure a continuation of high quality service provision.
13. Local Police data suggests that younger populations (16-34 year) and Black ethnic groups are more likely to have an alcohol and drugs related offence. Further investigation of why this might be is required.
14. The report does not cover families with multiple problems, the needs of children whose parents misuse substances, offending and substance misuse, the role of substance misuse and domestic violence, novel drugs, mapping strengths and services, location of services in relation to need, the needs of the student population, homeless population and comparative spend on treatment services. These areas would need further investigation in the future to understand their needs.

Drug recommendations

15. Leicester has the highest proportion of referrals into drug treatment from the criminal justice system, a high proportion of those in treatment referred on and a relatively low proportion of successful completions. Further work is needed to understand why this is i.e. is it eligibility criteria or awareness of services and what mechanisms there are to gain a higher proportion of referrals into treatment from community based services before they enter the criminal justice system. This may have an impact on successful exits from treatment. This will require an on-going review and appropriate plans in place to improve the outcomes.
16. Those injecting drugs and sharing needles have a high chance of acquiring blood borne viruses. Building on improvements in the coverage and treatment of those being offered and taking up vaccination to reduce the spread of blood borne viruses is required.
17. Emerging drug trends such as legal highs and steroid users are putting pressure on certain aspects of the treatment system, gaining better insights into the attitudes and behaviours of those at highest risk will need further exploration.
18. Outcomes of drug treatment are recorded through the TOP system. Low compliance at initial assessment has prohibited meaningful analysis of the outcomes of treatment. An increase in compliance of TOP starts is required.
19. Leicester has an average proportion of those in treatment who have problematic use of prescription and over-the-counter drugs. Leicester partnership should continue to develop services to ensure that all people, including those who develop addiction or substance dependence problems with prescription only and over the counter medicines, can achieve recovery.

Alcohol recommendations

20. There is a low level of reported drinking in the city (through survey data), yet there is a high rate of admissions to hospital and deaths. This may reflect the high rates of consumption and admissions in the west of the city and low levels in the east and the potential intervention coming when substance alcohol problems are deep-rooted. This need for alcohol treatment should be investigated further.

21. Within the alcohol-related admissions, Leicester has a much higher proportion of alcohol specific mental health admissions for males, a statistically higher rate of alcohol related recorded violent and sexual crimes and higher proportion of hospital admissions for violence. The reasons for this high proportion needs further investigation.
22. There are a much lower proportion of referrals for alcohol treatment that come from self-referral in Leicester compared to nationally and a higher proportion coming from health and mental health services. The complexity of clients in alcohol treatment also appears to be lower than nationally, although with similar outcomes from treatment. This may reflect current referral pathways, stigma attached to accessing treatment or how the services are marketed. Education, marketing i.e. using Mosaic, outreach and a review of access to services would be required to increase the proportion of those who self-refer.
23. The proportion of those in alcohol treatment services (roughly 6%) is much lower than the estimated national proportion of dependent drinkers and the aspiration set out by the Department of Health (15%). Understanding why this is needs further exploration.
24. Those in alcohol treatment had relatively higher proportion of 3+ treatment journeys compared to our peers, which are shorter, with a higher proportion of clients waiting longer for treatment and similar outcomes. An understanding of why there are more treatment journeys in Leicester treatment system would need further investigation.

Young people recommendations

25. There appears to be an increased number of young people coming into treatment, which could be a reflection of the improvement of access. Targeting the younger population of Leicester needs to be continued.
26. As with adults, a high proportion of referrals come through the criminal justice system. Leicester has a relatively high proportion of younger people in treatment with complex issues and as with adults' further work is needed to understand why is this and the mechanisms to gain a higher proportion of referrals into treatment from community based services before they enter the criminal justice system. The relatively high levels of need recorded at treatment entry also suggest the need to continue to target services that work with at risk groups of young people-for instance those who are NEET and with mental health difficulties.
27. Four wards (Braunstone/Rowley Fields, Beaumont Leys, Eyres Monsell and New Parks) in the city have a high number of young people in treatment and in treatment with the criminal justice team. Targeted work may be needed in these wards in order to prevent drug and alcohol related offending with young people.
28. There is limited local evidence on issues related to the transition of young people moving from young people's services to adult services. Further investigation of this is required to consider whether a young adults' service could be implemented for 16-25 year old.
29. There is an indication of the changing drug use, particularly with young people. Understanding the attitude and behaviours will need further investigation to help develop and adapt services for young people in the future.

Introduction and background

Alcohol and drugs are a priority theme for the shadow Health and Well-being Board. The priority board annual commissioning statement 2011-12 identified the need to reduce alcohol and drug misuse as part of its vision to improve the mental and physical well-being of the population. It recognises alcohol and drug misuse as key contributors to ill-health.

This health needs assessment will be used to inform the drug and alcohol commissioning plans and future local drug and alcohol strategies for adults and young people which is part of the wider Leicester Joint Strategic Needs Assessment programme (<http://www.oneleicester.com/leicester-partnership/jsna/>).

What is a Health Needs Assessment?

A Health Needs Assessment (HNA) is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities¹. Needs have been defined as *'the ability to benefit'*; therefore any action taken from the identified needs will have to benefit the patient/user. The report is divided into chapters to assess the impact of drug and alcohol across Leicester, map the current services, review effectiveness and summarise these findings. This report will use both quantitative and qualitative analysis of the drugs and alcohol needs in Leicester City.

Aims

The aims of the HNA are to:

- collect and appraise relevant data on drug and alcohol misuse, including the needs of problem drug/alcohol users, those individuals and families affected by that misuse, and those groups who are thought to be in need of early interventions
- identify how the current system is responding to the needs identified through this data, including the community based and criminal justice drug and alcohol services
- ensure that trends in substance misuse, that have not received sufficient focus in previous assessments, are given due consideration (e.g. alcohol misuse, steroid use, parental substance misuse)
- considers the 6 key equity strands in the analysis of need and considers the needs of different age groups-babies/children of substance misusing parents, young people (under 18) that misuse substances, adults and the 'ageing' drug using population
- identify national and local opportunities and threats to service development
- provide a view on how the current model(s) of services is responding to meet the needs identified; including the degree to which the system may or may not be meeting the needs of particular groups
- appropriately engage providers, service users/parents and relevant voluntary organisations and groups
- present the findings in ways that are easily understood by different audiences, which include providers, commissioners, users, parents, senior Managers within Health, Crime and Social care, and members of the public.

Objectives

The objective of the needs assessment is to provide a clear and accurate statement, supported by appropriate statistical and qualitative data, of the needs with regard to substance misuse in Leicester, of how the current system and services are able to respond to that need. The assessment will cover:

- a summary of drugs and alcohol policy and strategic background, national and local
- a description of the population of overall prevalence levels for drug and alcohol use
- an estimation of the current incidence of alcohol misuse identified through hazardous, harmful and dependent drinking and other drinking that can be problem defined including but not restricted to alcohol related criminality or comorbidity
- an estimation of the current incidence of drug misuse including but not restricted to dependency, drug related crime and co-morbidity
- an estimation of the current incidence of parental substance misuse and resulting needs of children and families
- a summary of evidence and guidance of effective targeted prevention, treatment and aftercare
- a description and assessment, against evidence and best practice, of the current response to need in the city - including strategic approach, prevention, models of care, capacity, costs, usage and outcome
- the identification of gaps and issues in services and interventions currently
- a forecast of numbers affected and future population need
- an indication of the strengths and limitations of the needs assessment and;
- provide recommendations.

Methodology

This HNA methodology is based on guidance issued by NICE¹ and Stevens et al. 2004². The HNA covers adults (above 18 years) and young people (under 18 years old).

There are a number of stages:

- review of the demographics of Leicester City
- analysis of existing data on drugs and alcohol
- use prevalence models
- review of the current services provided across Leicester City
- review the evidence of effective services/public health actions
- undertake qualitative analysis with key stakeholders
- analysis of gaps in provision to need (unmet need)
- disseminate and discuss these findings with stakeholders and
- provide recommendations to commissioners.

The following data sources were used in the quantitative analysis of the HNA:

- drug treatment data from the National Drug Treatment Monitoring System (NDTMS)
- alcohol treatment data from the National Alcohol Treatment Monitoring System (NATMS)
- centre based and pharmacy needle exchange data
- data from tier 1 and 2 drug and alcohol services and 'wraparound services'
- integrated drug and alcohol treatment systems in prisons
- Leicestershire and Rutland prison and probation service
- NHS hospital episode statistics and other Leicester City PCT data
- coroner's data
- Leicestershire Police data
- Leicestershire Fire & Rescue Service data.

Qa Research were commissioned to undertake seven focus groups over January 2012 to provide the qualitative aspect of the HNA. The seven groups consisted of service users, service providers, parents and carers of service users and wider stakeholders for alcohol and drugs, for both adults and children's services. Full methodology can be found in appendix 1.

Once the draft report was completed this was shared with stakeholders through email dissemination, discussion at a number of key meetings and a dissemination and discussion event to review in-depth the findings and help shape the recommendations. The output from the dissemination event can be found in Appendix 3.

National policy

Drugs

The 2010 National Drugs Strategy '*Reducing demand, restricting supply, building recovery: supporting people to live a drug-free life*'³ has two overarching aims; 1) reduce illicit and other harmful drug use and 2) increase the numbers recovering from their dependence. This is a fundamentally different approach to tackling drugs and a new ambition to reduce drug use and dependence, covering all drugs, both prescription and over-the-counter medicines. It recognises that severe alcohol interdependence with drugs, and sets out that services should be more integrated. The work of the strategy is based around three themes;

1. reducing demand – creating an environment where those who have not taken drugs continue to do so,
2. restricting supply – making the UK unattractive destination for drug traffickers, and
3. building recovery in communities – offering a route out of dependency putting the goal of recovery at the heart of what is done.

This is a national shift for a more integrated approach to commissioning public health outcomes, an approach that address the root causes and wider determinants of substance misuse to deliver the greatest gains. This is aimed to encourage more service users to complete their treatment, whilst not putting those at risk who are in existing treatment. The key principle is, that drug and alcohol commissioners work closely with all relevant partners to commission services based on outcomes. Four further principles are set out;

1. recovery is initiated by maintaining and where necessary, improving access to early and preventative interventions, and to treatment
2. treatment is recovery-orientated, effective and of high-quality and practice
3. treatment delivers continued benefit and achieves appropriate recovery-orientated outcomes, including successful completions
4. treatment supports people to achieve sustained recovery

The NTA provides guidance on what this might look like⁴.

Alcohol

In June 2007, the Department of Health and the Home Office jointly launched an updated government alcohol strategy, *Safe, Sensible, Social: The next steps in the National Alcohol Strategy*⁵ which set out clear goals and actions to promote sensible drinking and reduce the harm that alcohol can cause.

The strategy aimed to sharpen the criminal justice system for drunken behaviour, review NHS alcohol spending, help more people who wanted to drink less, toughen enforcement for under age sales of alcohol, have public information campaigns, consult on pricing and support local strategies on alcohol.

This strategy was from the previous government and the current Coalition government is yet to publish its strategy on alcohol. Alcohol is mentioned in the National drugs strategy, however an alcohol specific alcohol strategy is expected shortly.

Local policy/action

The Safer Leicester Partnership (SLP) is responsible for the implementation of the national drugs and alcohol strategies at a local level. The SLP is made up of a number of different agencies, including Leicester City Council, Leicestershire Constabulary, Leicestershire Fire & Rescue Service, Leicestershire & Rutland Probation Trust and Leicester City as well as partners from the private and the voluntary sector.

Drugs

Adults: The overall direction and purpose of the SLP strategy for adult drug treatment is to commission an effective drug treatment system that delivers positive recovery oriented outcomes for drug users and their families, as well as the communities within which they reside, with the public, private and third sectors commitment to tackling health inequalities, maximising the well-being of local citizens, creating thriving, safe communities, and investing in skills and enterprise.

The adult drug treatment strategy will achieve this by improving the health and well-being of Leicester residents through access to appropriate interventions; having a positive impact on the rates of acquisitive crime, and reoffending rates of Class A substance users; and overall importantly by championing recovery as a reality that will be achieved. The commissioning of substance misuse services are now integrated into the SLP structures to ensure accountability and ownership of strategic intent by partners.

Young People: The Leicester Young Person's Substance misuse plan⁶ aims to reduce alcohol and drug related problems in Leicester for young people, families and communities, and in doing so to improve outcomes for young people. The delivery group report to both the Children's and Safer Leicester Planning structures. The plan has a number of outcome indicators including;

- an increase in the proportion of young people leaving specialist treatment services that are drug free
- the proportion of young people in specialist services with an improved outcome in physical, psychological health or attainment/learning, on leaving treatment
- a reduction in the numbers and proportion of young people offending through alcohol use, in the 7 City wards where alcohol related offending is higher than the city wide rate.

The Plan specifies that there will be universal, targeted and specialist services for young people in Leicester and has specific targets for development in 2011/12. For example 100% of young people assessed as requiring specialist treatment that commence treatment within 15 working days of referral and 80% of young people should leave treatment in an agreed and planned way. The Plan also identifies, through the Children's Council, that those young people that express an interest in substance use services state that;

- services and staff should be as flexible as possible both in time and place-up to 24/7 flexibility with an emphasis on afternoon/evening appointments and in terms of responding to individual needs
- services should be marketed through large organisations such as Connexions and through the use of websites/Facebook

- services should be friendly and young person friendly and promoted in an attractive but discreet way
- the less staff that young people need to have contact with the better
- confidentiality is very important
- staff should be trained to work with young people
- peer workers should be used
- there should be a programme of Youth inspection, including mystery shopping.

Therefore the Plan is developing services that aim to meet the identified needs of young people in the city.

Alcohol

The Leicester Alcohol harm reduction strategy (2011) (a refresh from the 2008 strategy), sets out how alcohol harm is to be tackled in Leicester seeking to balance the benefits and harms that alcohol brings to individuals and the community. The original strategy was approved by the Safer Leicester Partnership and Alcohol reduction delivery group. The approach of the strategy focuses on local areas for action including; prevention, community safety, treatment and children and young people (increasing young people's access to treatment), while developing a strategic approach and addressing equality and diversity. Actions within the strategy have taken on board the findings from the Leicester and Leicestershire Total Place pilot that happened over 2009-10 and Alcohol harm reduction national support team visit in 2008. The NST made a number of recommendations for alcohol treatment and subsequent action is highlighted:

- The NST recommended the design of an integrated local alcohol treatment system based on identified need, which includes Probation and the wider Criminal Justice System, through the Tiered framework of provision which should be reflected in commissioning intentions. They recommended that this should be evidence based and desired outcomes should be specified. The intention is for this Health Needs Assessment to help inform future commissioning intentions and to enable this recommendation to be implemented.
- The NST suggested that consideration is given to the Primary Care Alcohol Pathway and other evidence-based models and the guidance on the Alcohol Directed Enhanced Service (DES) in developing this service. This should include identification tools, brief advice scripts, care pathway and Read codes. As a result of this recommendation, a Locally Enhanced Service (LES) was implemented; however, this needs to be evaluated to consider its effectiveness.
- The NST recommended the evaluation of the Hospital Liaison Worker post's impact on reducing alcohol related hospital admissions and consider a business case to increase its function and capacity across all hospital sites on an invest to save basis. Plans are in place to recruit a further four posts within the hospital setting to ensure that all three hospital sites have access to an Alcohol Liaison Worker post.
- The NST suggested that the capacity to deliver community detoxification within the treatment system is reviewed and agreed activity levels are established. The capacity to deliver more community detoxification packages were discussed with the provider service to pilot this service, after which more community service detoxification treatments are being delivered.

There have been a number of areas of progress since 2008 including; a downward trend in alcohol related crime, increased information/social marketing campaigns, identification and brief

intervention training for staff across a wide range of organisations and funding for Tier 2 and 3 services. There are still many actions that are being addressed through the current plan, these include; exploring new media regarding alcohol reduction messages, ensuring alcohol harm is reduced through the licencing system, and developing a more effective programme of alcohol education in schools.

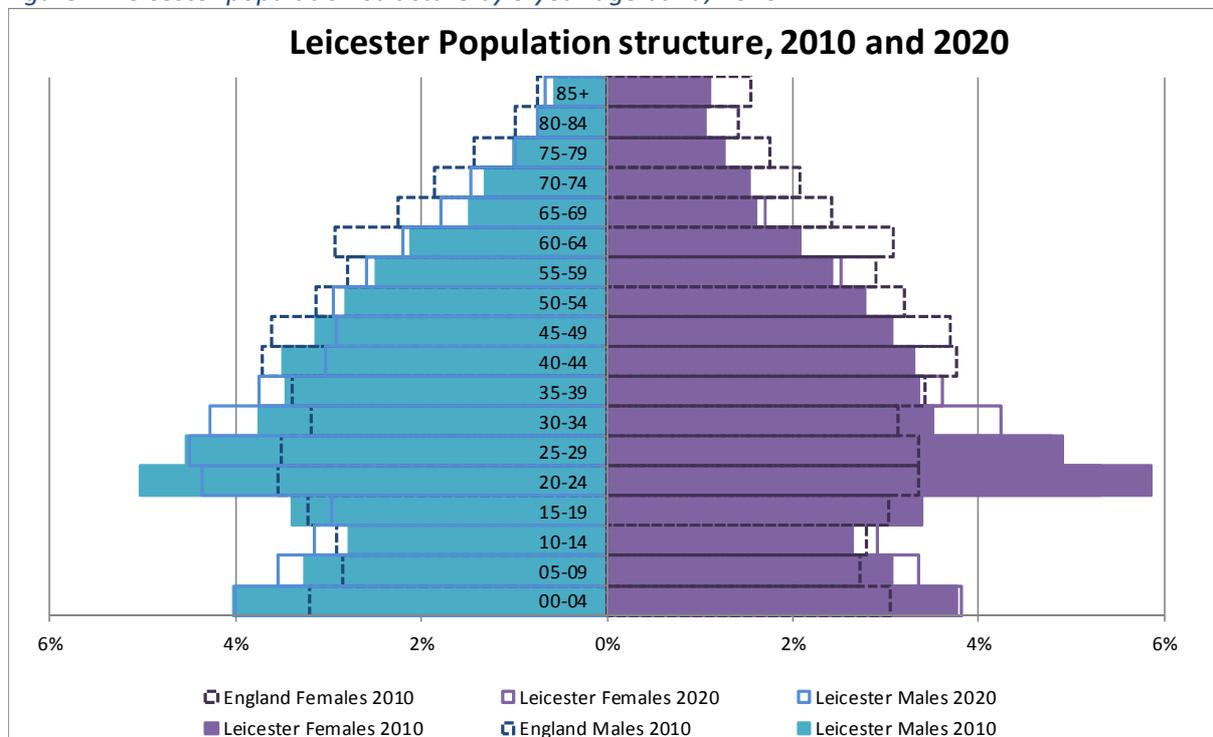
Demographics: Population profile of Leicester

The East Midlands is the second smallest region behind the North East with a population of just under 4.5 million. It is a less deprived area compared to the West Midlands and the North, but more deprived than areas of the South. Leicester is the largest city in the East Midlands, with a population of 306,600ⁱ and covers an area of 73.3 km². Much of the area is urban, with a high population density of 4,182 people/ km² making it the most densely populated area in the East Midlands and the 29th most densely populated area in the countryⁱⁱ.

The current population estimateⁱ for Leicester City is 306,631 of which 151,277 are males (49%) and 155,354 (51%) are females. Leicester’s population is relatively young compared with England; 20% (62,300) of Leicester’s population are aged 20-29 years old (14% in England) and 12% (35,600) of the population are aged over 65 (16% in England) (figure 1). The large numbers of young people in Leicester are partly students attending Leicester’s two universities and partly immigrants to Leicester.

The population is predicted to grow to around 346,000 by 2020ⁱⁱⁱ, an increase of nearly 40,000 from 2010. Projections indicate Leicester will have a smaller percentage of the population under 10 and a larger percentage aged over 40 years old.

Figure 1. Leicester population structure by 5 year age band, 2010



ⁱ Office for National Statistics mid-2010 population estimates

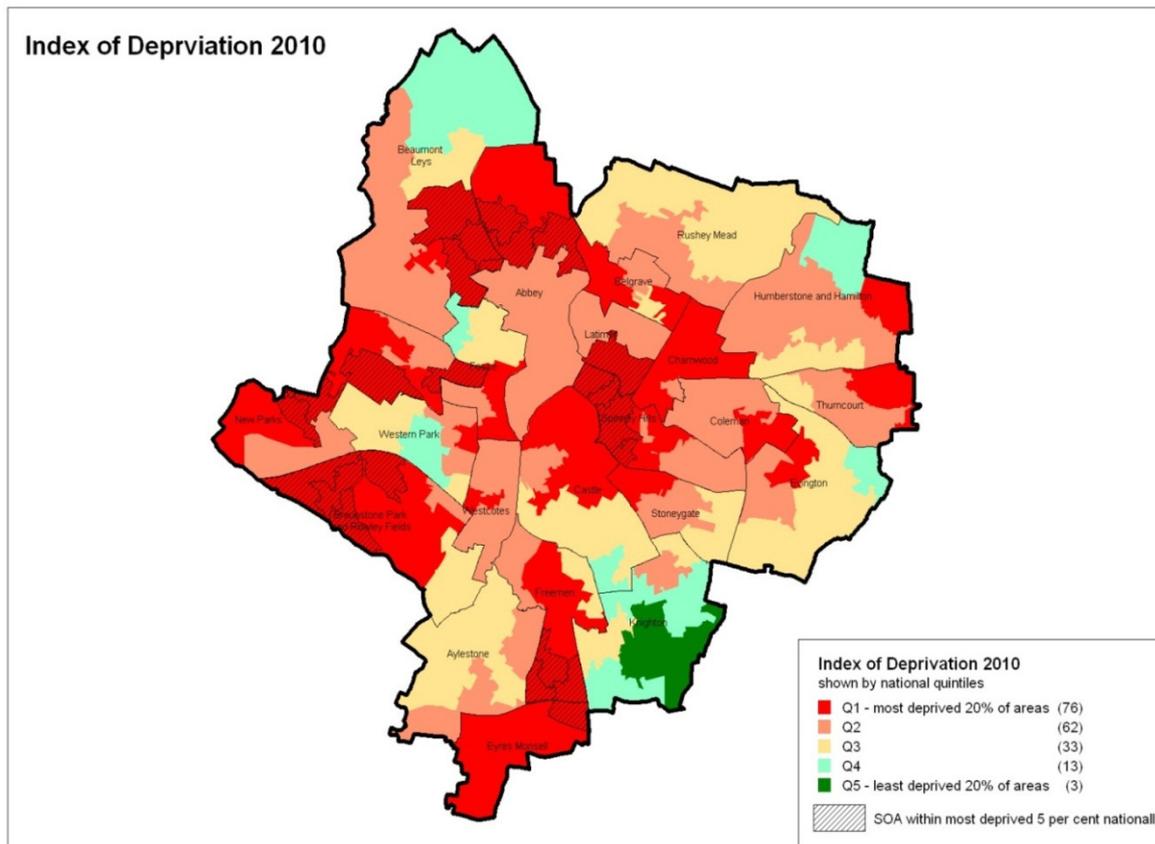
ⁱⁱ Office for National Statistics Population analysis tool, 2010

ⁱⁱⁱ Office for National Statistics 2008-based population projections

Data: ONS mid 2010 population estimates, 2008-based population projections

The average life expectancy for males and females in Leicester is lower than the England average. Men in Leicester have a life expectancy of 75.4 years which is over 3 years less than the national average (78.6 in England) and women in Leicester can expect to live to 80.1 years, 2 ½ years less than the national average of 82.6 years⁷. Poor life expectancy is linked to deprivation and Leicester has a high level of deprivation compared to the country as a whole; 41% of Leicester’s population live in the most deprived 20% of areas in England and a further 34% live in the 20-40% most deprived areas. Only 1% of Leicester’s population live in the 20% least deprived areas (figure 2). Across Leicester there is also a variation in life expectancy; for males there is a difference in life expectancy of 9.4 years and females 5.0 years between people living in the most and least deprived areas of Leicester⁸.

Figure 2. Index of multiple deprivation by ward, Leicester, 2010



Data: Index of deprivation 2010⁹

Leicester has a very diverse population compared with England as a whole; 36% of Leicester’s residents are from Black, Minority, Ethnic (BME) backgrounds compared with only 13% in England overall¹⁰. Around a quarter of Leicester’s population are of South Asian origin, (mostly Indian), 4% are Black/British, 3% mixed and 3% from other ethnic origins. The age profile of Leicester’s BME population is relatively younger than the White population.

It is estimated that there may be as many as 150 languages and/or dialects spoken in Leicester. Gujarati, Katchi, Punjabi, Urdu and Bengali are widely spoken and there are growing numbers of speakers of Somali, Polish or Slovak, Arabic, Tamil and various East African languages. Almost half of pupils in Leicester primary schools have a home language other than English¹¹.

Drug demographics

Prevalence of drug use

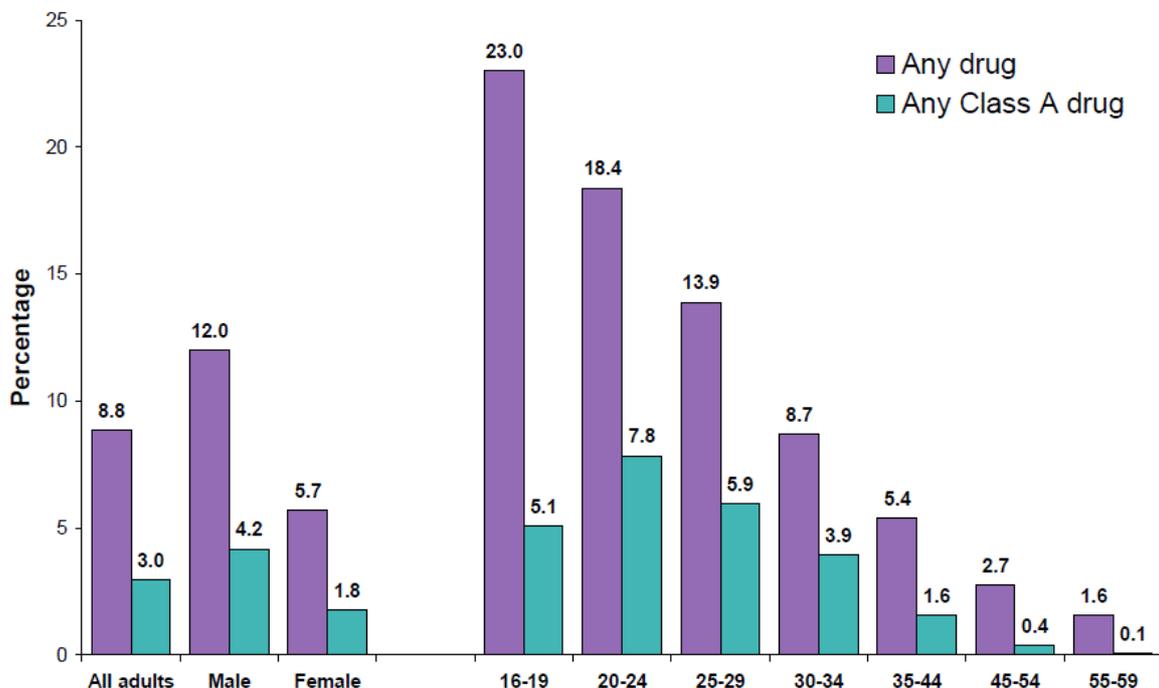
Nationally, the patterns in drug use are changing³. The numbers using heroin in England is reducing and those that are using it are aging, with fewer young people becoming dependent. Those aged 40 years and older make up the largest proportion of those newly presenting for treatment. Polysubstance (or multiple substance) abuse is increasingly seen as the norm, with alcohol and drugs being misused. Whilst drug dependence can affect anyone, those with a background of child abuse, neglect, trauma or poverty are disproportionately affected.

The Glasgow prevalence model (2009/10) estimates that there are 306,150 opiate and/or crack users (OCU) in England (95% CI 299,094 to 316,916)¹² which corresponds to 8.93 per thousand of the population aged 15 to 64 (95% CI 8.72 to 9.24). In Leicester City there is an estimated 2,539 opiate and/or crack users (95% CI 2,354 to 2,862).

National Survey data

The British Crime Survey¹³ (BCS) covering adults 16 to 59 years using self-reporting, estimates that 8.8% (almost three million people) (figure 3.) had used illicit drugs and that 3% (around a million people) had used class A drugs in the last year. Cannabis was the most used type of drug (6.8%, around 2.2 million people), followed by powder cocaine (2.1%, 0.7 million people) and then ecstasy (1.4%, 0.5 million people). When looking at 16 to 24 year olds, around one in five had used one or more illicit drugs in the last year (20.4%, an estimated 1.4 million people). This has fallen from previous years, largely due to a decline in cannabis use. Additionally, it appeared that single adults had higher levels of any illicit drug use compared to other marital status groups.

Figure 3. Proportion of 16 to 59 year olds reporting use of any drug by age group and sex in the last year, 2010/11 BCS.



Source: BCS

New questions introduced in the BCS in 2010/11 about attitudes to the acceptability of getting drunk, taking cannabis, cocaine and heroin showed that the majority of adults believed it is acceptable to get drunk occasionally (74%) and 6% frequently. The majority believed that it is never

acceptable to take cannabis (65%), cocaine (91%) or heroin (98%), with younger adults (16-24 years) twice as likely to believe that it be acceptable to frequently take cannabis (4%) compared to older adults (25-59 years) at 2%. Men were more likely to believe that it was acceptable to occasionally take cannabis and cocaine (38% and 11%) compared to women (27% and 6% respectively). Of those who had taken drugs in the last year, 59% reported having bought or been given drugs at home or in someone else's home, with 9% on the street, in a park or other outdoor area.

The national TellUs4 Survey (2009) covers years 6, 8 and 10 (11, 13 and 15 year olds) within a sample of schools from each local authority and asks questions about drug use. 64% of children in Leicester found drug information and advice in schools helpful (62% in England) and 19% found information/advice unhelpful. Only 7% of children in Leicester reported to ever having taken drugs compared with 9% nationally.

Leicester Lifestyles Survey

The Leicester Health and Lifestyle Survey (LLS) 2010¹⁴ was undertaken to provide accurate information about health-related behaviour, knowledge and attitudes in the adult Leicester population. The survey results are based on a representative sample of 2,310 twenty minute, face to face, in home interviews conducted with adults aged 16 and over living in Leicester, in 2010. The LLS asked those interviewed; 'Have you taken any of these drugs in the past 12 months?'. Table 1 shows that of the sample asked 6% (132) responded to have taken any drug. This is slightly lower than the national estimate of 8.8% from the BCS. Cannabis had the highest reported use, followed by cocaine/coke and then ecstasy.

Males were more likely to respond positively than females (9% and 3% respectively) and of all the 16-24 years olds who responded to the survey, 14% responded positively (the highest of all age groups). Within ethnic groups 8% of White groups responded positively compared to 3% of all BME groups.

Four wards had over 10 respondents who had taken drugs in the past 12 months; Castle (17), Stoneygate (16), Freeman (13), Humberstone and Hamilton (11), although the numbers are small to make any meaningful comparison.

Table 1. LLS results to the question: Have you taken any of these drugs in the past 12 months

| Drug type | No. taken any drug | % |
|--|--------------------|------|
| Amphetamines | 28 | 1.2% |
| Cannabis | 115 | 4.9% |
| Cocaine/coke | 37 | 1.6% |
| Crack/rock/stones | 11 | 0.5% |
| Ecstasy | 30 | 1.3% |
| Heroin | 11 | 0.5% |
| LSD/Acid 8 | 8 | 0.3% |
| Magic Mushrooms | 15 | 0.6% |
| Methadone/physeptone (not prescribed by a doctor) | 5 | 0.2% |
| Tranquillizers (Temazepam, valium, not prescribed by a doctor) | 11 | 0.5% |
| Amyl Nitrite (poppers) | 12 | 0.5% |
| Anabolic steroids (not prescribed by a doctor | 8 | 0.3% |
| Ketamine | 10 | 0.4% |
| Any other pills or powders (not prescribed by a doctor) | 9 | 0.4% |
| Any other drug | 6 | 0.3% |

Problems with prescribed and over the counter Medicine

In 2011 the NTA commissioned a study into problematic use of prescribed or over the counter medicine¹⁵. The report was unable to identify the precise level of prevalence of addiction and dependence in relation to prescription only medicines and over-the-counter medicines in the general population, however it highlighted for Leicester that in 2010-11, 42 clients had problematic use of prescribed or over the counter medicine but did not cite illicit drug use, whilst another 91 did cite illicit drug use. Amongst the former, prescribed Opioids were the main type of drug abused, whilst amongst those that also cited illicit drug use, Benzodiazepines were the main type of drug abused. This amounts to 9% of the structured drug treatment population citing problematic use of prescribed or over the counter medicine, compared with 12% for the region and 16% nationally.

Table 2. Proportion of all clients citing prescription or over the counter drugs (any use), 2011, NTA

| | Proportion of all clients citing prescription or over the counter drugs (any use) |
|----------------------|---|
| Wolverhampton | 2.3% |
| Sandwell | 3.1% |
| Nottingham | 5.0% |
| Manchester | 8.5% |
| Leicester | 8.5% |
| Barking and Dagenham | 11.4% |
| East Midlands | 12.0% |
| Birmingham | 12.7% |
| England | 16.0% |

Source: NTA, 2011

Reported substance misuse in young people

The 2010 national survey on smoking drinking and drug use in secondary school children (11-15 year olds)¹⁶, found that 45% of pupils said they had drunk alcohol at least once, with boys and girls equally likely to drink alcohol, with a marked increase from 11 years (10%) to 15 year olds (77%). Of those who had drunk alcohol, 54% reported being drunk at least once in the last 4 weeks. There was a strong relationship between pupils drinking behaviour and parental attitudes to drink; with 85% whose parents did not like them to drink had never drunk, compared to 27% who thought their parents would not mind as long as they did not drink too much.

The prevalence of drug use in this group has declined since 2001, with 18% reporting ever taking drugs in the last year in 2001 to 12% in 2010. Older pupils were more likely to report ever taking drugs ranging from 9% in 11 years to 32% in 15 year olds and cannabis was the most widely used drug (8.2%). However in a recent report of a survey of 754 young people (16-24 years old) reviewing the consequences of being out of work, education or training, found that 22% reported abusing alcohol or binge drinking and 13% taking drugs as a way of dealing with the feelings arising from their situation¹⁷. With rising youth unemployment the numbers abusing alcohol or drugs may increase.

Data from the Youth Offending Service (YOS) indicates a clear link between alcohol use and offending in Leicester. Over 2008-11, 15% of young people within the YOS were identified as having

a drug or alcohol issue that contributed to their offending, growing to 20% in 2010-11. The link between substance misuse and offending means that specialist services have a role to play in reducing the risk of custody for young people.

Data from Leicester Connexions suggest there are a number of young people whose learning is affected by substance misuse. Assessment Planning Intervention and Review (APIR) scores are recorded by Connexions staff when assessing and supporting 'at risk' young people. These include 5 scale measures for substance use (table 3). Over 2010-11 there were 1,253 APIRs undertaken by Connexions in Leicester of which 4.5% (57 assessments) were categorised as either 'critical' or 'significant' issues and 3.7% (45 assessments) with general issues. The levels 'significant' and 'critical' have a clear correlation with treatment need.

Table 3. Assessment Planning, Intervention and Review level and definition.

| APIR level | Definition of need |
|------------------------|---|
| 5 – Positive Strengths | No evidence of past or current substance use, evidence of protective factors – understanding of risks of substance use, supportive network of friends who do not misuse substances, positive rejection of substance use |
| 4 – No issues | No evidence of current substance use, evidence of prior use but not considered a major issue |
| 3 – General Issues | Occasional current substance use, evidence of peer influence, lack of commitment to stopping substance use |
| 2 – Significant Issues | Poly/chaotic substance use, lives/socialises within a drug taking environment, unwilling to address issues |
| 1 – Critical Issues | Poly/chaotic substance use, lives/socialises within a drug taking environment, unwilling to address issues, having immediate and serious impact on the young person. |

Source: Connexions, 2011

Alcohol demographics

Over 10m adults in England drink over the recommended daily limit, and 2.6m drinking more than twice that.¹⁸ There is an estimated £18-265 billion a year cost of alcohol misuse, spanning alcohol related disorders, crime, loss of productivity and health and social problems³. There has also been a dramatic rise in drinking among women, with heavy drinking increasing by almost a third in the decade prior to 2008.

The risks of drinking to excess are well established. Long term alcohol abuse can lead to numerous health problems, including liver and kidney disease, acute and chronic pancreatitis, heart disease, high blood pressure, depression, stroke, foetal alcohol syndrome and several cancers.¹¹

Alcohol consumption – definitions¹⁹

Recommended units of alcohol per day: Males: up to 4 units, Females up to 3 units

Hazardous drinking levels are defined as drinking over the recommended weekly limit of alcohol (21 units for men and 14 units for women).

Harmful drinking levels are defined as drinking over the recommended weekly amount of alcohol and experiencing health problems that are directly related to alcohol (over 50 units for men and 35 units for women)

Alcohol dependent is defined as feeling unable to function without alcohol, and the consumption of alcohol becomes an important, or sometimes the most important, factor in life

New definitions from 2010²⁰:

Increasing risk drinkers (who are at an increasing risk of alcohol-related illness) are defined as:

- Men who regularly drink more than 3 to 4 units a day but less than the higher risk levels
- Women who regularly drink more than 2 to 3 units a day but less than the higher risk levels

Higher risk drinkers (who have a high risk of alcohol-related illness) are defined as:

- Men who regularly drink more than 8 units a day or more than 50 units of alcohol per week
- Women who regularly drink more than 6 units a day or more than 35 units of alcohol per week

Lower risk drinkers (who are at a low risk of alcohol-related illness) are defined as:

- Men who regularly drink no more than 3 to 4 units a day
- Women who regularly drink no more than 2 to 3 units a day

Dependent drinkers cost the NHS twice as much as other alcohol misusers and that the largest and most immediate reduction in alcohol-related admissions can be delivered by intervening with this group³. It is estimated that 1.6 million people have mild, moderate or severe alcohol dependence nationally³.

For Leicester, it is estimated for adults (16 years+) that there are over 63,000 adults (26.2% of the population) drinking above low risk level, almost 13,000 (5.3%) drinking at harmful levels and almost 9,000 (3.6%) adults dependent on alcohol²¹.

National Survey data

National prevalence data relating to alcohol consumption can be found in surveys such as the General Lifestyle Survey (GLS) and Health Survey for England (HSE). The HSE is an annual survey collecting both socio-demographic and health measures, including consumption of alcohol. The HSE in 2010 reported for adults on their heaviest drinking day in the last week:

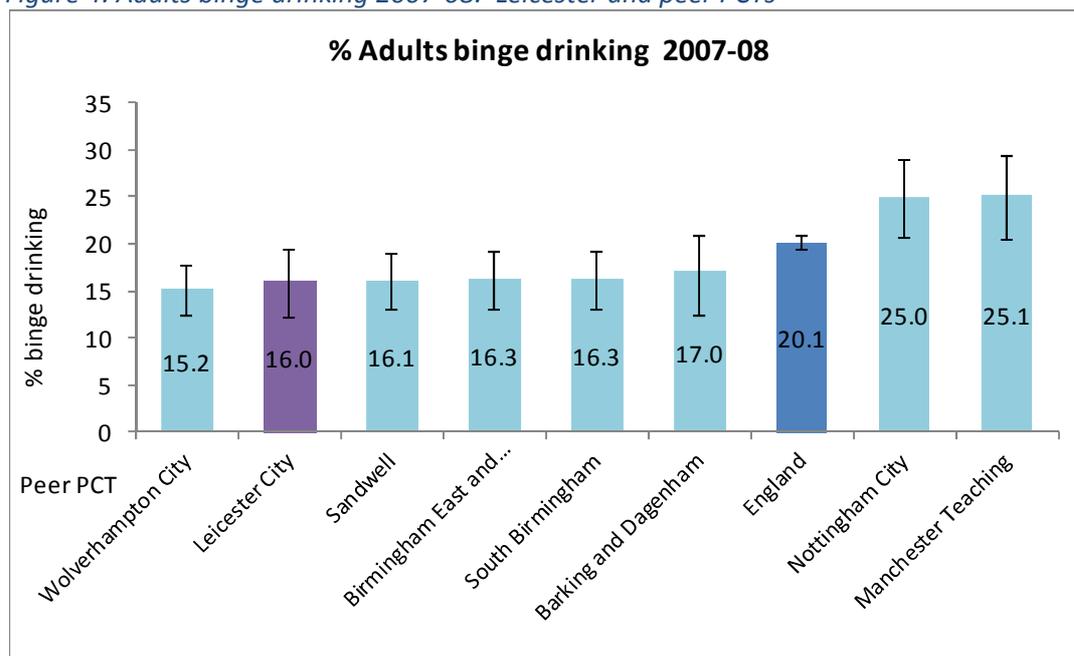
- 70% of male and 54% of female adults drank some alcohol in the last week
- 29% of male and 26% of female adults drank within the recommended daily limits of alcohol (males up to 4 units, females up to 3 units) and
- 23% of male and 14% of female adults drank more than double the daily recommended units of alcohol (males more than 8 units, females more than 6 units).

Binge drinking has been defined as consuming eight or more units in a single session for men and six or more for women. Drinking levels within the recommended limits, increase with age in both males and females. Males range from 15% at 16-24 years up to 50% in over 75s; females range from 14% at 16-24 years up to 36% in over 75s. Levels of drinking more than double the daily recommended units is high in males between 16 and 54 years (around 28%) then falls in the over 65s (9%) and over 75s to 5%. In females, the highest levels are in the 16-24s (21%), around 17-18% in 25-54 year olds and falling in the over 65s (4%) and over 75s (1%).

Alcohol consumption for different ethnic groups is not reported annually; however the GLS in 2005 reported that those drinking more than double the daily recommended units of alcohol the highest levels in males were found in Mixed White and Asian (26%), Mixed White and Black (25%) and White British (23%) groups. The lowest levels of binge drinking in males were found in Asian groups ranging from 1% in Pakistanis to 7% in Indians. Females show lower levels of binge drinking across all ethnic groups, with Mixed White and Black Caribbean (13%) and Mixed White and Asian (13%) have the highest levels of binge drinking. 10% of White British females and Other mixed groups binge drink, whilst several Asian groups report they do not drink at all (Pakistani, Bangladeshi, Chinese).

Alcohol prevalence data for Primary Care Organisations and Local Authorities has been estimated based on GLS 2008. Leicester had an estimated 16% of adults' binge drinking (2007-08); the second lowest within the peer PCTs which range from 15% in Wolverhampton to 25% in Manchester.

Figure 4: Adults binge drinking 2007-08. Leicester and peer PCTs



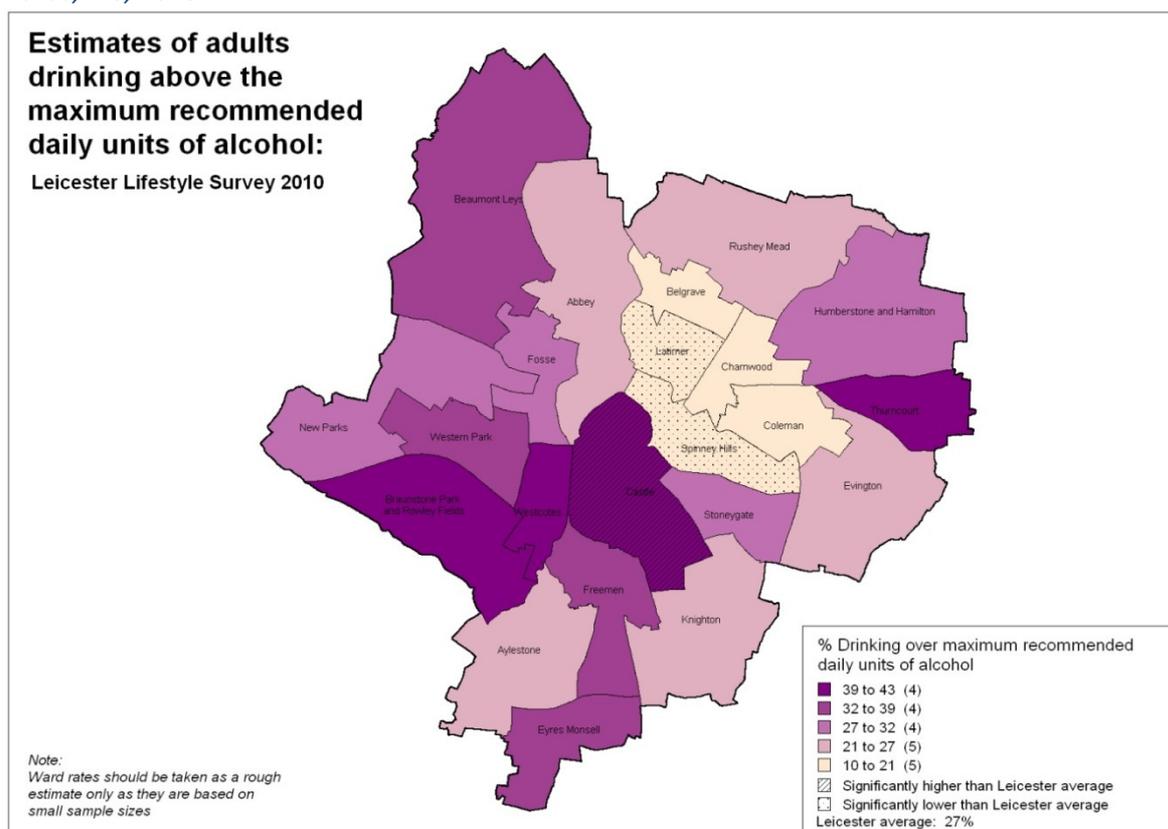
Source: GLS 2008.

Although the level of binge drinking within Leicester is relatively low overall compared with peer PCTs and the national prevalence, the LLS of 2010 suggests there is variation across the City. The LLS reported that around 27% of adults drink above the recommended daily units, compared to 28% who drink above the recommended daily units and 18% who drink more than double the daily recommended levels nationally (as reported in the HSE). The LLS also found that 32% of males and 23% of females drink above the daily recommendations and binge drinking is higher in 16-24s (33%) and decreases through 25-54 year olds (29%) to over 55s (19%). White populations show the highest level of binge drinking (36%), followed by Black groups (22%) and Asian groups (12%).

The LLS also showed that levels of drinking above the daily recommended units of alcohol are generally higher in the west of the city in areas of high deprivation. The highest levels of binge drinking (over 40%) were found in Castle (including the city centre and significantly higher than the Leicester average), Thurncourt and Westcotes and high levels (30-40%) were found in Beaumont Leys, Western Park, Freeman, Eyres Monsell and Braunstone Park (figure 5).

Wards in the east of Leicester show much lower levels of binge drinking with significantly lower levels than the Leicester average in Latimer (10%) and Spinney Hills (13%). The lowest levels were in Belgrave, Charnwood and Coleman. This may be because the wards with low levels of binge drinking in the east of Leicester that have mostly South Asian populations who typically reported lower levels of alcohol consumption.

Figure 5: Adults drinking above the maximum recommended daily units of alcohol in Leicester, by wards, LLS, 2010



Data: Leicester Lifestyle Survey 2010. NB Ward estimates will be subject to variation due to small sample sizes

Alcohol consumption in young people

The national TellUs4 Survey (2009) includes a question about alcohol consumption and drinking patterns. Of those children surveyed in Leicester, 20% of children reported to ever having an alcoholic drink (42% in England), 74% had never had an alcoholic drink (51% in England) and 6% didn't want to say. The majority of children (82%) who reported ever drinking had not been drunk in the last 4 weeks (68% in England), 3% had been drunk once, 2% twice, 2% three or more times, 9% didn't want to say or couldn't remember. These responses are around half of those nationally and suggest that of those surveyed, young people in Leicester have a lower proportion that drink and had been drunk from alcohol.

Alcohol use among the South Asian community in Leicester

A report commissioned by Leicester City PCT in 2010²² which aimed to explore the causes of alcohol misuse in the Leicester Sikh community and identify factors that motivate excessive alcohol consumption. A literature review, twenty-eight individual semi-structured interviews with problem drinkers and their family and a focus group with 12 Sikh community leaders was undertaken. The report found that British Sikh culture is evolving with changes in attitude towards alcohol use and the perception of alcohol abusers in the community, yet there is limited research on the drinking patterns of BME communities in general and the British Sikh community in particular.

Older Sikh men drink more than younger Sikh men and most of the participants confirmed that socialising was the reason for consuming alcohol. More women are beginning to drink in the Sikh culture, which necessitates further research.

There was evident concern amongst the focus groups about alcohol misuse amongst young people but the community leaders also said that substance abuse was a problem. It was also apparent that knowledge of the services available for problem drinkers was limited amongst the Sikh community as many had not heard of alcohol treatment services or seen publicity in the Sikh community centres. The reasons why BME communities do not access alcohol treatment services are diverse and complex, this may be because of the perceived Eurocentric nature of the services and having frontline staff from diverse ethnic backgrounds can demonstrate a more open service.

In a more recent analysis into the use of alcohol in the South Asian community²³, using two focus groups to explore the use of alcohol in South Asians (representing, mostly Hindu and Sikh communities), suggested that there is a strong sense of cultural taboo and stigma associated with the consumption of alcohol, social drinkers were drinking above the recommended weekly allowance as many were not aware of the units and recommended limits, and men and women were drinking openly at Hindu and Sikh weddings, which would have been unacceptable previously.

The groups felt that there were limited alcohol support services for South Asian young people in the city and generally the South Asian communities felt culturally unable to access alcohol services, domestic violence was an emerging issue and there was a need to improve the links between alcohol services and mental health services.

Multiple risk behaviours

From the Leicester Lifestyle survey, statistically significant associations were found between different factors of the survey. Table 4 below for example shows that the following groups are statistically significantly more likely to report taking drugs in the last year: males, 16-24 year olds, current smokers, those drinking more than the daily/weekly recommended amount of alcohol, those eating less than 5 portions of fruit and vegetables per day and those with a poor mental well-being.

The results indicate the importance of having more integrated interventions aimed at improving health behaviour and engaging communities, rather than parallel interventions for different issues such as alcohol, smoking, diet, physical activity and, mental health and well-being.

Table 4. Significantly higher likelihood of association and multiple risk factor, LLS, 2010

| Self-Reported Risk Behaviour | | | | | | | | |
|--|-------------------------------|----------------|--------------------------------|---|-------------------|-------------------------------|---------------------|------------------------|
| Self-Reported Status | Long term limiting conditions | Current Smoker | Allow smoking anywhere in home | Drink > daily and/or weekly recommended alcohol units | Drug in last year | Less than 5 fruit/veg per day | No regular exercise | Poor mental well being |
| Male | | √ | | | √ | √ | | |
| 16-24 | | | | | √ | √ | | |
| White | √ | √ | √ | √ | | | | |
| Current Smoker | √ | | √ | √ | √ | √ | √ | √ |
| Exceed Alcohol Weekly limit | | √ | | | √ | √ | | √ |
| Drug in last year | | √ | | √ | | √ | | √ |
| Less than 5 a day fruit and vegetables | | √ | | √ | √ | | √ | √ |
| Poor mental well being | √ | √ | √ | √ | √ | √ | √ | |

Data: Leicester Lifestyle Survey 2010

Experian Mosaic types

Mosaic by Experian is designed specifically for use by the public sector and focuses on the needs of citizens. It provides a detailed understanding of each citizen's location, their demographics, lifestyles and behaviours. It can be used to; anticipate and plan future resource requirements, understand the needs of customers and local areas to optimise the allocation of resources, target resources to facilitate entitlement and enrolment, develop personalised messaging and communication that changes behaviours. The top 10 profiles in Leicester below account for two thirds of Leicester's population:

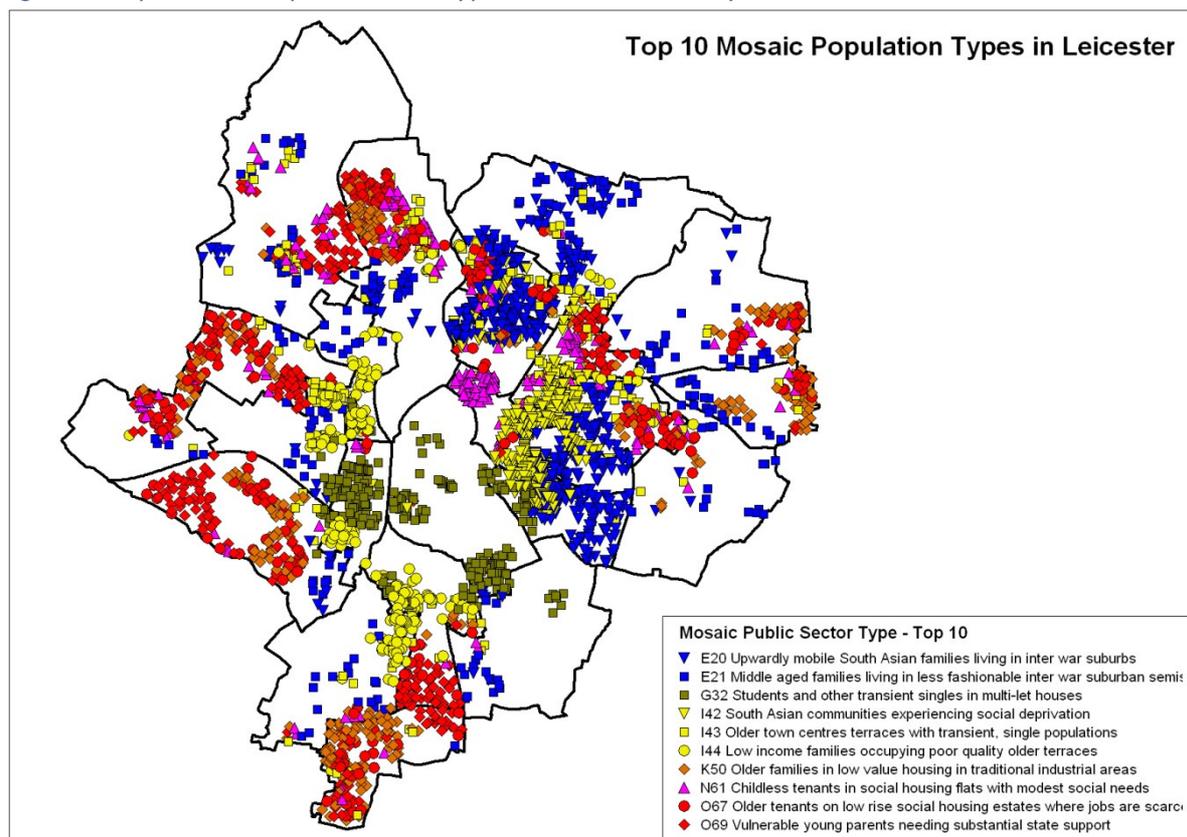
| Mosaic type | Population | % of Population |
|---|----------------|-----------------|
| 1. E20 Upwardly mobile South Asian families living in inter war suburbs | 45,886 | 13.0% |
| 2. I42 South Asian communities experiencing social deprivation | 37,259 | 10.5% |
| 3. O69 Vulnerable young parents needing substantial state support | 34,512 | 9.8% |
| 4. K50 Older families in low value housing in traditional industrial areas | 23,910 | 6.8% |
| 5. G32 Students and other transient singles in multi-let houses | 20,650 | 5.8% |
| 6. E21 Middle aged families living in less fashionable inter war suburban semis | 18,062 | 5.1% |
| 7. N61 Childless tenants in social housing flats with modest social needs | 15,058 | 4.3% |
| 8. I44 Low income families occupying poor quality older terraces | 14,806 | 4.2% |
| 9. O67 Older tenants on low rise social housing estates where jobs are scarce | 14,396 | 4.1% |
| 10. I43 Older town centres terraces with transient, single populations | 12,097 | 3.4% |
| TOTAL | 353,814 | 66.9% |

Data: Mosaic data, Leicester Population (GP-registered), 2011

The top Mosaic types in Leicester, E20 (mostly located in the centre west of the city) and I42 (located across the city) are both South Asian populations and typically show a lower than average prevalence of both drug taking and visits to pubs/wine bars. Types O69 'Vulnerable young parents' and K50 'Older families' as the third and fourth largest population types also show a lower prevalence of drug taking and fewer visits to pubs/wine bars.

Types showing higher than average levels of drug taking and visits to pubs/wine bars are G32 'Students and transient singles' with a high frequency of visits, N61 'Childless tenants in social housing' (high levels of drug taking only), I44 'Low income families' and I43 'transient singles'. I43 show high levels of cannabis and ecstasy and visit pubs/wine bars almost every day. These types with high levels of drug and alcohol consumption are found in areas of Leicester with high levels of deprivation. A full list and description of the Mosaic types can be found in appendix 2.

Figure 6. Top 10 Mosaic public sector types across Leicester by location.



Source: Experian, 2010

Alcohol and drug use amongst vulnerable groups

Some of the health experiences of asylum seekers may overlap with other disadvantaged and vulnerable groups in the UK, in which substance misuse problems have a prevalence which is higher than the population generally. There are physical and mental health issues specific to asylum seekers which, coupled with the impact of going through the asylum process, places them at risk of destitution and further inequality.

Most asylum seekers and refugees are relatively young, with health care needs which generally reflect those of the UK population of the same age²⁴, however ethnicity can act as a risk factor for certain conditions. Smoking and alcohol intake varies amongst different asylum seeker groups, with some groups having lower prevalence rates, with others higher²⁴. Asylum seekers and refugees often find that their changed status and feelings of powerlessness are difficult to manage. Levels of smoking and drinking may be exacerbated by feelings of boredom, displacement from their country of origin, social isolation, poverty and uncertainty about what may happen in the future.

Information about drug and alcohol use amongst asylum seekers and refugees is limited. Some cultures may stigmatise and prohibit drug and alcohol use, which may exacerbate the issue by making substance use more secretive. It is likely that some asylum seekers and refugees may use drugs and alcohol in a response to stress.

Whilst information is limited and dated, the ASSIST service in Leicester provides a model of care which is specifically focused on the health needs of asylum seekers and refugees. Data from the ASSIST practice in 2006 suggests that 96.9% men and 88.6% women who are registered with the practice do not drink alcohol²⁵.

In some communities, particularly Ethiopian, Kenyan and Somali there is a demand for Khat (a stimulant). Its use is unrestricted in the UK and its use has anecdotally been linked to social harms (i.e. family breakdown, unemployment and crime), although there is no clear evidence of harm indicated²⁶. With the large Somali community in Leicester an understanding of the use and consequences of using Khat needs further exploration.

Substance misuse and mental health problems: Dual-diagnosis

A clear association exists between mental illness and drug and alcohol dependence, with those experiencing mental ill-health having a higher risk of substance misuse³. In the UK it is estimated that 33% of psychiatric patients with serious mental illness have a substance misuse problem. Evidence suggests that the prevalence of dual-diagnosis is between 30% and 50% of psychiatric caseloads²⁷. Within Leicester in 2010-11, 9% of new drug treatment journeys for adults and 10% of new alcohol treatment journeys, the patient had a dual-diagnosis, compared to 14% and 16% nationally.

A local review of dual-diagnosis was carried out in 2009, with the definition of dual-diagnosis being agreed as *“referring to those people with co-existing problems of mental disorder and substance misuse (both drugs and alcohol)”*.²⁷

Those with dual-diagnosis are more likely to have a poor prognosis and often fail to receive appropriate care. Often people with dual-diagnosis have been either treated within one service (mental health or drug treatment service) or passed between services.

In response to these findings and the high number of clients with dual-diagnosis in the prison population, a dual-diagnosis Intercept Project has been set up in Leicester²⁸. The project has four main aims; to effectively identify mental health needs of arrestees and prisoners, ensure continuity of care and support, ensure effective liaison and diversion and help offenders with dual-diagnosis improve their lives. Within the first four months of the project (July to October 2011), 398 clients were screened, with 77% (305) testing positive for crack/cocaine or heroin on arrest, of which 61 (20%) indicated a dual-diagnosis. 33% (93) were arrested for alcohol related offences, of which 22 (24%) were tagged ‘positive’ for dual-diagnosis. Sixty-one of those identified with possible dual-diagnosis were referred to the project to additional support with their mental health needs. These are the first steps to identifying and supporting people with dual-diagnosis. In addition, a new project set up in 2012, between CJDT and LCPT which works through the gate of HMP Leicester will help support those with dual-diagnosis.

Maternity services: vulnerable mothers

The local maternity service collect data routinely on drug or alcohol use when women book into the midwifery service, although the data is not routinely reported. The local midwifery service provides two specialist midwives to care for young mothers (14-20 years old) living in Leicester and Leicestershire²⁹. The service also provides a drug and alcohol specialist midwife for those pregnant women who have been identified with substance misuse problems.

The teenage pregnancy and vulnerable mothers midwife (predominately focused on pregnant women under the age of 19 years), received 251 referrals between 2010-11 of whom 162 were from Leicester city. Of these 162 women, 9 were currently taking drugs or alcohol and 37 had ever taken drugs.

The substance misuse midwife supports women who have been identified with substance issues. In 2010-11, 66 women booked with the community midwives and were then referred on to the substance misuse midwife for additional support. 26 women booked directly with the substance midwife who had 34 on her caseload. In addition 37 women’s care was shared between the

substance misuse midwife and the community midwife for those women who needed some support. 22 women were referred back as they did not have a high enough risk or their issues were resolved. During 2010-11 there were 4,998 registered births (counting twins etc. as one birth) to residents in Leicester City at UHL hospitals, identifying only a small proportion had substance misuse problems. This shows there are a range of women who misuse substances and need support, however this data is not routinely reported to assess need and there is no clear pathway of support for women once they have given birth.

Health outcomes of drug and alcohol misuse

The misuse of drugs and alcohol can affect many different aspects of health and well-being of the individual, their family and wider community. For example it was estimated in 2008, in England that there were 630,000 working age individuals (women aged 18-59 and men aged 18-64) who were dependent drinkers³⁰ and 267,000 problem drug users (PDUs) in 2006 accessing the main Department for work and Pensions (DWP) benefits³¹. The impact on benefit claiming - interestingly, 80% of PDUs of working age in England are estimated to be in receipt of benefit, with only a quarter (25%) of AUDIT^{iv} 20+ dependent drinkers. This suggests that dependent drinkers are more able to sustain employment, or support themselves in other ways, than PDUs. To note, it is likely that many of those estimated to be a PDU will also be dependent on alcohol.

The Leicestershire Fire & Rescue service collect information on drugs and alcohol relating to dwelling fires. There were 261 dwelling fires attended in Leicester in 2010-11, alcohol and/or drugs was suspected to have been a contributory factor in 19 (7.3%) of fires. In 179 (69%) fires, alcohol and/or drugs was not suspected to have been a contributory factor and in a further 63 (24%) fires the role of alcohol and/or drugs in the fire was not known. There was no significant change from 2009-10 with both volumes and percentages remaining at very similar levels.

Alcohol and/or drugs data is collected for every primary fire i.e. a fire involving casualties or rescues, attended by 5 or more appliances or involves insurable property including buildings, vehicles and outdoor structures. Primary fires only account for 50% of fires attended and as stated above, in almost 25% of primary fires the suspected use of alcohol and/or drugs is not known (for example in the case of arson, where the perpetrator is not present). A fire where alcohol and/or drugs are suspected is therefore likely to be substantially higher.

Drug-related hospital admissions

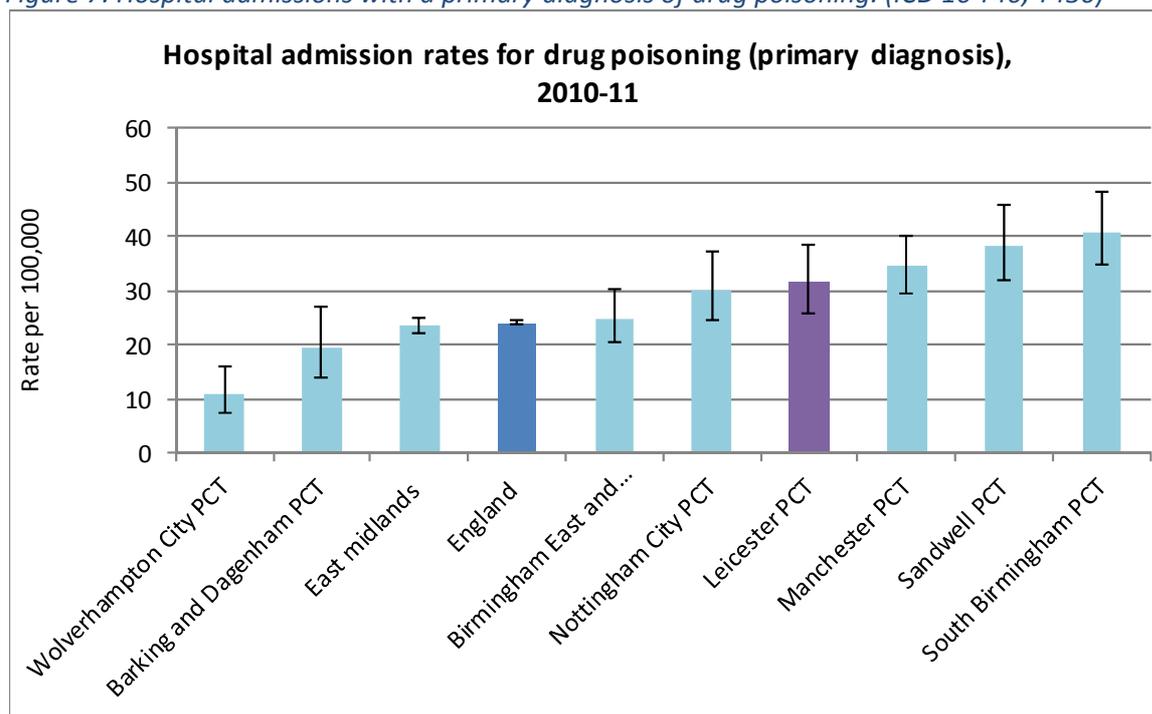
In 2010-11 there were 6,640 admissions to hospital nationally with a primary diagnosis of a drug-related mental health and behavioural disorder³², with more male than female admissions (Male: 4,814, Female: 1,827). This rose to 51,353 admissions where primary or secondary drug-related mental health diagnosis was recorded and there were 12,586 admissions with a primary diagnosis of drug poisoning. In Leicester in 2010-11 there were 97 admissions for drug poisoning, 69 admissions with a primary diagnosis and 418 admissions with primary or secondary of drug-related mental or behavioural disorder. Most of the admissions for primary diagnosis and related to mental health and behavioural disorders come from males in the 25-44 age groups.

The admission rate for drug poisoning in Leicester is statistically significantly higher than the national rate, as with many of the comparator PCTs (figure 7). The admission rate for drug-related mental or behavioural disorders in Leicester is also statistically significantly higher than the national rate for both primary and primary or secondary diagnosis, and higher than the majority of peer PCTs apart

^{iv} AUDIT – Alcohol Use Disorders Identification Test is a simple screening tool to pick up the early signs of hazardous and harmful drinking and identify mild dependence, and developed by WHO. Further details can be found at: http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf

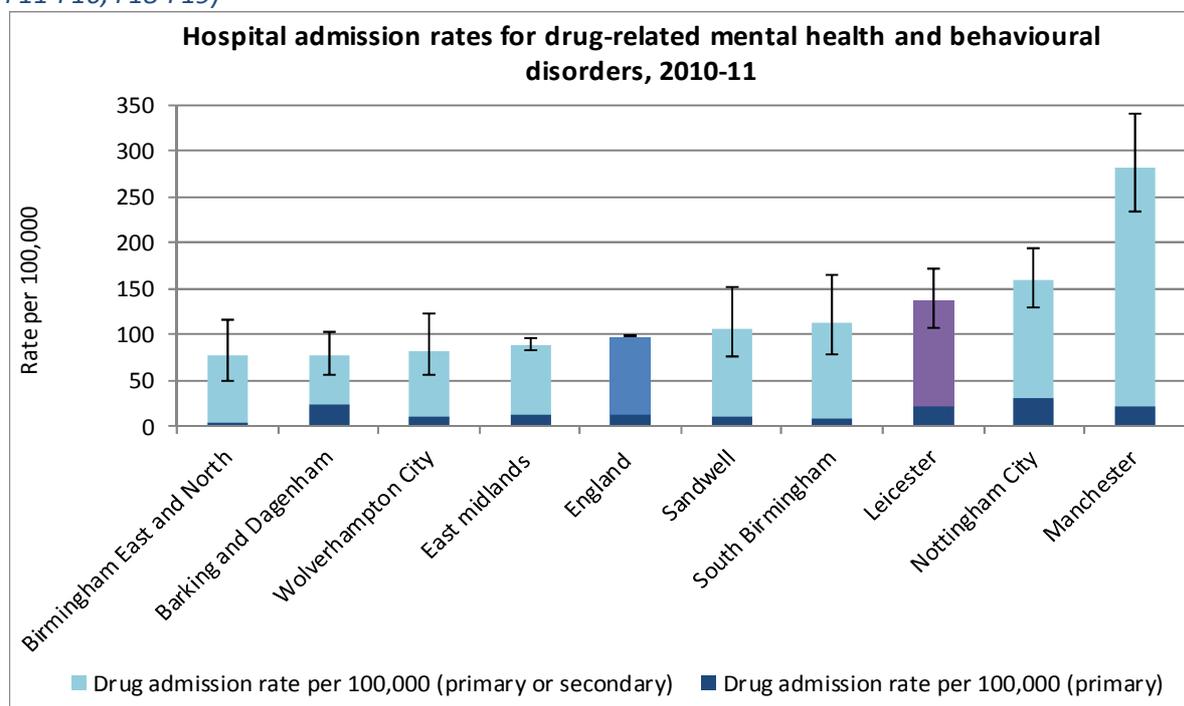
from Nottingham and Manchester (figure 8). The number of admissions is around 6 times higher in Leicester for any diagnosis, than for a primary diagnosis of mental health-related drug admissions.

Figure 7: Hospital admissions with a primary diagnosis of drug poisoning: (ICD 10 T40, T436)



Data: NHSIC, Statistics for Drug Misuse: England 2011

Figure 8: Hospital admissions for drug related mental and behavioural disorders, 2010-11: (ICD 10 F11-F16, F18-F19)



Data: NHSIC, Statistics for Drug Misuse: England 2011

Opioids are the largest cause (73%) of all drug poisoning hospital admissions in Leicester residents in 2008-09 to 2010-11, consisting of other opioids (46%), heroin (20%) and methadone (7%). Psychostimulants is the third largest cause of poisoning (14%). There were 1.5 times more admissions for males than females, however this varies with drug type; as for other opioids, admissions are 1.4

times higher in males, for heroin admissions are 9 times higher in males and for psycho-stimulants and cocaine are each nearly 3 times higher in males. The 25-44 year old age group account for 53% of all drug-related admissions, however this varies by drug type; with the 25-44 years accounting for 45% of all other opioids admissions, 85% of heroin, 38% of psycho-stimulants, and 65% of methadone, highlighting the difference in drug use by gender and age.

Table 5: Hospital admissions with a primary diagnosis of drug poisoning in Leicester by diagnosis, 2008-09 to 2010-11: (ICD 10 T40, T436)

| Diagnosis | Admissions 2008-09 to 2010-11 |
|--|-------------------------------------|
| Poisoning by Other opioids | 137 |
| Poisoning by Heroin | 60 |
| Poisoning by Psychostimulants with abuse potential | 42 |
| Poisoning by Methadone | 20 |
| Poisoning by Cocaine | 11 |
| Poisoning by Other and unspecified narcotics | 9 |
| Poisoning by Other and unspecified psychodysleptics [hallucinogens] | 8 |
| Poisoning by Other (synthetic narcotics, cannabis, LSD, Opium) | 9 |
| Total | 296 |

Data: SUS inpatient data

Of mental health related drug admissions for Leicester residents in 2010-11, opioids is the largest cause (45%), with cannabinoids the second largest (26%), followed by multiple/psychoactive drug use (14%) and cocaine (10%). These account for 95% of all mental health related drug admissions. Admissions are nearly 3 times higher for males than females overall and for cannabinoids 3.6 times higher in males. The 25-44 year olds account for two thirds of all mental-health related drug admissions. This is slightly lower for cannabinoids (56%) and higher for psychoactive drugs, stimulants and cocaine (around 70%).

In 2010-11 there were nearly 100 hospital admissions for drug poisoning, with males 1.4 times more likely to be admitted than females. Again the highest number were seen in the 25-44 year olds (50% of poisoning admissions), followed by 45-64 (27%) and 15-24 year olds (16%). The number of hospital admissions with drug and alcohol misuse as a primary diagnosis has fluctuated over the past 6 years, with a minimum of 238 admissions in 2005-06 and maximum of 368 in 2010-11^v. Admissions are nearly 3 times higher in males than females and the highest numbers of mental health related drug admissions are seen in those aged 25-44 years (around two thirds of all drug misuse admissions).

The majority of all drug-related hospital admissions are for the White ethnic group (81% White British, 11% Asian, 8% Other) and 85% of all mental health related drug admissions are for White ethnic group (7% Asian, 3% Black, 5% Other). This suggests a higher admission rate within the White population than other groups in Leicester (in 2009, 63% of Leicester's population (16-64 years) were of White ethnic group).

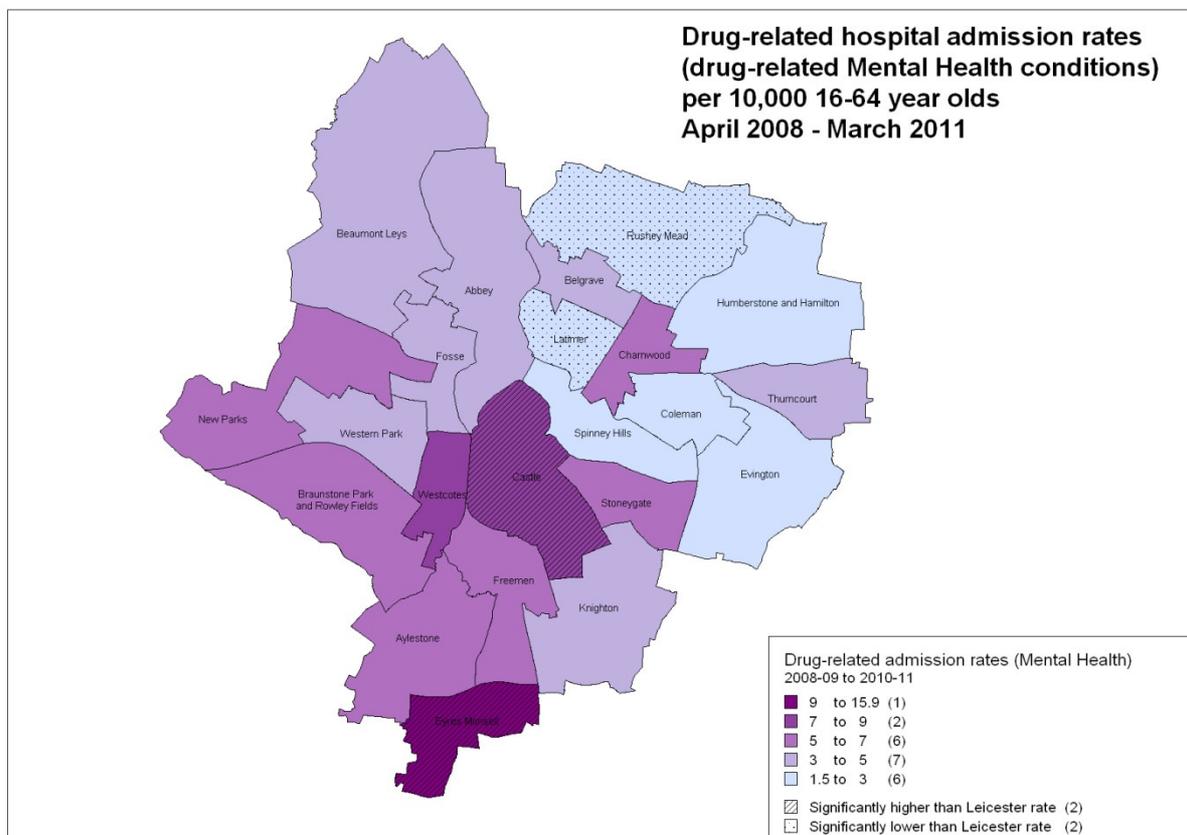
^v NB: Local hospital inpatient data (SUS) is shows a lower figure than published (368 admissions in 2010-11 versus 418 published by NHS Information Centre).

Drug-related hospital admissions in Leicester by ward

Numbers of drug-related hospital admissions are relatively small by ward in Leicester. Therefore the numbers have been aggregated over 3 years to calculate admission rates per 10,000 population 16-64 years old.

Castle and Eyres Monsell wards show a significantly higher rate of hospital admissions for drug poisoning than the Leicester average. The Castle rate is nearly double and Eyres Monsell over 3 times the Leicester rate. Four wards show a statistically significantly higher mental health-related drug admission rate than the Leicester average: Castle, New Parks, Stoneygate and Abbey. Castle ward shows the highest overall number of drug related admissions for mental and behavioural disorders. To note the hostels that provide accommodation for those who misuse drugs or alcohol are located in the Castle ward and may be a reason for the high rate in this ward if place of residence is recorded as the hostel.

Figure 9: Hospital admission rates per 100,000 16-64 year olds for drug related mental and behavioural disorders in Leicester by ward, 2008-09 to 2010-11: (ICD 10 F11-F16, F18-F19)



Data: SUS

Drug-related crime and disorder

As the majority of drug use is illegal, there are associated drug-related crime and disorder offences. Data provided by Leicestershire Police covering 2010-11, shows that there were over 1,400 recorded offences for possession of drugs (a rate of 46 offences per 10,000 population aged 16 years+), nearly 600 drug-attributable offences and over 40 recorded crimes relating to acquisition. Of the 600 drug-attributable offences (where drugs are considered the cause of the crime) the majority were for theft from stores, intending to supply or manufacturing of drugs (Drugs category) or assault and harassment (table 6). To note there may be discrepancies in the data due to coding.

Table 6: Crime attributed to drugs, 2010-11, Leicestershire police.

| Other crime attributed to drugs | % |
|---------------------------------|-------|
| Theft from stores | 29.1% |
| Drugs* | 27.3% |
| Assault and harassment | 21.2% |
| Theft | 5.3% |
| Anti-social behaviour | 5.1% |
| Damage | 3.0% |
| Miscellaneous | 2.3% |
| Fraud | 1.9% |
| Burglary (other) | 1.4% |
| Damage to motor cycle | 1.2% |
| Public Order | 0.9% |
| Theft (Cycle) | 0.5% |
| Indecency | 0.4% |
| Non-recordable | 0.2% |
| Theft (person) | 0.2% |

Data :Leicestershire police. *Drugs category relates to intent to supply drugs or for the growth/manufacturing of drugs

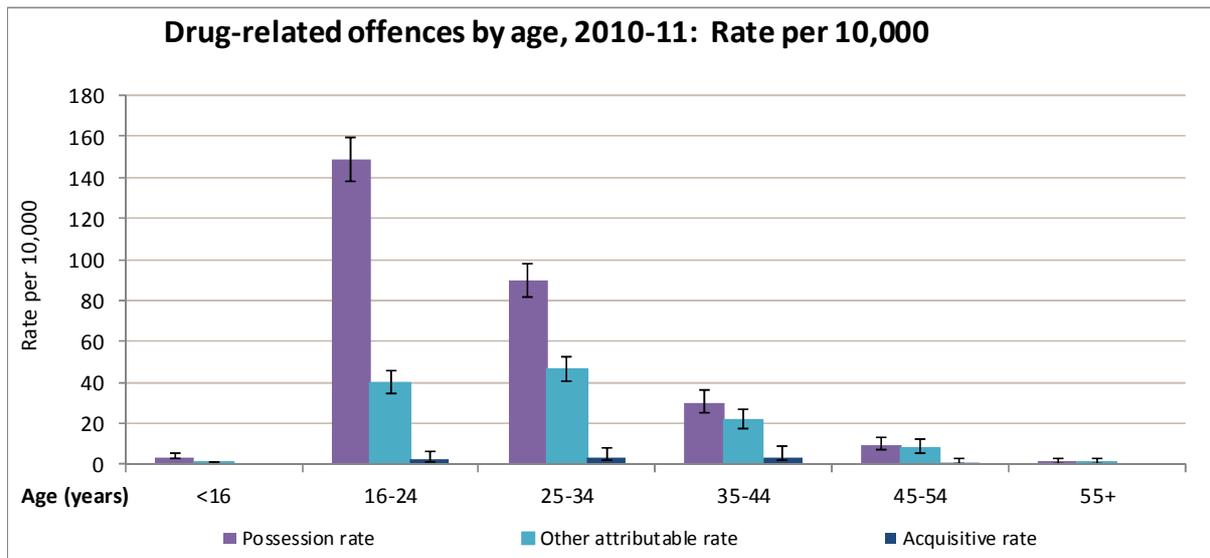
The majority of offenders were male (table 7) and younger age groups (16-24 and 25-34 years old) were significantly more likely to have a drug related offences than the other age groups (figure 10) and rates of possession are significantly higher than the overall average in Black and other BME groups. In terms of numbers, this relates to 192 offences (White) and 436 (BME Other) of the 1,404 total recorded crimes for possession (table 8).

Table 7: Drug-related offences by gender in Leicester, 2010-11:

| Drug offence | Males | Females | Total | Females | | Total % |
|------------------|-------|---------|-------|---------|-----|---------|
| | | | | Males % | % | |
| Possession | 1289 | 115 | 1404 | 92% | 8% | 100% |
| Other attributed | 488 | 79 | 567 | 86% | 14% | 100% |
| Acquisitive | 40 | 2 | 42 | 95% | 5% | 100% |

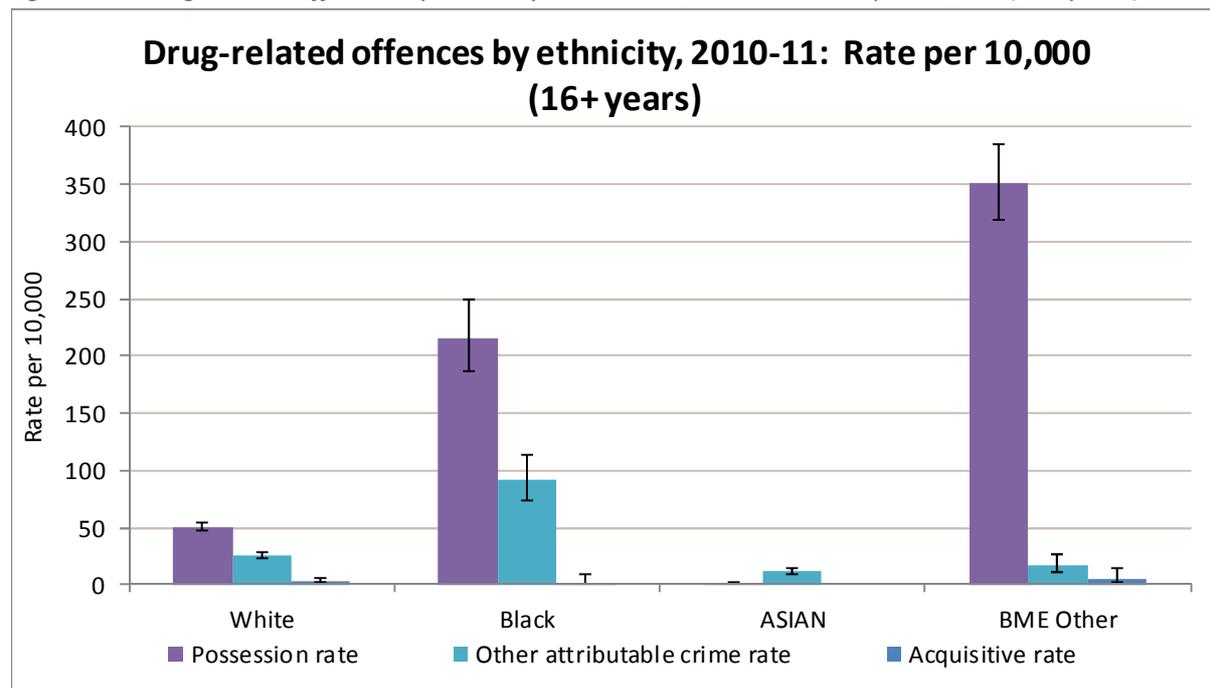
Date :Leicestershire police . To note the data from Leicestershire Police are recordings of where an officer has judged that either the victim or offender was under the influence of drink or drugs. Roughly 1/3 of all the data has no record; therefore interpretation should be made with caution.

Figure 10: Drug-related offences by age in Leicester, 2010-11: Rate per 10,000 (16+ years)



Data: Leicestershire Police

Figure 11: Drug-related offences by ethnicity in Leicester, 2010-11: Rate per 10,000 (16+ years)



Data: Leicestershire Police

Assessing the possession and other drug attributable offences by ward shows that the majority of drug-related offences take place in Castle ward (which includes City Centre). Castle, Freeman, Abbey and Westcotes show significantly higher rates for possession per 10,000 population (2010-11) than in Leicester overall (table 8). It should be noted that the location of the offence is where the person was caught rather than where they live, therefore it is unsurprising that Castle, which includes the city centre is where the majority of other drug attributable offences occur i.e. theft from stores.

Table 8: Drug-related offences by ward in Leicester, 2010-11: Rate per 10,000 (16+ years)

| Ward name | Possession offences | Other drug-attributable offences | Possession rate | Other attributable crime rate |
|-----------------------------------|---------------------|----------------------------------|-----------------|-------------------------------|
| Abbey | 109 | 38 | 100.3 | 35.0 |
| Aylestone | 31 | 16 | 35.2 | 18.2 |
| Beaumont Leys | 58 | 45 | 47.3 | 36.7 |
| Belgrave | 35 | 5 | 40.0 | 5.7 |
| Braunstone Park and Rowley Fields | 36 | 19 | 27.5 | 14.5 |
| Castle | 431 | 170 | 231.5 | 91.3 |
| Charnwood | 39 | 30 | 42.8 | 32.9 |
| Coleman | 42 | 18 | 40.7 | 17.4 |
| Evington | 11 | 9 | 12.9 | 10.6 |
| Eyres Monsell | 42 | 18 | 49.0 | 21.0 |
| Fosse | 34 | 24 | 34.7 | 24.5 |
| Freemen | 102 | 19 | 122.3 | 22.8 |
| Humberstone and Hamilton | 74 | 17 | 55.3 | 12.7 |
| Knighton | 35 | 11 | 27.3 | 8.6 |
| Latimer | 60 | 12 | 59.4 | 11.9 |
| New Parks | 66 | 34 | 53.2 | 27.4 |
| Rushey Mead | 30 | 13 | 23.2 | 10.1 |
| Spinney Hills | 47 | 19 | 29.5 | 11.9 |
| Stoneygate | 31 | 13 | 21.3 | 8.9 |
| Thurncourt | 3 | 9 | 3.8 | 11.3 |
| Westcotes | 65 | 18 | 78.9 | 21.8 |
| Western Park | 23 | 10 | 28.9 | 12.6 |
| Leicester Total | 1404 | 567 | 57.7 | 23.3 |

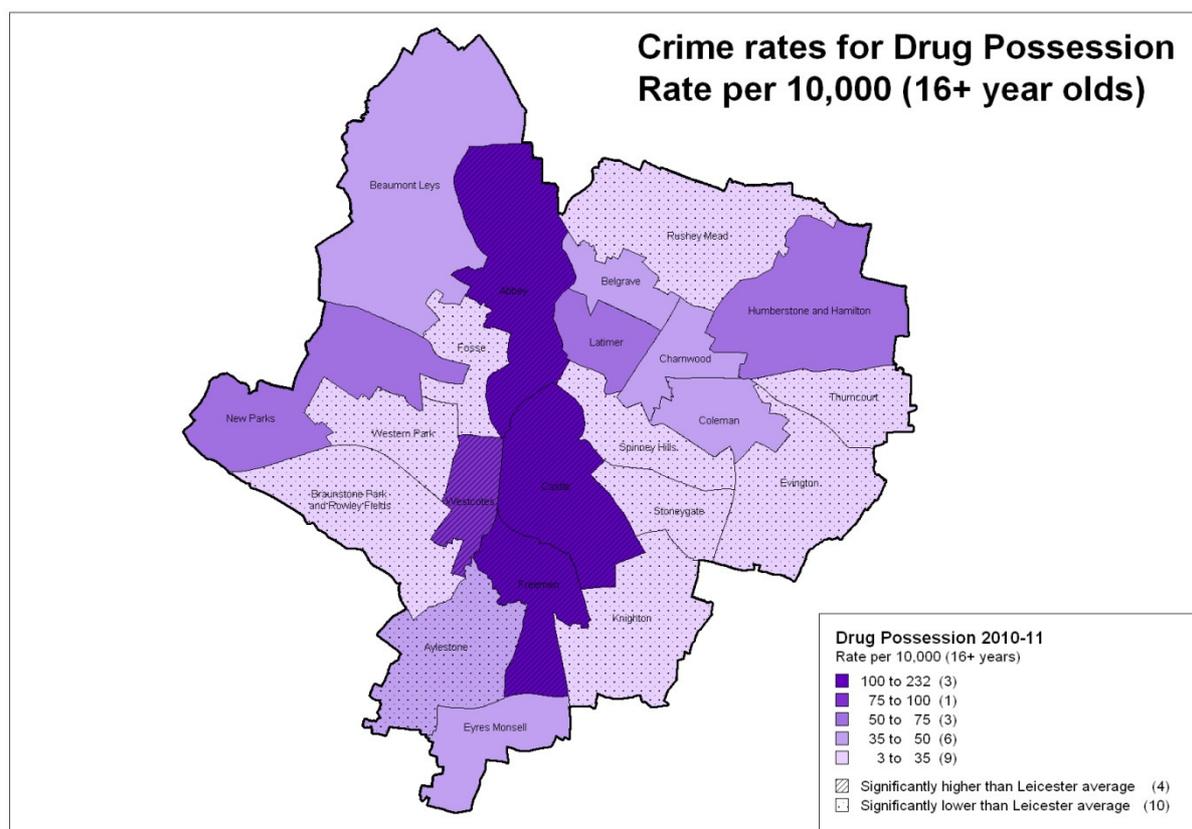
Data: Leicestershire Police

Significantly higher than the Leicester rate

Significantly lower than the Leicester rate

Possession offences show significantly higher rates in the band of wards which are central (north-south) in Leicester; Abbey, Castle, Westcotes and Freemen.

Figure 12. Crime rates for Drug Possession, rate per 10,000 (16+ year olds), 2010-11

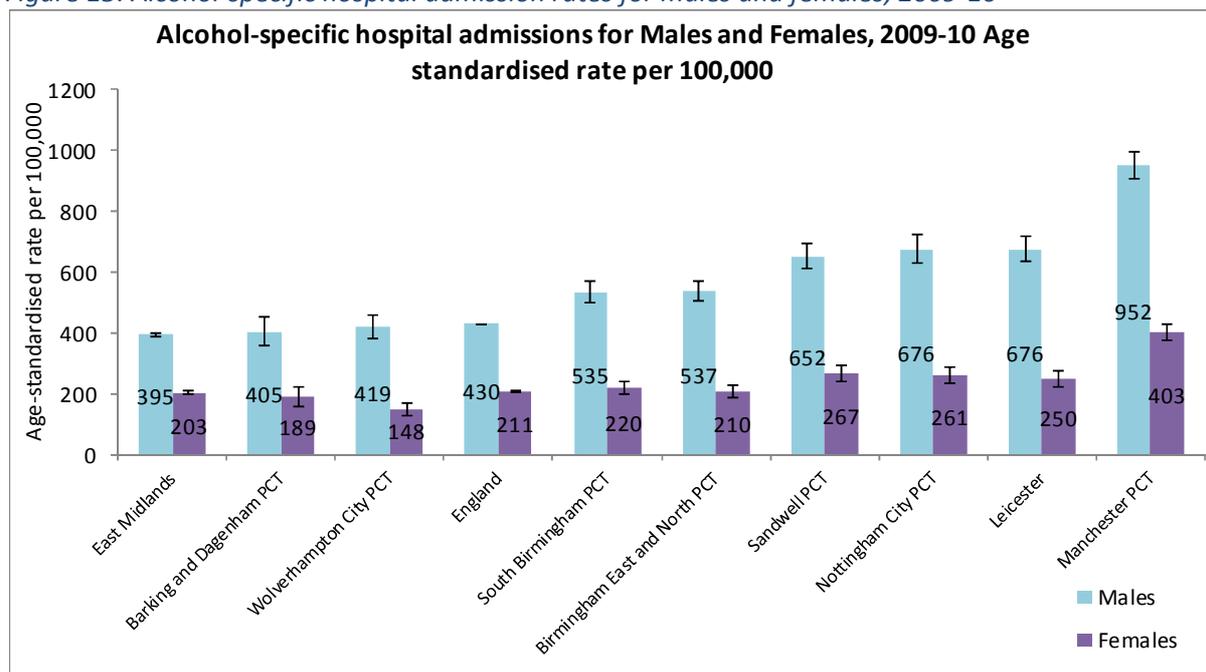


Data: Leicestershire Police

Alcohol-related hospital admissions

Alcohol-specific admission rates include those conditions where alcohol is causally implicated in all cases of the admissions, e.g. alcoholic liver cirrhosis and alcohol-induced behavioural disorders. The alcohol-specific hospital admission rates have been rising nationally and locally since 2004³³ with 169,911 admissions nationally in 2009-10, and males more likely than females (Males: 113,997, Female: 55,934). Locally Leicester has seen a similar rise to England (around 70 per 100,000) for male and a lower increase in admission rates for females (27 per 100,000 in Leicester compared to 38 per 100,000 in England) since 2004. However admission rates for both males and females in Leicester are significantly higher than in England, and rates in males are nearly 3 times higher than females in Leicester compared with double nationally (figure 13). The alcohol specific admissions by ethnic group show that 77% of admissions are White and 15% from Asian ethnic groups. This is a lower rate in BME groups as BME groups represent around 36% of Leicester's population, however with changing attitudes and behaviours this may change in the future.

Figure 13: Alcohol-specific hospital admission rates for males and females, 2009-10

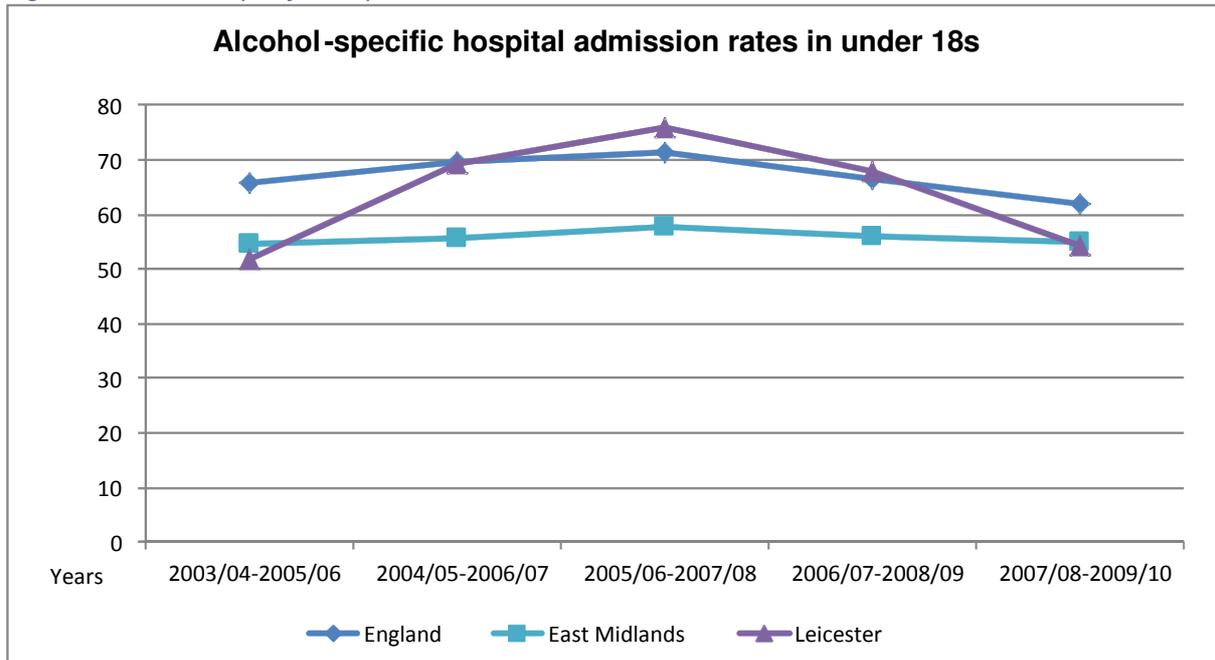


Data: Local Alcohol Profiles for England (LAPE)

There were 113 alcohol-specific admissions in under 18s in Leicester (2007/08 - 2009/10), equivalent to around 38 admissions per year in under 18s. The main causes of admissions are mental and behavioural disorders due to alcohol (66%) and around 30% are due to ethanol poisoning and other toxic effects of alcohol. The trend in admissions in the under 18s appears to be decreasing (figure 14), however within the peer group, Leicester has the fourth highest admission rate of the seven PCTs.

In Leicester under 18s, 78% of alcohol-specific admissions are for White ethnic groups, 12% for Asian groups and 10% of other black and minority groups. For all ages, there are 77% White, 15% Asian and 8% BME Other.

Figure 14: Alcohol-specific hospital admission rates in under 18s, 2009-10



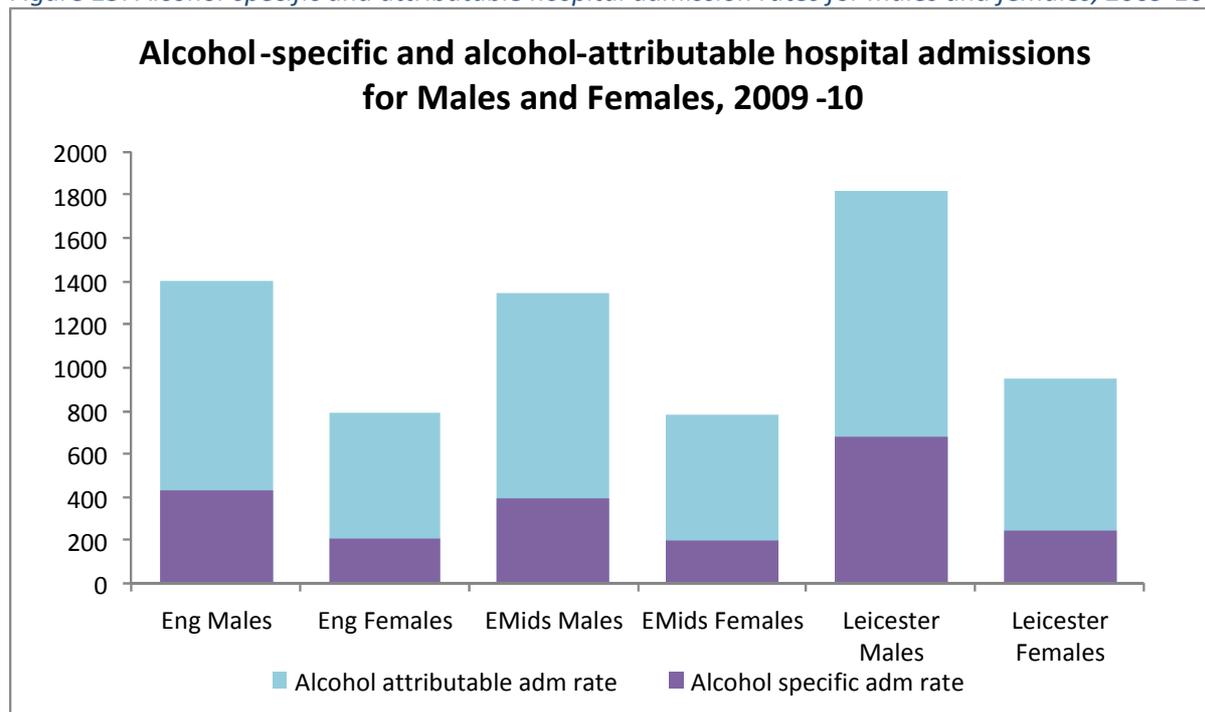
Data: Local Alcohol Profiles for England (LAPE)

Alcohol-attributable admissions to hospital

Alcohol-attributable or related conditions include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the condition, for example, hypertensive diseases, various cancers and falls. The attributable fraction for alcohol-attributable conditions (AAF) ranges from between greater than zero and less than one e.g. AAF for assault is 0.27; AAF for alcoholic liver disease is 1, indicating that an assumption has been made that 27% of admissions for assault are alcohol-related and 100% of admissions for alcoholic liver disease are alcohol-related. In England in 2009-10 there were 663,281 alcohol-attributable admissions with males, almost twice as likely to be admitted than females (Males: 406,873, Females: 256,408).

Alcohol-specific admissions make up around 30% of all national alcohol-related admissions in males (around 37% in Leicester males) and around 25% of female admissions. Alcohol-attributable hospital admissions in Leicester are significantly higher than in males and females nationally (figure 15).

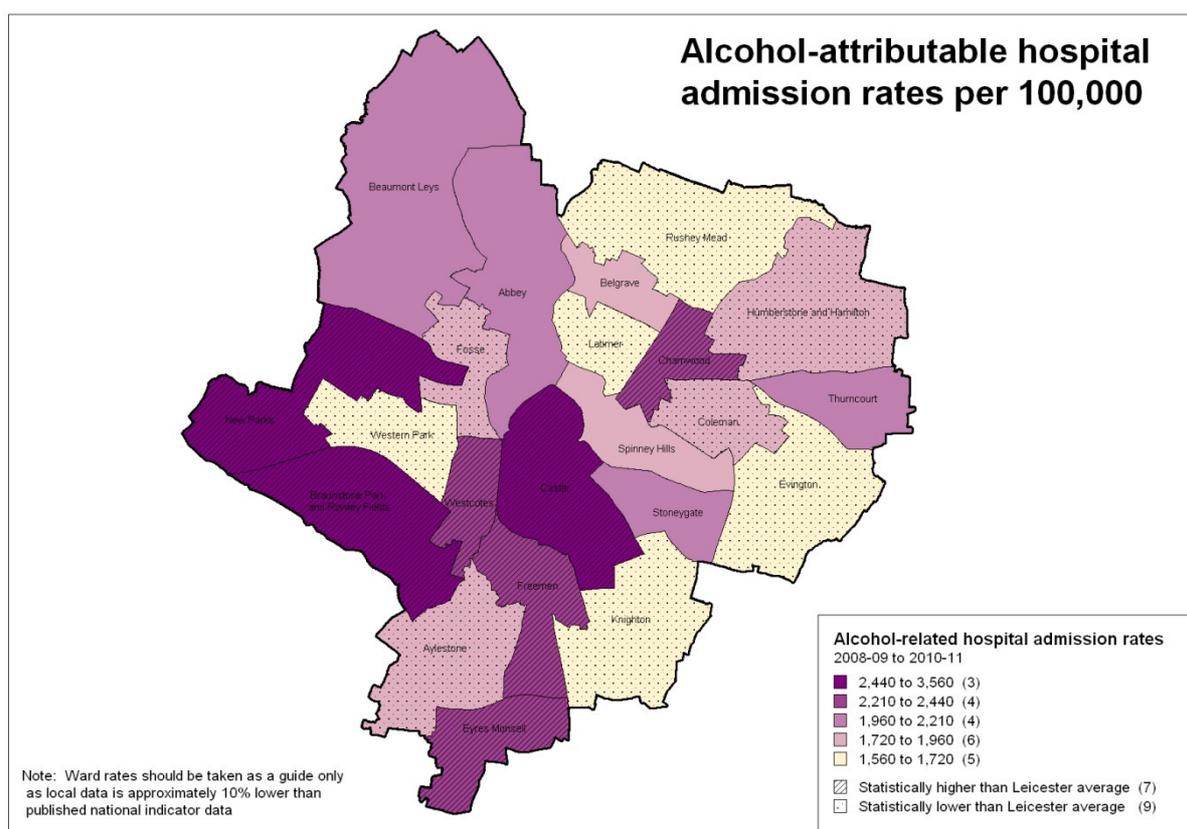
Figure 15: Alcohol-specific and attributable hospital admission rates for males and females, 2009-10



Data: Local Alcohol Profiles for England (LAPE)

The top 3 causes of alcohol-attributable hospital admissions in Leicester in 2009-10 were hypertensive diseases (27% of all alcohol-related admissions (18% male, 9% female), mental disorders due to alcohol and digestive disorders. Males and females in Leicester show a higher proportion of mental disorders from alcohol than nationally, and lower proportion of hypertensive and digestive admissions (table 8). Hypertensive diseases account for 35% of hospital-attributable diseases in England (23% male, 12% female). Alcohol-specific causes account for 40% of admissions in Leicester (32% in England), broken down into; mental: 24%, (England 17%), acute 10% (England 10%) and chronic 6% (England 5%). There is a higher rate of alcohol-attributable admissions in the west of the city than the east, which reflects the estimates of adults drinking above the maximum recommended daily units of alcohol.

Figure 16: Alcohol-attributable hospital admission rates per 100,000, by ward 2008-09 to 2010-11



Data: Local Alcohol Profiles for England (LAPE)

Table 8: Alcohol-attributable hospital admissions; top 10 causes as a % of all alcohol-attributable admissions, 2009-10

| Alcohol-related condition | % of alcohol-related admissions | | | | | |
|----------------------------|---------------------------------|-----------------|-------------|--------------|-----------------|-------------------|
| | England Males | England Females | Emid Males | Emid Females | Leicester Males | Leicester Females |
| Hypertensive (Chronic) | 23.3 | 12.0 | 23.7 | 12.0 | 18.1 | 9.4 |
| Alcohol specific (Mental) | 12.1 | 4.5 | 10.7 | 4.0 | 18.7 | 5.1 |
| Digestive (Chronic) | 10.3 | 7.0 | 10.9 | 7.0 | 7.0 | 5.0 |
| Alcohol specific (Acute) | 4.5 | 5.5 | 4.5 | 5.7 | 4.7 | 5.7 |
| Alcohol specific (Chronic) | 3.7 | 1.5 | 3.3 | 1.4 | 4.5 | 1.3 |
| Cardiac arrhythmias | 2.1 | 1.1 | 2.0 | 1.1 | 2.1 | 1.2 |
| Violence (Acute) | 2.0 | 1.9 | 2.1 | 2.3 | 1.7 | 1.6 |
| Other diseases | 1.6 | 1.4 | 1.6 | 1.7 | 2.8 | 2.8 |
| Cancer | 1.5 | 1.8 | 1.5 | 2.0 | 2.6 | 2.6 |
| Accidents & Injury (Acute) | 1.4 | 0.8 | 1.5 | 0.9 | 1.9 | 1.2 |
| Total | 62.5 | 37.5 | 61.9 | 38.1 | 64.1 | 35.9 |

Data: Local Alcohol Profiles for England (LAPE)

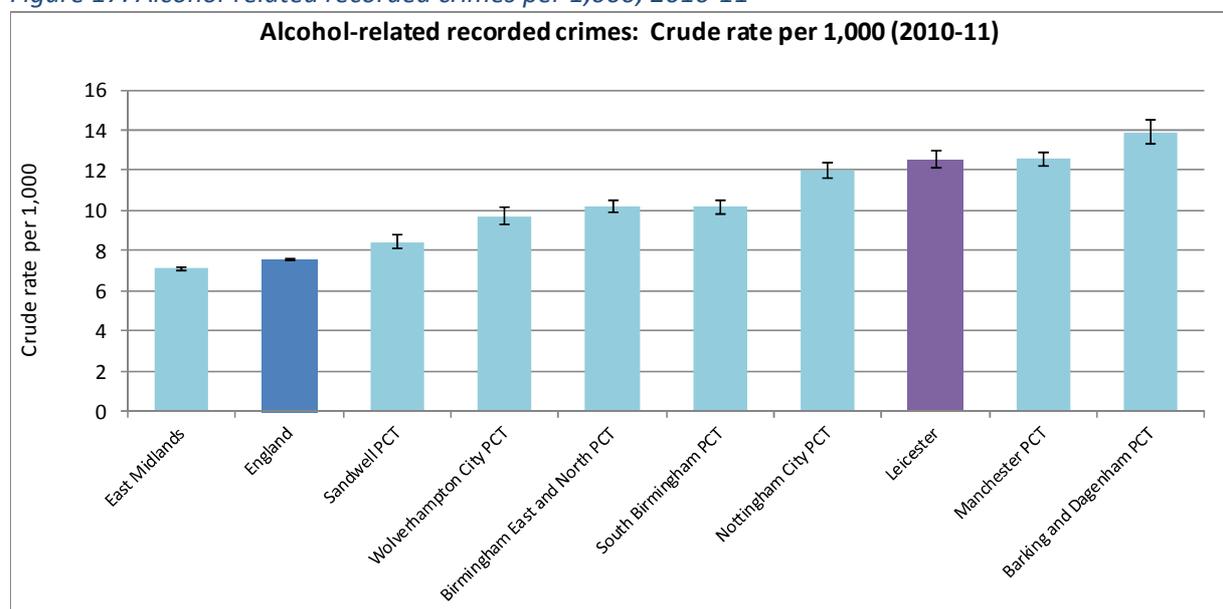
When looking at alcohol attributable admissions by different age groups, they increase between 18 and 49 years, then decrease in the over 50s; 30-49 olds accounting for around 42% of all alcohol-related hospital admissions. Compared with England, Leicester has a higher proportion of 18-49 year olds admitted to hospital for alcohol-related harm, nationally around 34% of acute alcohol admissions due to accidents and injury, 35% are alcohol-specific and 31% due to violence. In Leicester, 23% are due to accidents, 37% alcohol-specific and nearly 40% due to violence.

Alcohol-related crime and disorder

Although drinking alcohol itself is not illegal as with the majority of drug use, alcohol misuse frequently plays a part in crimes such as anti-social behaviour, assault and robbery. In violent crimes 45% of the victims believed their attackers had been drinking and 37% of domestic violence cases involve alcohol³⁴.

Alcohol-attributable crimes are an aggregate of six offences - violence against the person, sexual offences, robbery, burglary dwelling, theft of a motor vehicle, theft from a motor vehicle. Alcohol-related recorded crime rates have decreased in the last few years both nationally and in Leicester, with nearly 4,000 alcohol-related crimes recorded in Leicester in 2010-11. Although on the decrease, this is a statistically significantly higher rate per 1,000 than the England average and amongst Leicester's peer PCTs, Leicester has the third highest of 8 recorded crime rates relating to alcohol (figure 17).

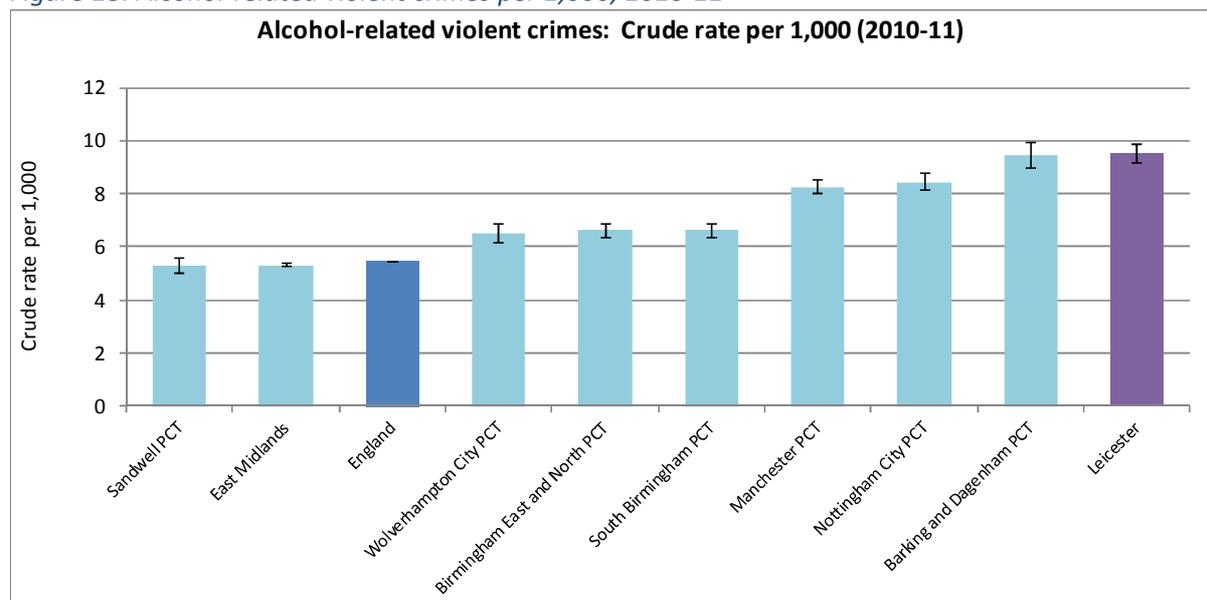
Figure 17: Alcohol-related recorded crimes per 1,000, 2010-11



Data: Local Alcohol Profiles for England (LAPE) To note: Alcohol-related recorded crime indicator is based on annual counts of the following recorded crime offences, by location of incident in 2010/11, multiplied by the relevant alcohol-attributable fraction.

Alcohol-related violent crime rates show a general downward trend between 2006/07 and 2010/11 both nationally and in Leicester. The Leicester rate (9.5 per 1,000) is significantly higher than the national rate (5.5 per 1,000) (1.7 times higher than England in 2010-11). Leicester also has the highest alcohol-related crime rate within the 8 peer PCTs (figure 18).

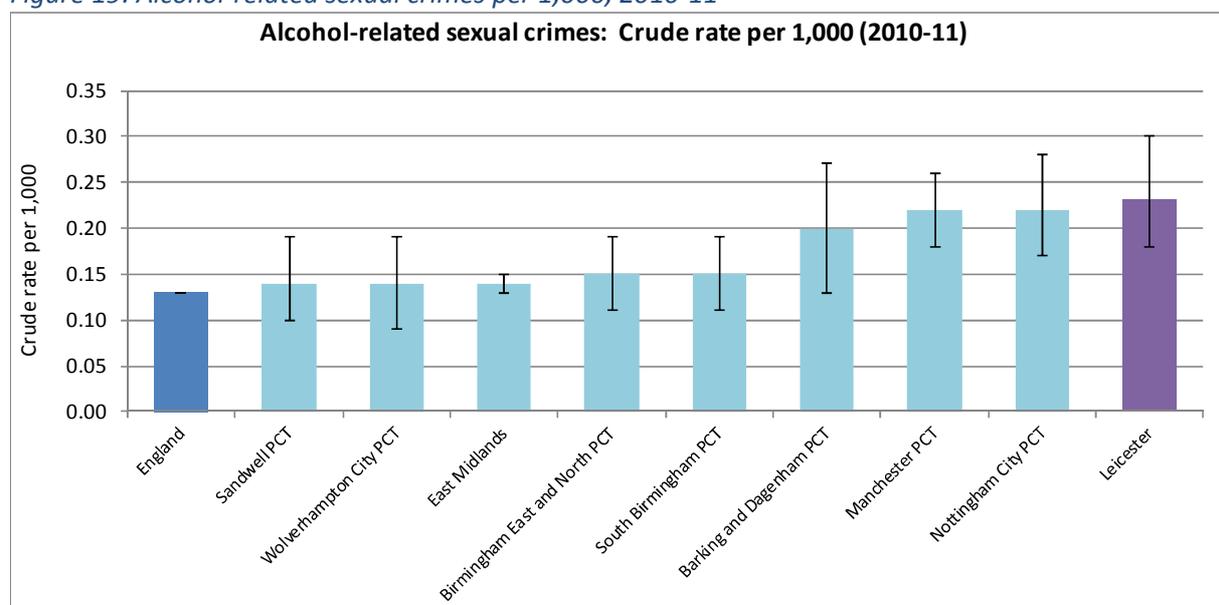
Figure 18: Alcohol-related violent crimes per 1,000, 2010-11



Data: Local Alcohol Profiles for England (LAPE) To note: alcohol-related violent crime is based on annual counts of recorded crime offences of violence against the person, by location of incident in 2010/11, multiplied by the relevant alcohol-attributable fraction.

Alcohol-related violent crime rates have remained fairly stable between 2006/07 and 2010/11 nationally, whilst Leicester has seen a slight fall in the rate, however as the number of offences is relatively small, a small reduction in the number of offences can reduce the rate substantially. Again the Leicester rate (0.2 per 1,000) is statistically significantly higher than the national rate (0.1 per 1,000) (1.8 times higher than England in 2010-11) and Leicester has the highest alcohol-related crime rate within the 8 peer PCTs.

Figure 19: Alcohol-related sexual crimes per 1,000, 2010-11

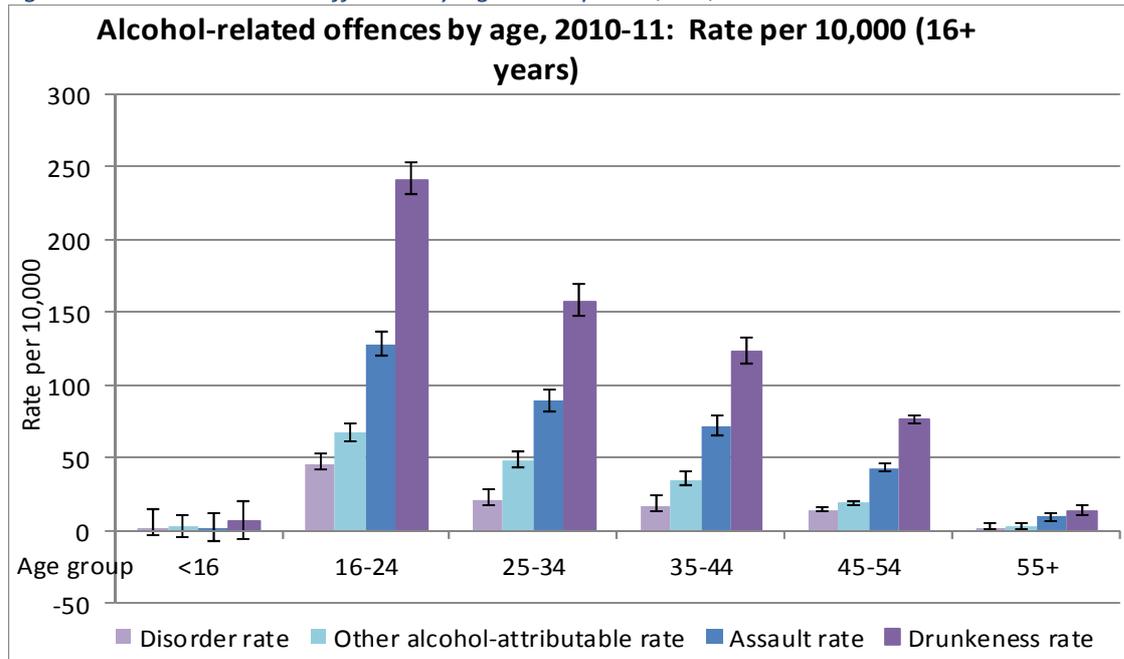


Data: Local Alcohol Profiles for England (LAPE) To note: Alcohol-related sexual crime is based on annual counts of recorded sexual offences, by location of incident in 2010/11, multiplied by the relevant alcohol-attributable fraction.

Alcohol-related crime by age and ethnicity

Data provided by Leicestershire Police covering 2010-11, shows that rates of alcohol related offences for drunkenness, assault, disorder and other attributable offences are highest amongst 16-24 year olds and decrease with increasing age. Drunkenness rates are significantly higher in 16-24, 25-34 and 35-44 year olds, assault rates are significantly higher in 16-24, 25-34 and 35-44 year olds, disorder rates are significantly higher in 16-25 year olds and other alcohol-attributable rates are significantly higher in 16-24, 25-34 and 35-44 year olds (figure 20). This suggests that younger people are at the greatest risk of alcohol-related crime.

Figure 20: Alcohol-related offences by age: Rate per 10,000, 2010-11

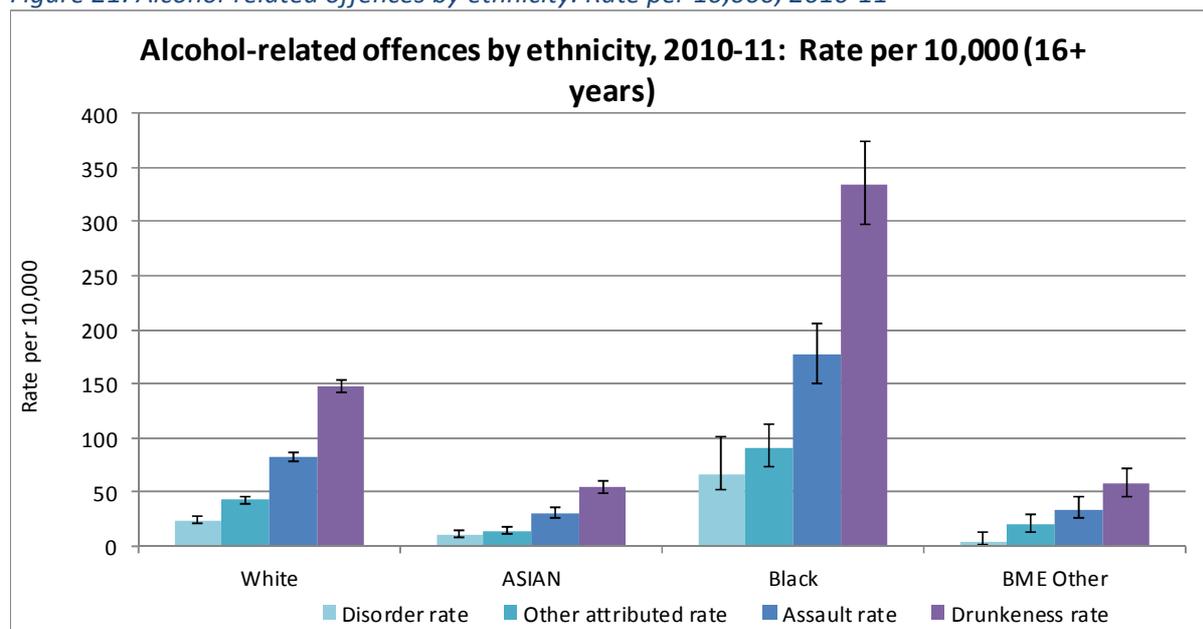


Data:

Data: Leicestershire Police

Rates of drunkenness, alcohol-related assault and other alcohol-attributable offence rates are significantly higher than the overall average in White and Black groups. In terms of numbers, this relates to 2,252 offences for drunkenness (White), 297 (Black), 1249 assaults (White) and 157 (Black). Alcohol-related disorder rates are significantly higher than the overall average in Black groups (figure 21).

Figure 21: Alcohol-related offences by ethnicity: Rate per 10,000, 2010-11



Data: Leicestershire Police

The table below shows the number and rate of alcohol-related offences by ward. To note this is the ward the offence took place in rather than the ward of residence of the offender. Alcohol-related offences are highest in Castle ward (which includes the city centre), with 40% of all assaults, 57% of all disorder offences, 34% of other alcohol-attributable crime, and 41% of drunkenness offences. Statistically significantly high rates of alcohol-related offences are found in; Castle – assaults, disorder, other alcohol-attributable crime and drunkenness, Abbey – assaults, Freeman - assaults, disorder and drunkenness and Westcotes - assaults, disorder and drunkenness.

Table 9: Alcohol-related offences by ward: Rate per 10,000, 2010-11

| Ward name | Assault | Disorder | Other attributed crime | Drunkenness | Assaults per 10,000 | Disorder per 10,000 | Other attributable crime per 10,000 | Drunkenness per 10,000 |
|-----------------------------------|-------------|------------|------------------------|-------------|---------------------|---------------------|-------------------------------------|------------------------|
| Abbey | 100 | 19 | 36 | 155 | 92.0 | 17.5 | 33.1 | 142.6 |
| Aylestone | 35 | 11 | 31 | 77 | 39.8 | 12.5 | 35.2 | 87.5 |
| Beaumont Leys | 51 | 4 | 33 | 88 | 41.6 | 3.3 | 26.9 | 71.8 |
| Belgrave | 38 | 5 | 13 | 56 | 43.5 | 5.7 | 14.9 | 64.0 |
| Braunstone Park and Rowley Fields | 59 | 12 | 39 | 110 | 45.0 | 9.2 | 29.7 | 83.9 |
| Castle | 646 | 272 | 287 | 1205 | 347.0 | 146.1 | 154.2 | 647.3 |
| Charnwood | 42 | 12 | 22 | 76 | 46.0 | 13.2 | 24.1 | 83.3 |
| Coleman | 49 | 13 | 25 | 87 | 47.5 | 12.6 | 24.2 | 84.3 |
| Evington | 18 | 9 | 5 | 32 | 21.2 | 10.6 | 5.9 | 37.6 |
| Eyres Monsell | 47 | 10 | 13 | 70 | 54.8 | 11.7 | 15.2 | 81.6 |
| Fosse | 62 | 6 | 31 | 99 | 63.2 | 6.1 | 31.6 | 101.0 |
| Freemen | 90 | 16 | 63 | 169 | 107.9 | 19.2 | 75.5 | 202.6 |
| Humberstone and Hamilton | 39 | 4 | 30 | 73 | 29.1 | 3.0 | 22.4 | 54.5 |
| Knighton | 25 | 13 | 14 | 52 | 19.5 | 10.2 | 10.9 | 40.6 |
| Latimer | 23 | 24 | 17 | 64 | 22.8 | 23.8 | 16.8 | 63.4 |
| New Parks | 68 | 13 | 26 | 107 | 54.8 | 10.5 | 21.0 | 86.3 |
| Rushey Mead | 14 | 1 | 8 | 23 | 10.8 | 0.8 | 6.2 | 17.8 |
| Spinney Hills | 39 | 7 | 22 | 68 | 24.5 | 4.4 | 13.8 | 42.7 |
| Stoneygate | 41 | 8 | 24 | 73 | 28.2 | 5.5 | 16.5 | 50.2 |
| Thurncourt | 38 | 7 | 14 | 59 | 47.9 | 8.8 | 17.6 | 74.3 |
| Westcotes | 78 | 8 | 61 | 147 | 94.7 | 9.7 | 74.0 | 178.4 |
| Western Park | 28 | 4 | 22 | 54 | 35.2 | 5.0 | 27.6 | 67.8 |
| Leicester Total | 1630 | 478 | 836 | 2944 | 67.0 | 19.6 | 34.4 | 121.0 |

Data: Leicestershire Police

Significantly higher than the Leicester rate
 Significantly lower than the Leicester rate

UHL collect information on assaults when they arrive at A&E, i.e. where the assault occurred, the weapon used and day/time. Many of those (anecdotally) involve alcohol, although this is not currently collected. Collecting information on alcohol would enable a better understanding of potential causes of assault and therefore appropriate action could then be taken.

POLAMB

PolAmb is a dedicated clinical and law enforcement response designed for use during night time economy in Leicester City Centre on Friday and Saturday night. It is a dual response initiative which is both staffed by Police and Ambulance staff. The aim of the pilot is to; record the link between alcohol consumption, incident (either self-inflicted or inflicted by another), and assess whether collecting data of this kind leads to new information and new initiatives.

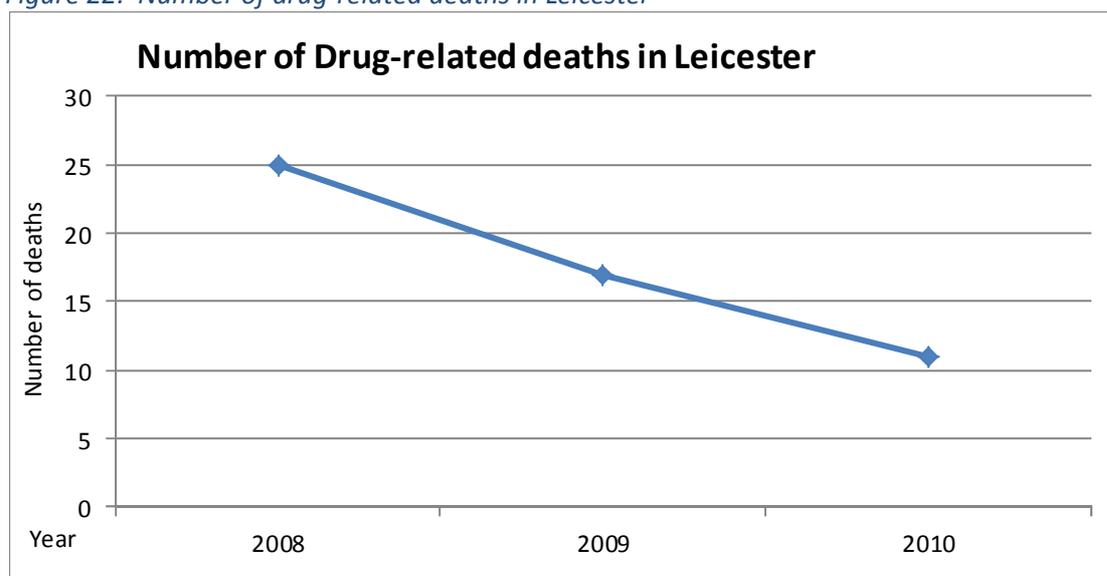
There are two main questions asked by the team; 1) have you been drinking alcohol in the 3 hours prior to the incident and 2) where was the last place you drank alcohol. There were 139 records for data collected between June 2011 to September 2011. The majority of them were coded as 'other' (50), and fighting (29). Of the records collected 58 required transport, 21 walked or made their own way on and 19 the police dealt with or arrested.

The majority (83%) stated they had been drinking within the 3 hours prior to the incident and 102 stated that the venue was unknown or had missing data. This initiative provides some insight that alcohol causes incidents, although improved quality of the data could improve targeting of preventative action.

Drug related deaths

In 2010 there were 1,784 deaths due to drug misuse nationally³⁵ of which 1,382 (78%) were male and 402 female (22%). Two thirds of drug misuse deaths occur in 20 to 49 year olds, with a third in 30-39 year olds. Half of drug misuse deaths were due to accidental poisoning, a further 17% from intentional self-poisoning and a third from drug-related mental and behavioural disorders. Heroin/morphine was the most common drug involved (791 deaths). Within Leicester in 2010, there were 11 deaths with a primary cause of drug-misuse. This is half the number of drug-related deaths in 2008.

Figure 22: Number of drug-related deaths in Leicester

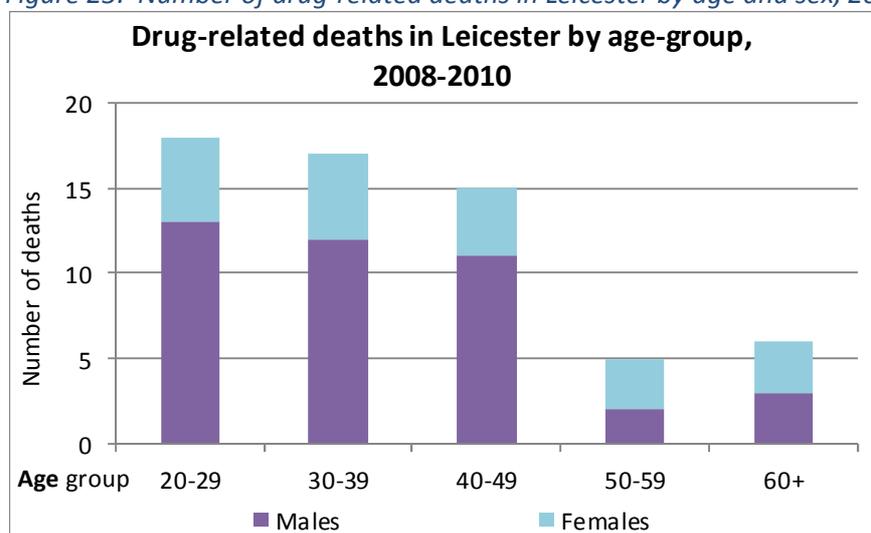


Data: ONS mortality data

Between 2008 and 2010 there were 49 deaths in Leicester with a primary cause of drug misuse. Of these, 31 (63%) were male and 18 female (37%). Eighty percent of deaths were in the under 50s and the majority of deaths were in the younger ages; 17 deaths (35%) in 20-29 year olds, 11 deaths (22%) in 30-39 year olds and 11 deaths (22%) in 40-49 year olds. Deaths in females show small numbers across all ages so that there are relatively more female deaths in the older age groups.

Ethnicity data is not known for around 25% of the deaths, but where available, the majority are reported as White. Most deaths occurred at home (30), with 8 in hospital and 9 other locations. Over 70% of drug-related deaths in Leicester were from accidental poisoning, a further 16% from intentional poisoning, 8% undetermined intentions and 4% from drug-related mental and behavioural disorders. Opiates are the main drug involved in the majority of deaths as nationally, with heroin/methadone accounting for around half. Many deaths are caused by poisoning from a mixture of multiple drugs or from a drug and alcohol mix.

Figure 23: Number of drug-related deaths in Leicester by age and sex, 2008-2010



Data: ONS mortality data

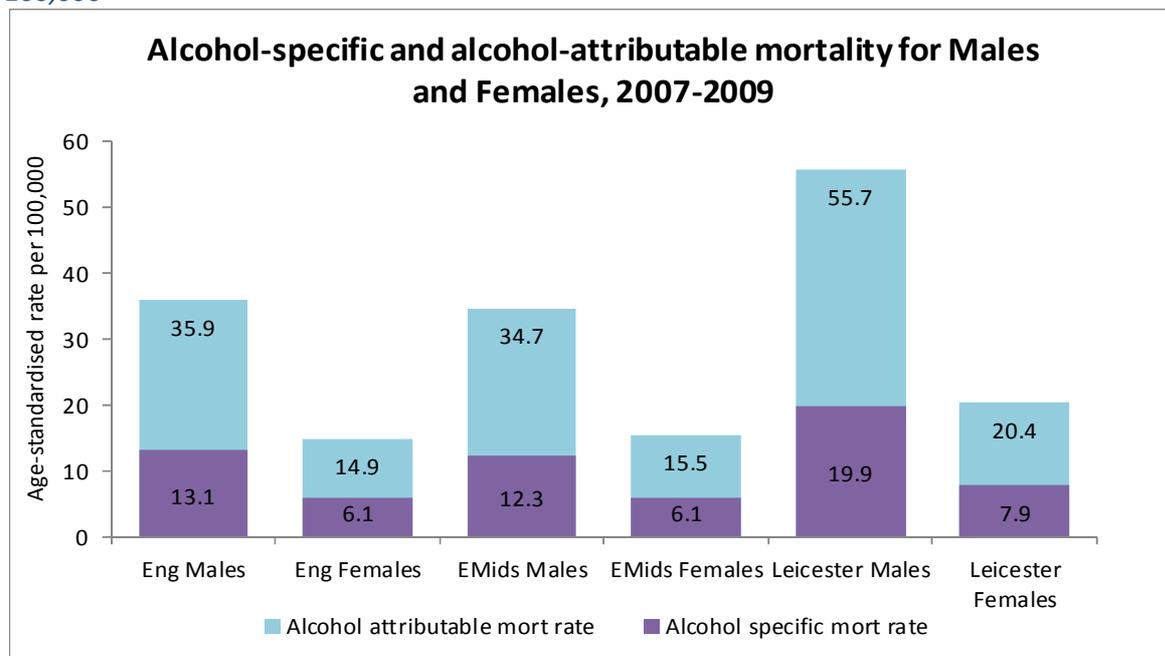
Alcohol related deaths

In 2010 there were 6,669 alcohol-related deaths in England, 87 more than in 2009 (6,582)³⁶. There are more alcohol-related deaths in males than in females, with 67% of all alcohol related deaths in the UK in 2010 being male. Studies have been undertaken in many countries, including the USA, Australia and Canada to determine the costs of alcohol to society and the World Health Organisation has estimated that alcohol consumption accounts for 4.0% of all disease burden worldwide³⁷, although this excludes many of the indirect effects of alcohol. In England, alcohol-attributable fractions (AAFs) are annually applied to Hospital Episode Statistics (HES) and mortality data to provide an indication of the wider effects of alcohol.

As with alcohol-attributable admissions, alcohol-attributable deaths include all alcohol-specific conditions, plus those where alcohol is causally implicated in some but not all cases of the condition, for example, hypertensive diseases, various cancers and falls. In 2005, it was estimated that there were 14,982 deaths that were attributable to alcohol consumption in England³⁸. Alcohol specific deaths account for around a third of the total alcohol-attributable rates in males and females in England, East Midlands and Leicester, with death rates for both alcohol specific and attributable causes higher in males than females (Male: Female in England = 2.1, East Midlands = 2.0, Leicester = 2.6) (figure 24).

In Leicester there are over 30 deaths per year from alcohol-specific causes (mostly chronic liver disease) of which around two thirds are in males and over 100 alcohol-attributable deaths per year, of which 70% are in males. Leicester males have statistically significantly higher death rates from both alcohol-specific and alcohol-attributable causes than nationally. Nationally there has been a small decrease in alcohol-attributable mortality rates; although Leicester rates are more variable due to relative small numbers per year, however, these rates have increased over the last 2 years.

Figure 24: Alcohol-specific and alcohol-attributable death rates 2007-09; age-standardised rates per 100,000



Data: Local Alcohol Profiles for England (LAPE)

Drug and Alcohol treatment services in Leicester

The NTA, models of care of adult drug misusers: update 2006³⁹ has described a tiered system of treatment modalities. This provides a checklist with which to benchmark the local treatment system against to ensure a full and comprehensive range of interventions are being commissioned;

- **Tier 1 interventions:** include provision of drug-related information and advice, screening and referral to specialised drug treatment. These comprise of drug-related information and advice, screening, assessment, and referral to specialised drug treatment
- **Tier 2 interventions:** include provision of drug-related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare
- **Tier 3 interventions:** include provision of community-based care coordinated specialised drug assessment and co-ordinated care planned treatment and drug specialist liaison (including harm reduction advice and blood borne virus screening and vaccination programme, substitute prescribing, structured psycho social interventions and structured abstinence based programmes)

- **Tier 4 interventions:** include provision of inpatient and community based detoxification for drug and alcohol, residential specialised drug and alcohol treatment, which is care planned and care coordinated to ensure continuity of care and aftercare.

Models of care for alcohol misusers⁴⁰ provides best practice guidance for local health organisations and their partners in delivering a planned and integrated local treatment system for adult alcohol misusers and has similarly classified care into four tiers;

- **Tier 1 interventions:** alcohol-related information and advice; screening; simple brief interventions; and referral to include provision of: identification of hazardous, harmful and dependent drinkers; information on sensible drinking; simple brief interventions to reduce alcohol-related harm; and referral of those with alcohol dependence or harm for more intensive interventions
- **Tier 2 interventions:** open access, non-care-planned, alcohol-specific interventions to include provision of open access facilities and outreach that provide: alcohol-specific advice, information and support; extended brief interventions to help alcohol misusers reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment
- **Tier 3 interventions:** community-based, structured, care-planned alcohol treatment to include provision of community-based specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned
- **Tier 4 interventions:** alcohol specialist inpatient treatment and residential rehabilitation to include provision of residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare.

Figures 25 and 26 provide a graphical view of what the different tiers offer.

Figure 25. Modality Tiers of drug and alcohol provision.

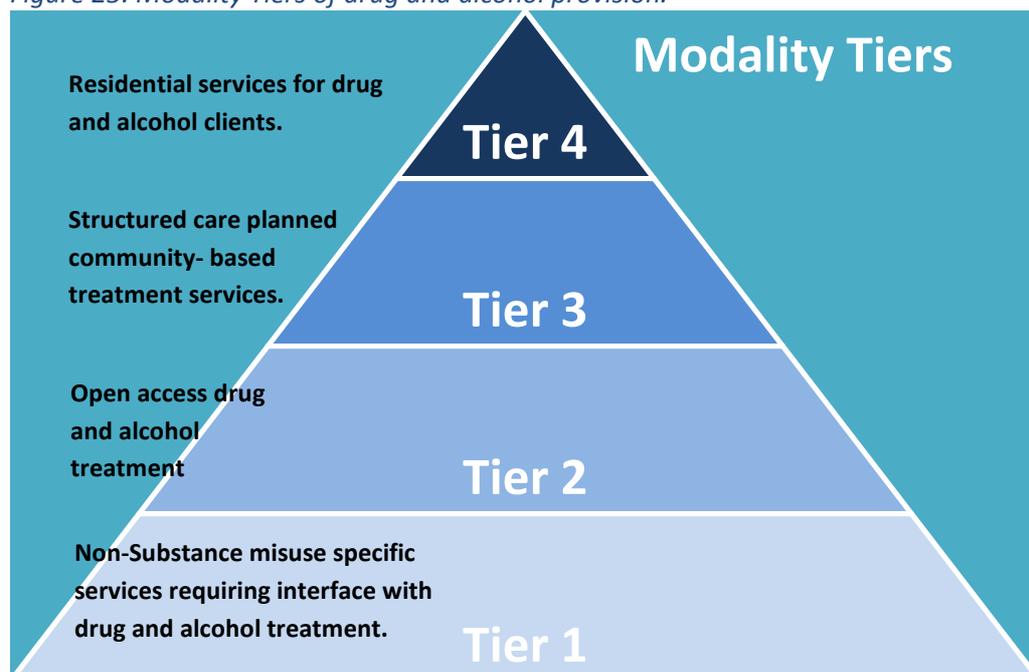
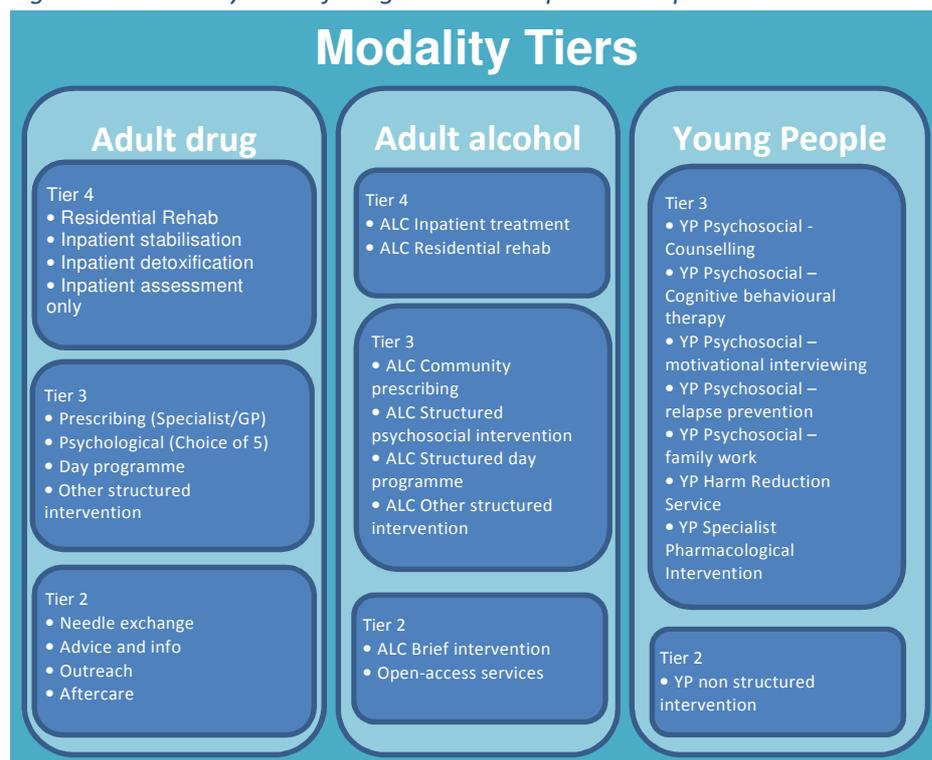


Figure 26. Modality tiers of drug and alcohol provision split between adults and young people.



To note the NTAs model of care framework will be superseded sometime in 2012 by the Building Recovery in the Community guidance which is currently in the post consultation phase. 'BRIC' is intended to reflect emerging evidence based practice, place greater emphasis on recovery and is aligned to the expectations of the National Drugs Strategy 2010. The aim is to provide a more coherent and consolidated approach to tackling a myriad of substances (including legal highs, alcohol etc.) across a range of settings (from community to prisons).

Service provision review

In Leicester, the drug and alcohol treatment system has grown since the consolidation of the central government funding over the last decade. Additional investment in alcohol services have only recently been made. Consequently services have evolved in an incremental way as and when funding opportunities presented, with additional alcohol services funded. In April 2009 Leicester City Council took lead commissioning responsibility for drugs and subsequently alcohol and embarked on an extensive programme of consultation, service redesign and tendering.

The consultation involved surveys, community based workshops and face to face consultation. A series of workshops with providers and service users in January and February 2010 reviewed the feedback from the community engagement phase and considered different service redesign options. Having considered the feedback, preferred models for both adult and young person systems were produced for formal consultation. The formal consultation process began in June 2010 and ended in September 2010. In total 404 responses were received for the adult survey and 110 responses for the young person survey. Analysis of the feedback revealed a high level of support for all of the proposed changes for both adults and young people's services, including support for a:

- dedicated team working with GPs in primary care
- discrete service that addressed the training, employment and housing needs of clients
- sub regional criminal justice integrated team.

The newly reconfigured services were divided into 5 commissioning lots detailed below (in bold is the current provider):

- **Lot 1-** Adult community based drug and alcohol services including open access provision, pharmacy and community syringe distribution, stimulant services, prescribing services and specialist community drug and alcohol treatment services. This contract was not awarded and the contract was extended with the existing providers- **Leicestershire Partnerships Trust and Leicestershire Community Protects Trust**
- **Lot 2-** Primary Care Services (Drugs only) to support the development of GP led services - **Leicestershire Partnerships Trust**
- **Lot 3-** Quality of Life services that will support users into recovery and community integration - This service is commissioned to offer a choice of structured programmes to those affected by substance misuse, either on a one to one basis or within groups, based on the 12 Steps and SMART models with input from housing and employment services. - **Leicestershire & Rutland Probation Trust**
- **Lot 4-** Criminal Justice Drug and Alcohol services (on behalf of Leicester, Leicestershire and Rutland County Councils) that provide a fully integrated criminal justice service developed out of the Systems Change Programme including an alcohol treatment pathway - **Leicestershire& Rutland Probation Trust**
- **Lot 5-** Young People's Specialist Drug and Alcohol Services, which includes specialist treatment and support for non-specialist services in responding to drug/alcohol issues across City neighbourhoods - **Leicestershire Partnerships Trust**

Following the service re-configuration there are three main providers delivering services in the community; Leicestershire Community Projects Trust (LCPT), NHS Leicestershire Partnerships Trust (LPT) and Leicestershire and Rutland Probation Trust (LRPT).

LCPT acts as the gateway into the treatment system and houses the needle exchange, outreach, initial screening, assessment and signposting functions. There is also a dedicated service for clients affected by crack cocaine addiction known as Baseline.

In delivering Service Lots 1,2 and 5, LPT Community Alcohol and Drugs Team has responsibility for providing pharmacy based needle exchange, screening and vaccination for blood borne viruses, specialist prescribing, structured psycho social interventions and access to community based and inpatient detoxification. In addition, LPT practitioners provide direct advice and consultancy support to GPs and work in partnership with them to enable service users' needs to be met within primary care from a range of intermediate clinics and practices. The inpatient detoxification services are provided from Glenfield Hospital. LPT clinicians provide support to individuals across Leicester, Leicestershire and Rutland that come into contact with the Criminal Justice Team requiring treatment for substance misuse and the Youth Offending Service provide their own drug and alcohol service to young people.

Leicestershire and Rutland Probation Trust have recently been awarded the contract to provide the psychosocial and structured interventions to those within HMP Leicester as well as within the community of Leicester and Leicestershire. This service is known as the Criminal Justice Drug Team (CJDT) and is provided as a commissioned service rather than a statutory function of the

Leicestershire and Rutland Probation Trust. This integration of through the gate provision resulted from a National System Change Pilot.

There is a mix of providers for substance misuse treatment. Within HMP Leicester, SERCO health provide clinical aspects of treatment such as substitute prescribing, testing and vaccination for blood borne viruses and general healthcare assessments. The custodial establishment is a complex picture of provision with no one organisation holding accountability for all delivery or data therefore much of data seems to present a confusing and sometime contradictory picture of need and demand for substance misuse treatment interventions.

Outside of the lots described above, there are a range of other services commissioned locally including; alcohol liaison workers in UHL (operating at tier 2/3), a substance misuse midwife, alcohol Locally Enhanced Service whereby GP practices receive payment for carrying out brief interventions, an alcohol worker within the Dawn Centre working predominately with the homeless population (tier 3), and the anchor centre (a wet day centre working predominately with street drinkers) providing advice and signposting to other services. There was also a two year programme commissioned between November 2009 and 2011 providing training for a wide range of staff (housing/ police/ probation/ health etc.) in identification and brief advice and a mentoring project for street drinkers. Information on 'wraparound services' is presented below.

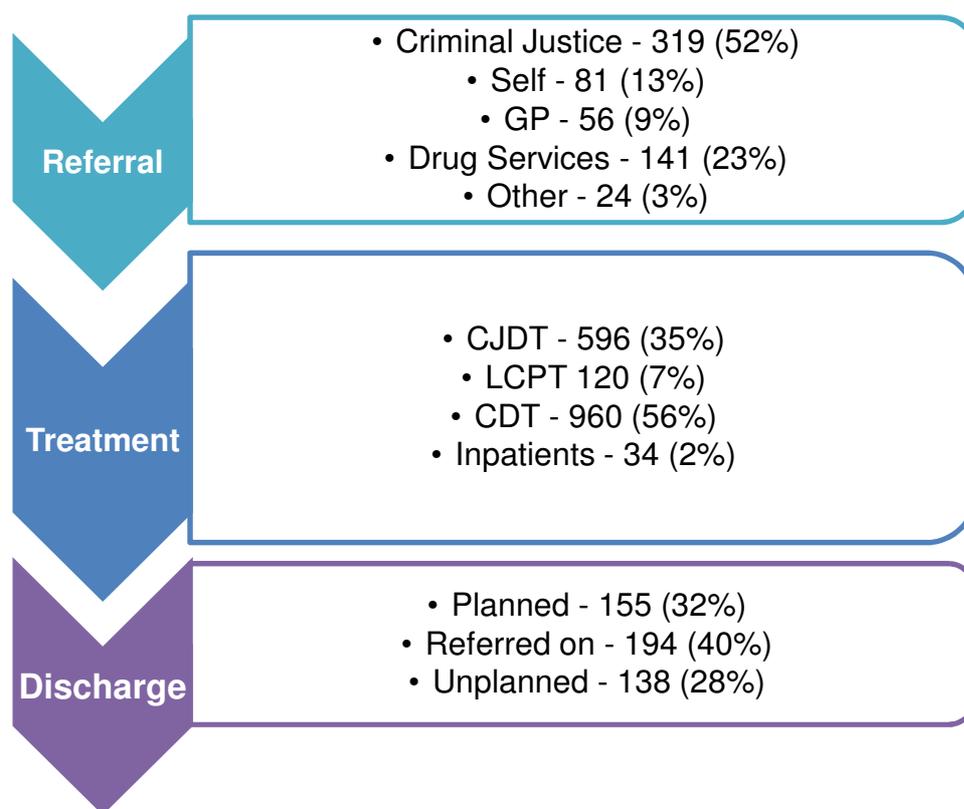
Drugs treatment provision for adults

In Leicester treatment services are delivered by a small number of organisations. LCPT provides the main access point into the treatment and delivers tier 2/3 services including needle exchange, harm reduction, brief interventions, other structured interventions and key working for non-opiate users. One of the largest tier 3/4 agencies is the Community Alcohol and Drugs Team providing harm reduction, healthcare assessments, substitute prescribing, medical interventions, psycho-social support and facilitates access to shared care and in-patient detoxification. The Criminal Justice Drugs Team (CJDT) (previously a merger of Addaction and Probation services but now exclusively the latter) provides case management support, day time activities and clinical interventions to individuals on statutory and non-statutory orders. With the start of the Quality of Life Service clients now have access to abstinence based programmes, activities, peer mentors, family support and wraparound support. The profile of the treatment system has changed in recent years with the proportion of primary opiate users dropping.

Leicester city drug treatment map, 2010-11

The adult drug treatment map for Leicester city is shown below (figure 27). The majority of referrals (52%) to Leicester treatment services come from the criminal justice system and therefore the majority of clients are seen by CJDT (54%) who treat those in the criminal justice system. Nationally self-referrals make up 38% of referrals and 30% are made up from the criminal justice system. Within Leicester, 40% of referrals are referred on within the system, which might be a consequence of the high proportion of referrals coming from the criminal justice system, as these clients tend to be referred on within the criminal justice treatment system. The low proportion of self-referrals may be because to enter tier 3 treatment services, people generally have to be referred in either by their GP or via another service.

Figure 27. Leicester adults drug treatment map, 2010-11, data from NDTMS.



To note: referral and discharge numbers are unique counts of individuals and treatments are the number of treatment journeys delivered (an individual could have more than one treatment journey in one year and could be in treatment in more than one agency). There are also individuals being in treatment from the previous year.

The number of all adult drug users and opiate and/or crack user (OCU) in effective treatment has increased since 2008-09 to 2010-11 (table 10). This is partly due to action to improve rates of planned discharge, which have increased the proportion of clients who do not drop out before 12 weeks in treatment.

Table 10. All adults and OCU in Leicester in effective treatment, 2008-11, NDTMS

| | 2008-09 | 2009-10 | 2010-11 |
|---|---------|---------|---------|
| No. of all adult drug users in effective treatment | 1309 | 1354 | 1450 |
| No. of OCU adults in effective treatment | 1200 | 1255 | 1328 |

Data: NDTMS

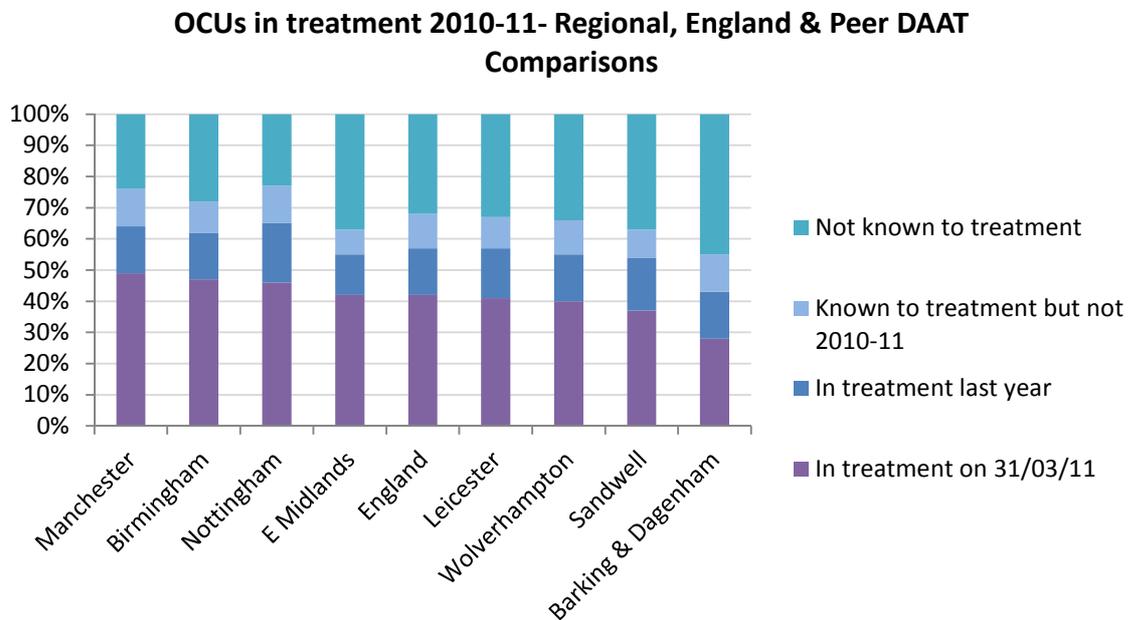
Estimates of opiate and or crack use

Information about the prevalence of opiate and/or crack cocaine use is an essential part to inform service provision, and assess the wider population impact of interventions. Although direct enumeration is not possible, indirect techniques can provide estimates of drug misuse prevalence⁴¹.

An OCU is defined as a client presenting with opiates and/or crack cocaine as their main, second or third drug recorded at any episode during their latest treatment journey. Figure 28 below shows that there is an estimated 41% of OCU in treatment in Leicester on the 31/03/11 and 57% (95% CI 50% to 61%) in treatment over 2010-11. This is similar to national and regional levels, and in the middle of the comparator DAATs. This estimated number in treatment of the last year of 57% is an increase from 49% in 2008-09 and 51% in 2009-10, which shows a steady improvement in the

estimated proportion of OCU in treatment in Leicester. One of the long-term aims of the DAAT team is to reduce the treatment naïve and this shows progress towards this. Nationally 81% of the in treatment population were classed as opiate users, of which two thirds reported con-current crack cocaine use.

Figure 28. OCU in treatment 2010-11, with national, regional and comparator DAATs, NDTMS.



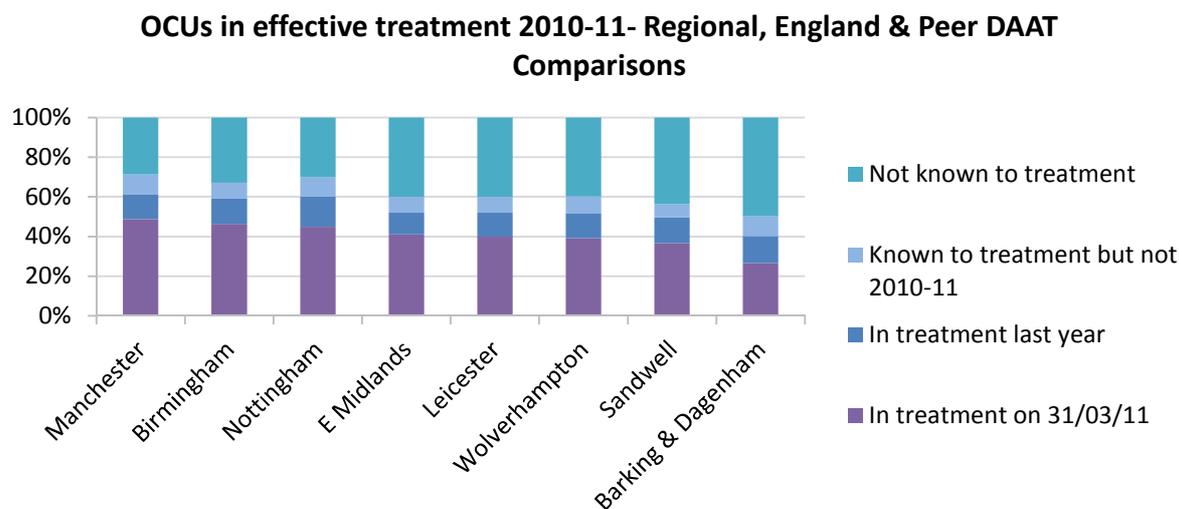
Data: NDTMS

OCUs in effective treatment 2010-11

To be defined as being in effective treatment, an adult OCU must have been retained in treatment for 12 weeks (84 days) and have started one or more types (as defined by the type start date). If the treatment journey is less than 12 weeks in this period but ended in a planned treatment system exit, then it will also be counted.

Figure 29 shows that 52% (95% CI 47% and 57%) of OCUs in Leicester have been in effective treatment for the year 2010-11, this has increased from 47% in the previous year. This is slightly lower than nationally and the same as the region. As with those in treatment, Leicester is in the middle of our comparator DAATs.

Figure 29: OCU in effective treatment 2010-11 with national, regional and comparator DAATs, NDTMS

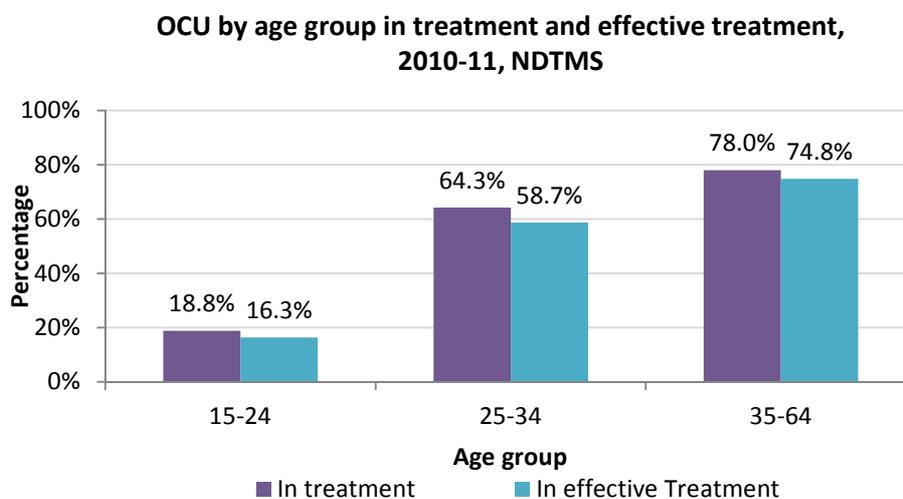


Data: NDTMS

Assessment of substance usage and engagement with treatment services shows there are an estimated 61% of opiate users in treatment compared to 53% of crack users. Only 32% of crack users were in effective treatment, compared with 57% for opiate users. An estimated 55% of male OCU were in treatment and 51% in effective treatment. This is compared to 63% of the estimated OCU females in treatment and 60% in effective treatment in 2010-11.

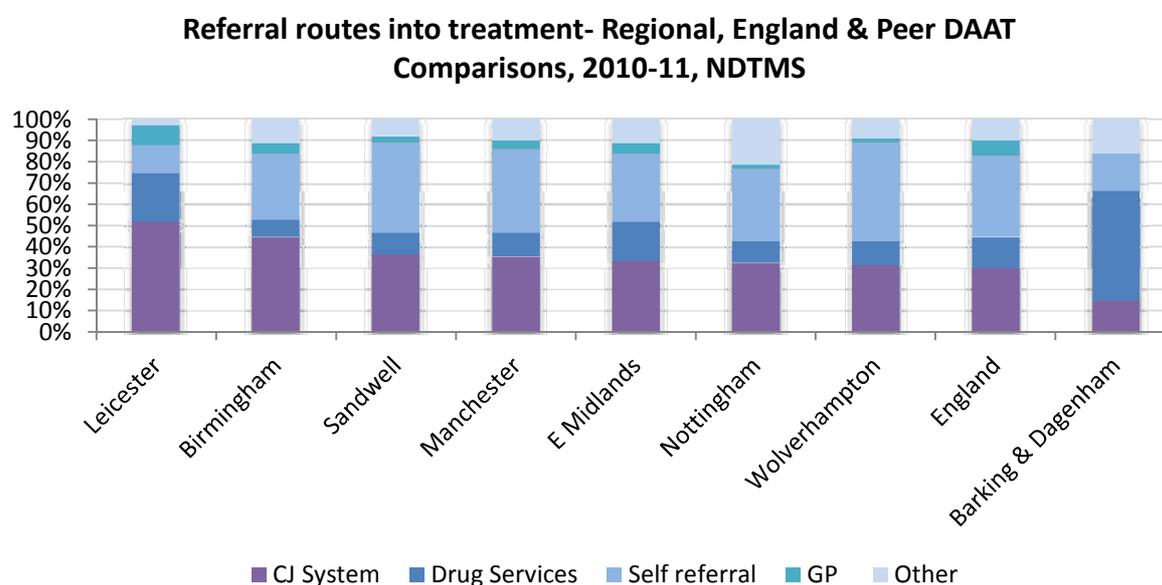
Prevalence and treatment data has been divided into 3 age groups, 15 to 24 years, 25 to 34 years and 35 to 64 years. Levels in treatment of OCU appear higher for older OCUs in Leicester. The 15 to 24 year old group shows only 19% in treatment and 16% in effective treatment, compared with 78% in treatment and 75% in effective treatment in the 35-64 year age group (figure 30), although the small numbers expected in the 15-24 age small differences can impact on the overall proportion. The prevalence estimates of OCU does not include estimates by ethnicity therefore no breakdown by ethnicity is reliably possible.

Figure 30: OCUs in treatment and effective treatment by age group, 2010-11, NDTMS



Data: NDTMS

Figure 31: Referral routes into treatment- Regional, England & Peer DAAT Comparisons, 2010-11, NDTMS



Data: NDTMS

Leicester has the highest proportion (52%) of all drug referrals from the criminal justice system into treatment compared to nationally, regionally and comparator DAATs. The majority of comparator DAATs had their highest proportion from self-referral, apart from Barking & Dagenham where drug services was highest. This may reflect the local access to service pathways, where the majority are referred into services or that people may not know how to self-refer into services.

The type of treatment needed to tackle substance misuse is dependent upon the individual needs of those referred for treatment. There are a range of drug treatments available in Leicester. Specialist prescribing has the highest treatment type (996) followed by GP prescribing (426) in 2010-11 (table 11). Both these types have shown a steady increase in numbers since 2004/5. There is drive to move more of the treatment to GP prescribing by enlarging capacity in primary care, in order to provide clients with choice and balance their wider healthcare needs. The number of psycho social interventions captured by NDTMS is low although treatment services universally apply them, this might be a data reporting or coding issue.

Table 11: Alcohol-related treatment, 2004 to 2011, NDTMS*

| | 2004/5 | 2005/6 | 2006/7 | 2007/8 | 2008/9 | 2009/10 | 2010/11 |
|-------------------------------|--------|--------|--------|--------|--------|---------|---------|
| Specialist prescribing | 668 | 755 | 796 | 892 | 931 | 965 | 996 |
| GP prescribing | 186 | 265 | 285 | 330 | 369 | 417 | 426 |
| Structured daycare | 166 | 244 | 305 | 289 | 279 | 210 | 215 |
| Psychosocial intervention | 39 | 44 | 67 | 89 | 84 | 69 | 51 |
| Other structured intervention | 101 | 278 | 571 | 509 | 470 | 352 | 380 |
| Inpatient Detox | 29 | 37 | 32 | 39 | 27 | 25 | 30 |
| Residential Rehab | 10 | 22 | 21 | 13 | 14 | 12 | 22 |

Data: NDTMS *To note the total number of treatments, will be higher than the number of people seen over the year as more than one type of treatment can be given at the same time, and a number of treatments can be given over a year to an individual.

Since 2006, there has been a requirement for tier 3 and 4 services to provide each new client with a general healthcare assessment to; identify unmet health needs and address these through healthcare planning, and ensure other health problems that could interactive with drug treatment are considered to improve drug treatment outcomes. In 2010-11 99% of individuals starting a new treatment journey had a general healthcare assessment completed.

Demographic profile of adult drug treatment population

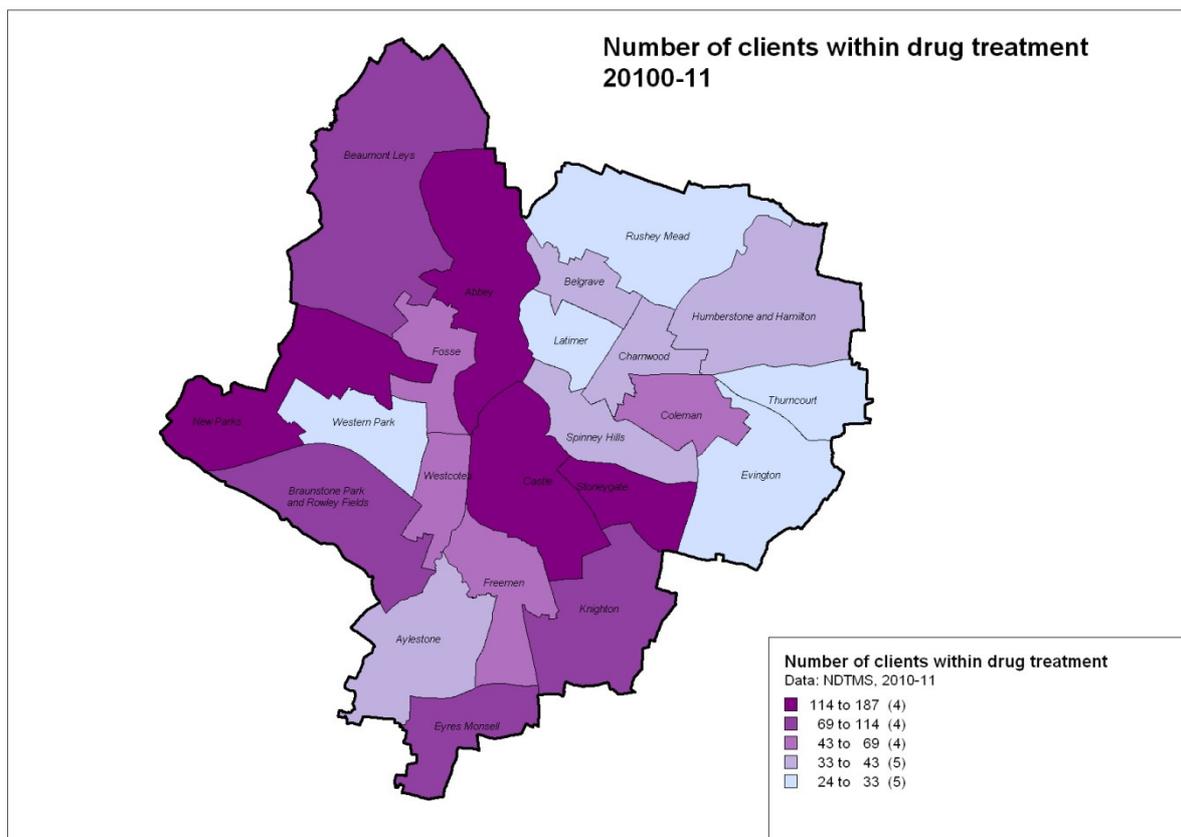
Nationally of the 204,473 clients aged 18 and over in treatment during 2010-11, 191,129 were engaged for 12 weeks or more or completed treatment free of dependency before 12 weeks, which represents 93% of the caseload. The local demographic profile is broadly similar to the rest of the England and Wales with 76% of those in structured treatment being male, compared to 73% in England.

Of those in structured treatment for drugs, 78% of those in drug treatment were White- British, (compared to a national profile of 83%) with 22% from BME groups (including Irish), compared to 64% of the general Leicester population being White-British. Asian-Indian was the largest BME group at 6%. Leicester has a higher proportion of clients who are from BME groups including Irish, than the national and regional profiles, with the majority of comparator DAATs having higher BME proportions, most notably Birmingham at 35%.

These figures may reflect that generally drug use is lower among minority ethnic groups than among the White population and therefore there is a lower proportion in treatment, with lowest levels of reported use from people with Asian backgrounds (Indian, Pakistani or Bangladeshi)⁴². However due to high levels of stigma attached to drug use in some BME groups (particularly South Asians and Chinese), can lead to users hiding the extent of their use and therefore levels of drug problems being underestimated.

Of clients in treatment in 2010-11, the wards with the highest numbers of drug users are (in descending order), Castle, New Parks, Abbey, Stoneygate and Beaumont leys. These 5 wards represent 49% of all drug treatment in the city. The wards with the lowest numbers in drug treatment were Evington, Rushey Mead, Belgrave, Latimer and Thurncourt which represented 9% of those in drug treatment. As with admissions data hostels that support substance misusers are located in Castle ward and therefore may skew the figures.

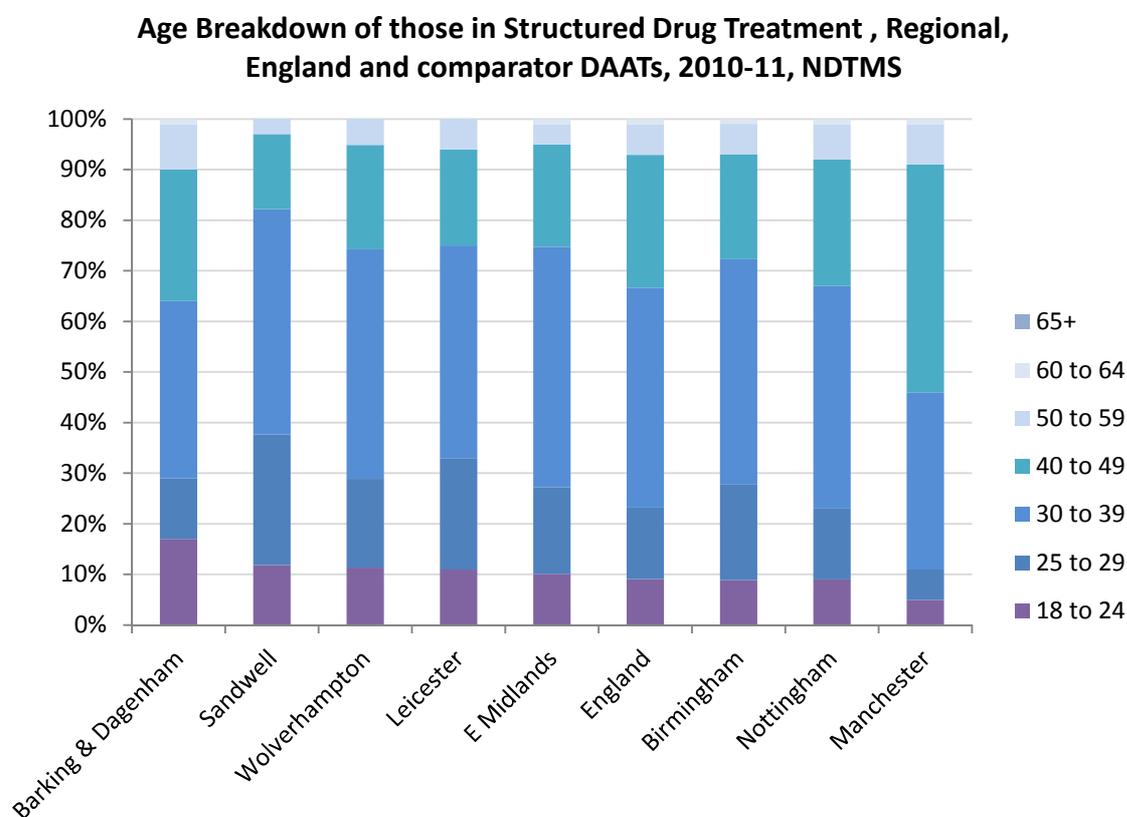
Figure 32: Clients in drug treatment by ward, 2010-11



Data: NDTMS: To note: numbers are shown due to ward level data is based on partial postcode and is between 72-100% accuracy

The profile of the local treatment population is comparatively younger than the regional and national pictures, as 64% of those in treatment are aged 25 to 39, which reflects the younger population of Leicester. Only Sandwell has a higher proportion of in this age group. Of all new treatment journeys for drugs in 2010-11 in Leicester there were 135 (23%) adults for which there were children living with the client, this is comparable to comparator DAATs, although further work is needed to understand the issues faced by children whose parents are being treated for drug misuse and whose parents are absent due to substance misuse.

Figure 33: Age Breakdown of those in Structured Drug Treatment , Regional, England and comparator DAATs, 2010-11, NDTMS



Data: NDTMS

Types of drug used by those in structured drug treatment

NDTMS collects data from clients recording their primary, secondary, and tertiary problem drug. Nationally 81% of all clients in treatment identified opiates as their primary drug, of which two thirds reported adjunctive crack cocaine use. The majority of the remaining drug users were in treatment for cannabis (7%), powder cocaine (5%) or crack cocaine (3%). In all adults being treated in structured treatment Leicester, opiates are the primary problem drug (88%), typically heroin users. Cannabis users made up only 4% of those in treatment. Of the secondary or tertiary problem substance recorded, 9% of those in treatment indicated alcohol, and 11% clients indicated cannabis as a problem drug.

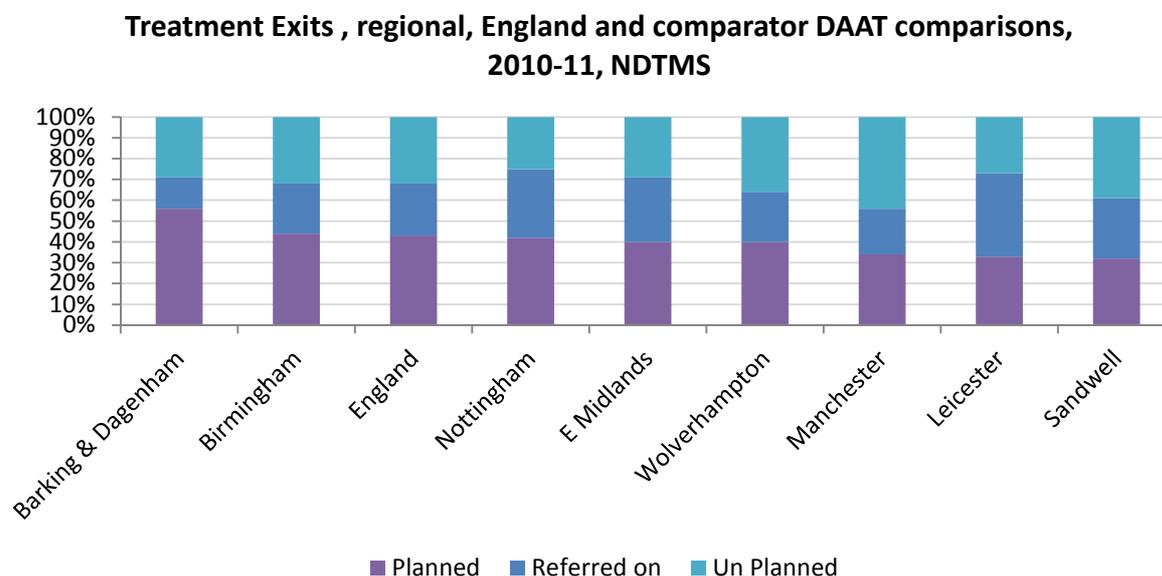
Discharge from treatment

In line with the expectations within the National Drugs Strategy there is increased emphasis on individuals successfully completing treatment and re-integrating back into mainstream society free of their dependence on substances. For 2011-12 the NTA announced that it would be changing the way that it defined planned discharge/successful completions. This will now be as a proportion of the whole treatment population instead of just amongst discharges. In 2010-11 nationally in total 64,994 individuals left treatment of which 27,969 (or 43% of the total) were discharged as successful completions, free of their drug dependence and not using either heroin or crack.

Information on discharge is collected with the reason– completed (planned) (drug free, alcohol free, occasional user), referred to further structured treatment (referred on) (not in custody, in custody)

or incomplete (unplanned) – dropped out, treatment withdrawn by provider, retained in custody, treatment commencement declined by client, or client died.

Figure 34: Treatment Exits , regional, England and comparator DAAT comparisons, 2010-11, NDTMS



Data: NDTMS

For those adults in treatment in Leicester, 33% had planned exits in 2010-11 (figure 34). This is lower than the national, regional and the majority of comparator DAATs (apart from Sandwell). This is the first year that the proportion of planned exits exceeded unplanned, however Leicester had the highest proportion of adults referred on which may be a reflection of the high proportion of those in treatment in the criminal justice system. The CJDT refer to CADT which accounts for the majority of the clients being referred on as there is an expectation (within the local system) that offenders with treatment needs are initially seen within the CJDT and transferred once they have stabilised to the CADT. Of those adults in treatment, 9.8% had a successful completion (abstinent from drugs), compared to 13.3% nationally.

Waiting times

It is important once a client is referred to treatment services for them to be treated quickly as this improves their chances of recovery. Nationally 96% of all referrals into treatment were seen within three weeks. Within Leicester 94% of first treatment clients were seen for assessment within three weeks of referral. This is up from the two previous years of 92% and 91% respectively. For those on their second or more treatment journey 96% were seen within three weeks in 2010-11. However, there have been long waits for certain treatment such as psychosocial intervention and residential rehabilitation.

Blood borne Viruses

There are a number of harms associated with drug use, including the spread of blood-borne viruses via sharing drug using equipment, including injecting equipment or sexual activity. People who use drugs and share injecting equipment have a high risk of infection; therefore those who start a new treatment journey are offered a hepatitis B vaccination. In 2010-11, 97% were offered a course of HBV vaccination, however only 33% started or finished the course, in comparison to 36% nationally who accepted HBV vaccinations. For Hepatitis C, for those starting a new treatment journey 97% were offered a hepatitis C test in 2010-11, with 80% having the test which compares favourably with a national figure of 64%. The CADT Harm Reduction Team has implemented a local plan aimed at increasing the number of nurses that are able to deliver HBV vaccinations and ensuring there is

coverage throughout the treatment system offering clients multiple opportunities for interventions to be delivered. It is hoped this will increase uptake.

Outcomes of treatment

When someone is referred to treatment they should agree a care plan which outlines their treatment goals. This should be regularly reviewed with the client typically every three months and review with the Treatment Outcomes profile (TOP) at least every six months and ideally three months for adults and every three months for young people.

Since 2007, the TOP tool which was developed to monitor and assess the effectiveness of the national drug treatment system and support commissioners and treatment providers in making improvements has been collected from clients receiving treatment. The TOP is a 20 item measure that focuses on four treatment areas; substance use, injecting risk behaviour, crime and health & social functioning. These reflect the problem areas that can make a real difference to clients' lives and that of wider communities. The TOP is collected at three different stages of treatment; the start, periodically throughout treatment (review every 3 to 6 months) and when the client leaves (exit). In order to ensure reliability of this information a TOP threshold compliance of 80% has been set by the NTA.

In Leicester in 2010-11, 84% of new starts had a TOP, with 88% having a TOP review and 79% having a TOP completed at exit. In the four sections clients are asked questions in relation to:

1. substance use – number of days substances have been used within the past four weeks and the average amount on a using day
2. injecting risk behaviour – number of days clients have injected non-prescribed drugs in the last four weeks
3. crime – number of days in the past 4 weeks clients may have been involved in shoplifting, selling drugs or other crimes
4. health & social functioning – clients are asked to rate their wellbeing against a rating of 0 to 20 (with 0 being bad and 20 good in the spectrum). In this section they are also asked to report how many days in the past 4 weeks they have been in paid work or attended college. Questions are also asked in relation to housing.

At the six month review stage there were in total 425 valid TOPs completed and 111 completions at the treatment exit stage. The TOP data generally shows that there have been reductions in use of drugs whilst in treatment for most substances, a reduction in reported crime and a small increase in the proportion in paid work or education. There were also small improvements in the self-reported quality of life measures and a reduction in the number who had housing problems. However due to the lack of data completeness it is difficult to draw firm conclusions from this data.

Tier 4 drug treatment services

Tier 4 services as defined by the NTAs Models of Care framework include inpatient detoxification and residential rehabilitation services and form an integral part of the treatment system. Inpatient detoxification services play an important role within the treatment system provide the optimal local treatment for clients with complex drug, alcohol and other health needs; those in crisis and those requiring medical stabilisation. Residential rehabilitation is especially important in providing a pathway out of dependency and in a location away from the environment that encouraged the substance misuse.

There are 7 beds currently available within Leicestershire Partnerships Trust Adult Psychiatry dedicated to carrying out drugs and alcohol detoxification. These services are provided to patients who have difficulty in achieving abstinence through treatment in a community setting and who

require assessment, stabilisation and assisted withdrawal from substances, as these patients cannot be managed adequately by the referring specialised services.

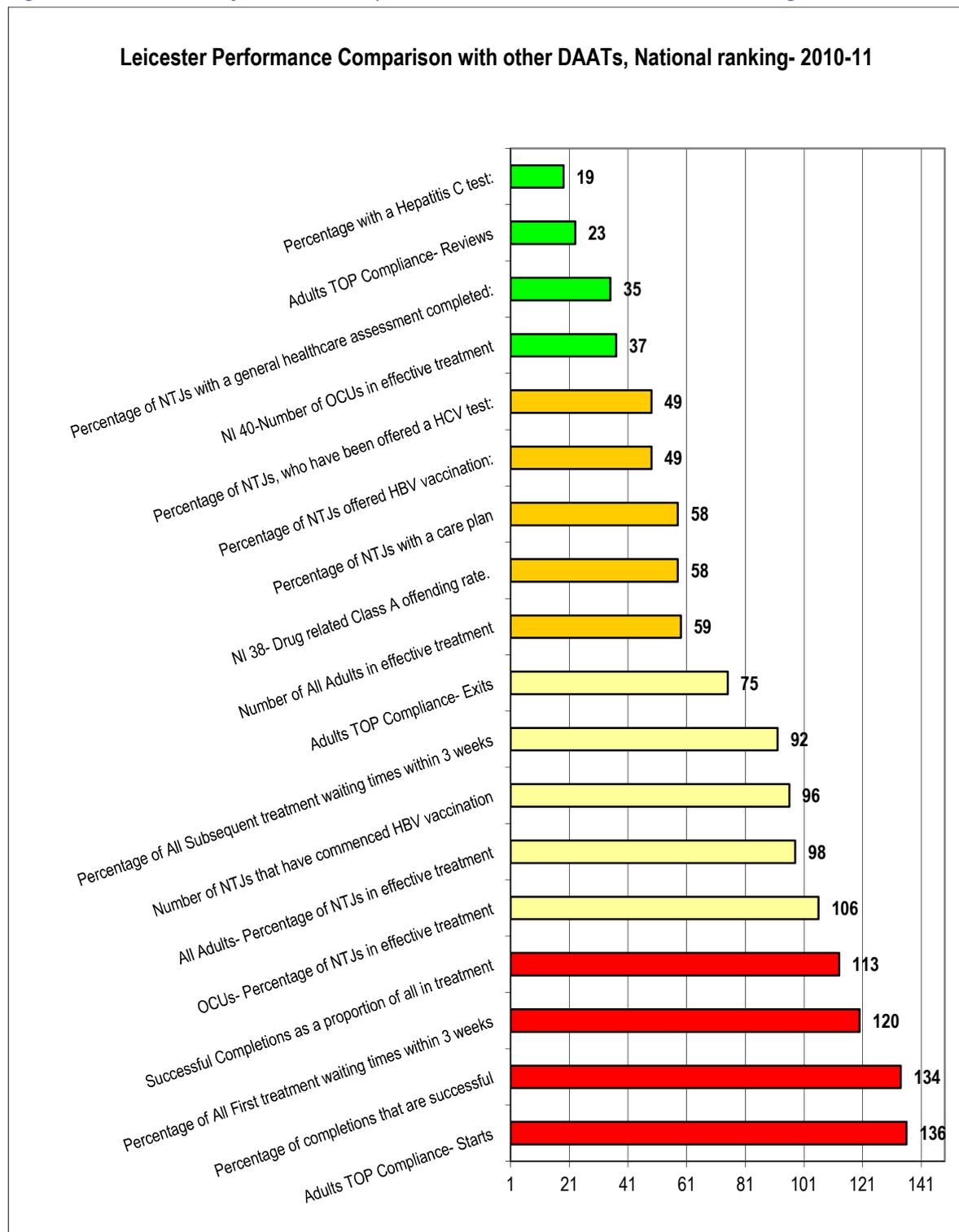
The NTA⁴³ estimates that 10% of clients receiving care would benefit from Tier 4 inpatient care, equating to 9 beds for Leicester city for drug and alcohol treatment. Access to residential rehabilitation is via a community care assessment. In the course of 2010-11 there were 57 referrals made to this team, of which half were deemed appropriate for comprehensive assessment, 27 were assessed and 13 were approved for funding. Only 6 of the 13 clients that entered rehabilitation had a successful completion.

In 2010/11 there were 7 new journeys started in Leicester. There were 46 persons in treatment, with the majority of those (34) in an inpatient setting and the remainder in a community setting (residential rehab). There were 13 exits out of tier 4 treatment in 2010/11, with 23% being planned, 46% being referred on and the remaining 31% being unplanned. The small numbers make it difficult to review the differences in success between inpatient and community treatment outcomes; on-going monitoring over a number of years would help in making this comparison. Finally, there were 6 transfers in 2010/11, with the majority of those (83%) being from a community to an inpatient setting.

Summary of drug treatment service provision

The summary table (figure 35) provides a snapshot of how Leicester has performed in 2010-11 in a range of indicators relative to the other 146 DAAT partnerships across the country. Leicester performs relatively well for those having a Hepatitis C test and OCU in effective treatment, however performs relatively less well for adult TOP compliance starts, successful completions and waiting time within 3 weeks. To note: Leicester performs relatively well for adult TOP compliance reviews, however if the number of reviews is small to start with i.e. TOP compliance at start, therefore having a high proportion of reviews will mean a much smaller number of reviews needed to be completed to have a high proportion and a relatively good performance.

Figure 35: Leicester Performance Comparison with other DAATs, National ranking- 2010-11



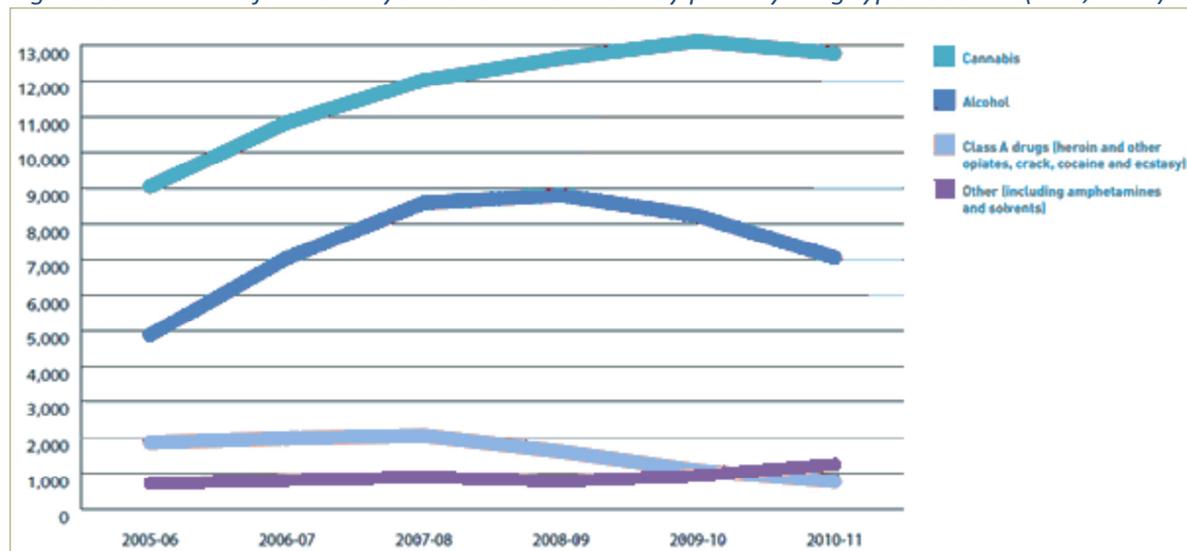
Source: NTA

Young people's drug and alcohol treatment provision

Drug and alcohol misuse among teenagers is usually a symptom, rather than the cause of their vulnerability, as many have broader difficulties such as family breakdown, inadequate housing, offending, truancy, anti-social behaviour, poor educational attainment and mental health concerns⁴⁴. There were 21,955 under 18 year olds needing help for substance misuse in England in 2010-11, a fall from the two previous years (24,052 in 2008/09 and 23,528 in 2009/10). Treatment

for the use of cannabis has the highest number of under 18 years in treatment, followed by alcohol (figure 36).

Figure 36. Number of under 18 year olds in treatment by primary drug type 2005-11. (NTA, 2011)



Source: NTA

Young people’s treatment services have an important role to play in providing specialist and immediate help and support to young people whose current functioning is impaired through substance misuse. Substance misuse can cause immediate and longer term problems for young people; the risk of overdose, longer term physical and psychological problems, withdrawal from family and learning and engagement in anti-social/criminal behaviour. Investing in young people’s specialist substance misuse treatment, can save £5-£8 over a lifetime for every £1 spent⁴⁵.

The current treatment system

Specialist treatment services require a high degree of professional specialism as interventions range from harm reduction interventions, evidence based psychosocial interventions such as motivational interviewing and cognitive behavioural therapy (CBT) and pharmacological interventions such as short term substitute prescribing. Interventions can range from 4 weeks to 6-12 months.

Through the redesign of young people’s drug and alcohol service in 2010-11, an emphasis for services was to identify and support more young people with alcohol-related needs, offer earlier and more flexible support to those using substances, streamline referrals into just one community based organisation with multiple access points (where previously there had been up to 4 different agencies and access points with varying referral criteria), and to help prevent young people from engaging in criminal behaviour.

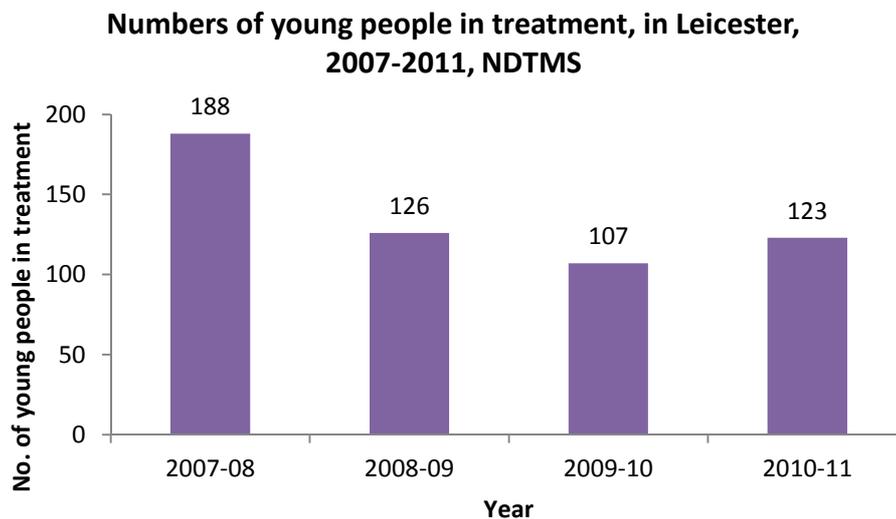
Prior to redesign, the range of pathways into specialist services were complex; with a number of different ‘specialist’ roles within different agencies causing the potential for confusion and duplication on which agency took the lead or at what point specialist support roles should refer to specialist treatment services. The new service design provides a more streamlined treatment service for young people. The new contract for this community based service was awarded to Leicestershire Partnership Trust in April 2011, who work in collaboration with Leicestershire Community Projects Trust, beginning July 2011. The Youth Offending service continue to provide specialist substance misuse services including treatment to young people in the criminal justice system.

It should be noted that young people’s treatment figures are not comparable with statistics relating to adult drug treatment. This is because access to treatment for young people requires a lower severity of substance misuse and associated problems and data shown below represents data derived from the previous treatment system prior to July 2011.

Those in the treatment system

The following information on treatment data is derived from the NDTMS and from local agency data reported directly to the DAAT. The overall number of young people (under the age of 18) in treatment across all agencies has declined since 2007-08, where 188 young people in Leicester were in treatment to 123 in 2010-11 (figure 37). The fall in overall numbers of young people in treatment reflects a drop in YOS treatment numbers of first time entrants to the criminal justice system over 2007-10. Nationally numbers of young people in treatment peaked in 2008-09 and has declined since. The number of young people in treatment continues to fall nationally, whereas in Leicester this number has increased in the last year. In September 2011 Leicester’s treatment numbers were 18% up (99) on a 12 month rolling comparison whereby nationally there had been an 8% reduction, however this may be a reflection of the Leicester’s young population.

Figure 37: Numbers of young people in treatment in Leicester, 2007-2011, NDTMS



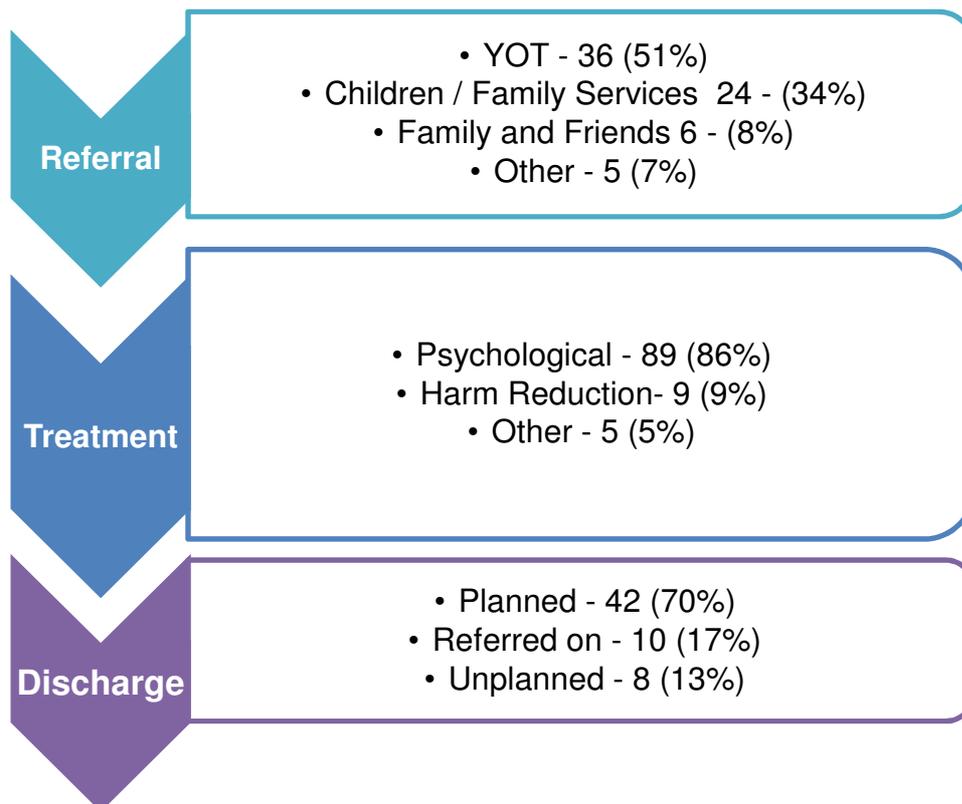
Data: NDTMS

The newly designed services in Leicester are required to improve referral pathways with health related services and have developed links with the CAMHS ‘triage’ system in order to ensure there are stronger pathways with mental health services. Additionally a system of screening and follow up with the A&E department has been set up to ensure that young people who go to A&E with, for example, alcohol poisonings are put in touch with services.

Prior to September 2011 schools were advised to contact the schools drug advisor as the first ‘port of call’ if it was thought personal support around substance use was needed. It was the schools drug advisor role to link the young person into specialist treatment services as they judged appropriate. In order to make the referral pathways between individual schools and specialist treatment services stronger, schools have been advised to contact services direct. This is very likely to lead to an increase in referrals to specialist services, although it is possible this might include a proportion where treatment is not required.

There were 71 new referrals into treatment in 2010. The most common referral route for young people into specialist services is the youth offending team (51%), followed by children and family services (34%) and family and friends (8%) (figure 38). Leicester has a comparatively high proportion of its treatment referrals coming via the criminal justice system, with only Sandwell having the same proportion. Leicester has traditionally had a low level of referrals from community based services. Consequently it has one of the lowest rates amongst the peer comparators and England of referrals from children’s services and health/mental health services.

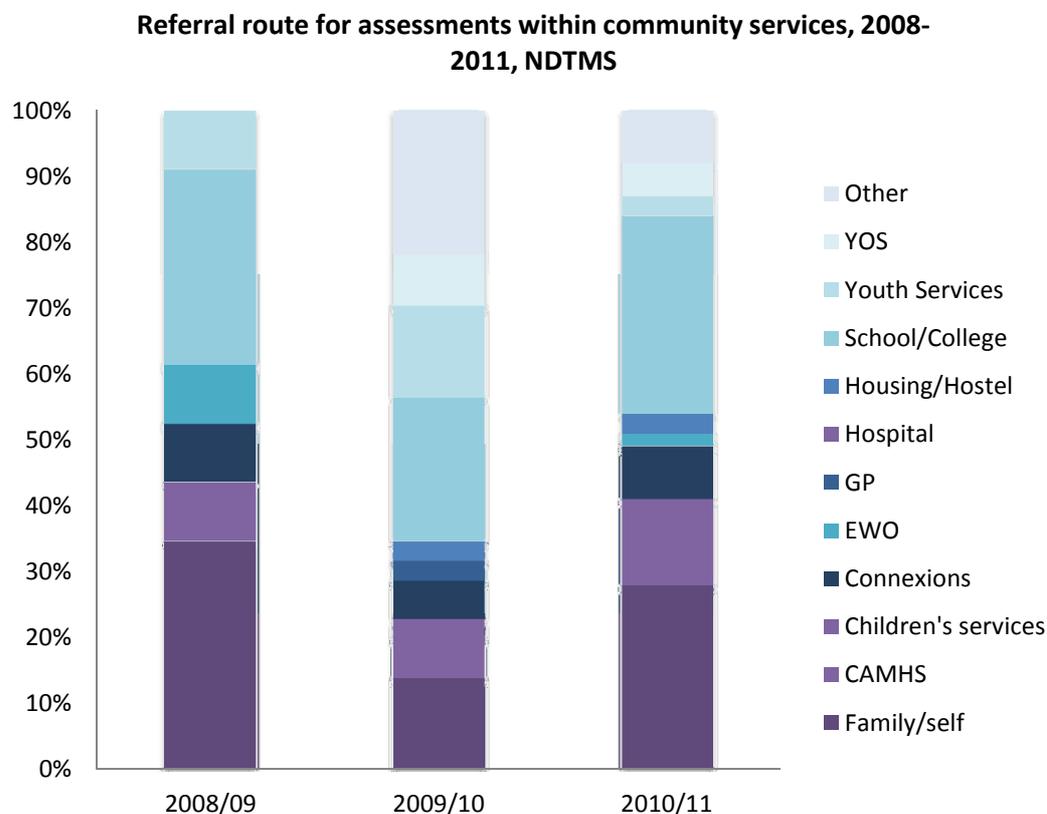
Figure 38: Leicester young person’s drug treatment map, 2010-11, data from NDTMS.



Self and family referrals are an important avenue to services, although traditionally young alcohol/drug users have been less likely to refer themselves to services than their adult counterparts. Of the peer comparators only Manchester had a self-referral rate higher (12%) than the England rate (11%). Leicester, (along with Sandwell and Wolverhampton) had the lowest score 5% (6 referrals) over a period of 18 months. The newly designed services are required to increase the accessibility and attraction of their services to young people through consultation, marketing and increased accessibility within localities, and this has included including the opening of a young person only service centre with artwork specifically created by young people.

When viewing who refers to treatment services; referrals for assessment in the non-criminal justice community based drug/alcohol services are a better basis for looking at the range of referrals, as new referrals come from a variety of sources. Assessment data shows who was referred for specialist assessment (figure 39).

Figure 39: Referral route for assessments within community services, 2008-2011, NDTMS



Data: NDTMS

This range of referrals to treatment reflect the number of different pathways between drug/alcohol services and those services which are in contact with young people who are more likely to be at risk of drug and alcohol issues. These include young offenders, looked after children, truants, those excluded from school, young people who are homeless and those with mental health issues. Community drug/alcohol services need to be positioned so that young drug/alcohol users with more complex needs are being supported.

Demographics of those in treatment

Four wards in the city appear to have relatively higher levels of young people presenting for treatment as the majority of young people receiving treatment between October 2009 to September 2011 came from just four wards (53%, 105 young people). These were Braunstone/Rowley Fields, Beaumont Leys, Eyres Monsell and New Parks. This level of presentation has been fairly constant, with the proportion of referrals in 2008-09 from those four wards being 48%. Within these four wards in 2010-11, the majority of referrals came through the criminal justice system (88%, 92 out of 105) which suggests targeted work may be needed in these wards in order to prevent drug and alcohol related offending with young people.

Over October 2009 to September 2011 eight wards had numbers in treatment of less than 5 (Knighton, Westcotes, Coleman, Humberstone, Latimer, Spinney hill, Charnwood and Fosse) with the last 2 having lowest numbers in treatment over this two year period.

The age of those in treatment in Leicester in 2010-11 ranged from 10 years old to 17 years old. The majority of those in treatment (89 people, 74%) were aged 15 to 17 years old; 73% were males and 75% white-British, a drop from 88% in 2008-09. Nationally those aged 15 to 17 accounted for 78% of all young people in specialist treatment in 2010-11; 64% were male and 84% white-British. Two ethnic groups saw an increase in proportion of referrals to treatment: Indian and White/Black Caribbean increasing from 4% to 10% and 2% to 9% of referrals respectively. The ethnic breakdown of those accessing open access drug and alcohol services delivered by LCPT indicates that in 2010-11, almost 50% of those who had information advice and guidance (IAG) were of Asian ethnicity (101 out of 204), while only 15% (9 of 59) required specialist assessment after IAG. This suggests that a larger proportion of White young people who contact open access services need specialist assessment than Asian young people who contact the service.

In Leicester, of those young people in treatment, 78% (69 young people) were male in the criminal justice system and 58% (19) were male in the community system. The per cent of referrals to community services for females has dropped 58% in 2008-09 to 42% in 2010-11. This may be as a result of the type of drug usage; where there has been a drop in young female heroin users presenting to services and an increase in referrals of male Cannabis users.

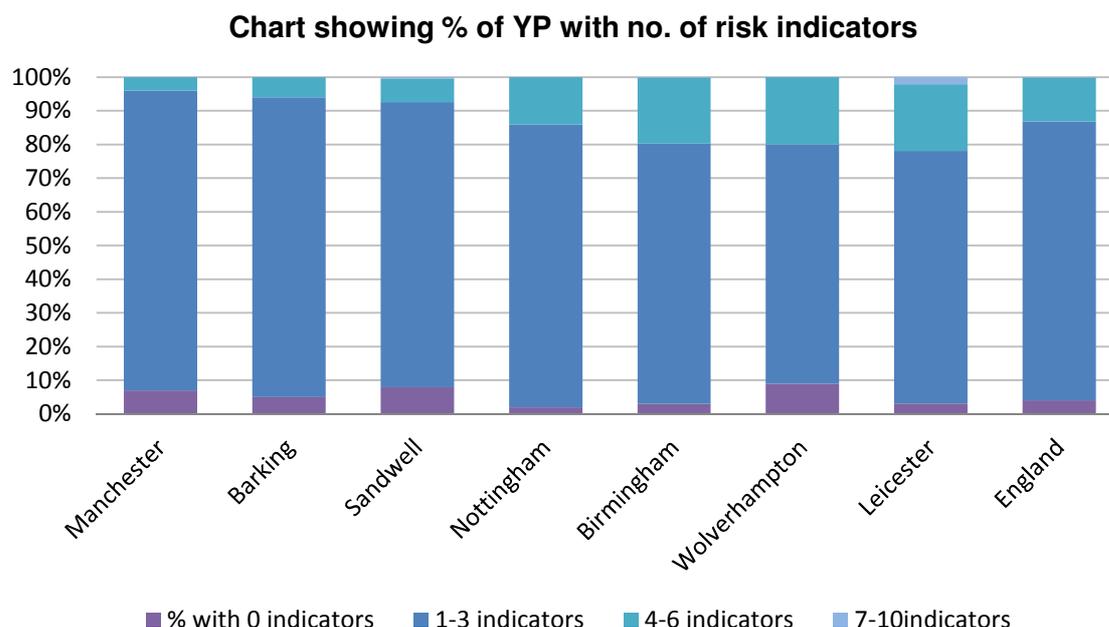
Complexity of need of those in treatment

There are some indications that the needs of young people in Leicester's treatment system are relatively high compared to other areas and that young people are coming into treatment services when their problems are relatively well entrenched. The NTA have developed a risk/harm profile of local treatment populations based on data uploaded to the NDTMS. The profile 10 indices of harm/complexity of need are identified as part of the assessment at the beginning of treatment^{vi}.

Between April 2009 to March 2011 Leicester had the highest proportion of young people (new to treatment) that had 4 or more indicators of harm (21%, 28 out of 130 YP) compared to our comparator areas and nationally (14%) (figure 40).

^{vi} The 10 indices include: OCU, higher risk drinkers, poly drug use, NFA, offending, NEET, early onset (first drug use under 15 years), involved in self-harm, pregnant or a parent, is a looked after child.

Figure 40. Per cent YP with number of risk indicators, 2009-11, NDTMS



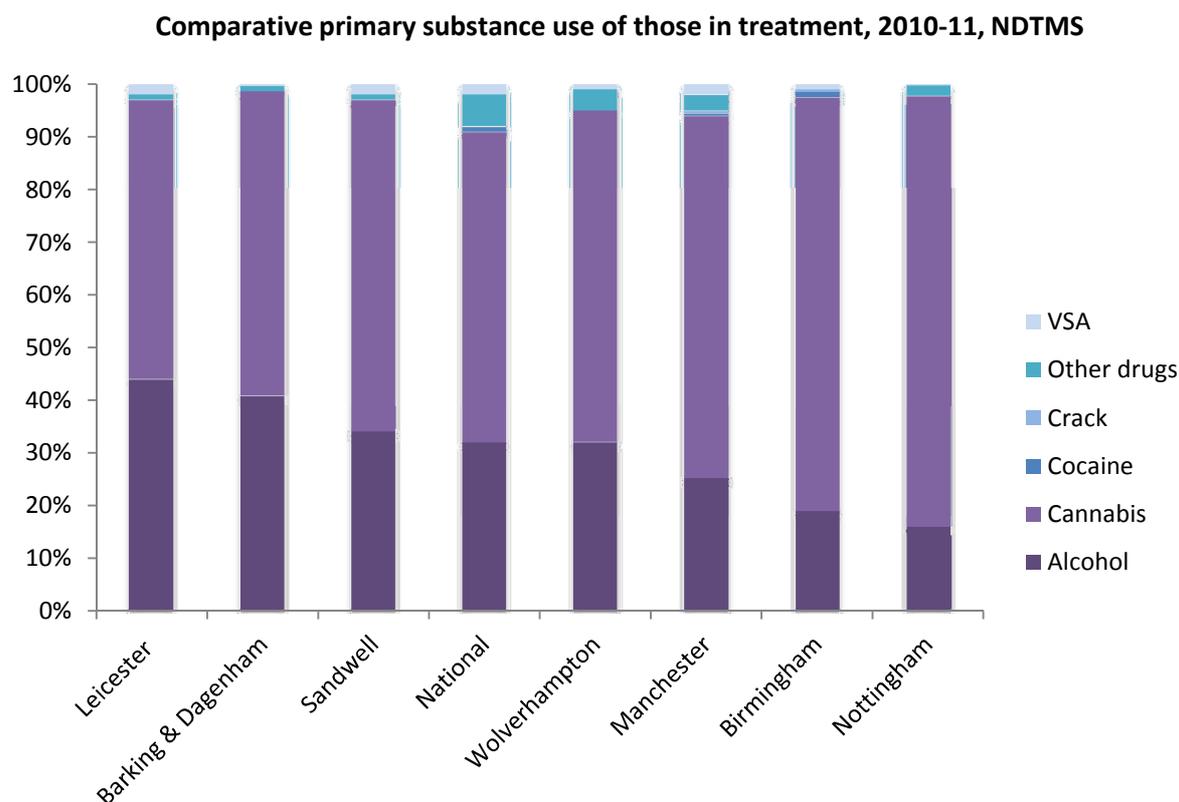
Data: NDTMS

When looking at the 10 individual risk factors over 2010-11, Leicester had the highest proportion of young people in 4 out of the 10 categories (high risk drinking, no fixed abode, not in education, employment or training and self-harm) and the second highest proportion in a further three categories (offending, early onset and pregnancy). There were only two areas where Leicester's proportion was below the national rate: poly use (using 2 or more drugs) and looked after child status. The latter perhaps reflects the relatively low level of referrals to treatment from Children's services, yet shows the higher degree of complexity of those coming into treatment, perhaps a consequence of the higher proportion of young people being referred through the criminal justice system.

Treatment type and outcomes

In Leicester the majority of young people are receiving treatment for alcohol (44%) and cannabis (53%). The proportion being treated for alcohol is higher than the national and other comparators and consequently the lowest for cannabis treatment (figure 41). The proportion of young people being treated for alcohol in the YOS was 48% over the April 2009 to March 2011 period compared to 25% for community drug/alcohol services. There were no young heroin users being treated in 2010-11 and other drugs including volatile substance abuse (VSA) have remained a small proportion of those in treatment, as with other areas.

Figure 41: Comparative primary substance for those in treatment, 2010-11, NDTMS.



Data: NDTMS

Comparing within Leicester between community and criminal justice services, 12% (4) were being treated for 'other drugs' in the community based services, compared to 0% in the YOS; 33% (11) were being treated for alcohol in the community based system, compared to 48% (42) in the YOS. 55% (18) and 52% (46) were being treated for cannabis in the community and YOS respectively (table 12).

Table 12. Proportion of young people by type of treatment in the community and criminal justice system, 2010-11, NDTMS.

| Type of treatment | Community | Criminal Justice (YOS) |
|--------------------|-----------|------------------------|
| Alcohol | 33% (11) | 48% (42) |
| Cannabis | 55% (18) | 52% (46) |
| Other drugs | 12% (4) | 0% (0) |
| Total | 100% (33) | 100% (88) |

Data: NDTMS

Nationally, while the number of young people accessing services is dropping, the number successfully completing treatment continues to rise. No young person had to wait long to start treatment with a specialist service with 98% receiving help within three weeks nationally, compared to 95% in Leicester for 2010-11.

During the first year where statistics were collected (2005-06), nationally 48% completed successfully. This has risen steadily over the past few years, reaching 69% in 2009-10 and 75% in 2010-11. In Leicester in 2010-11 70% (42) of young people had planned exits from treatment and of

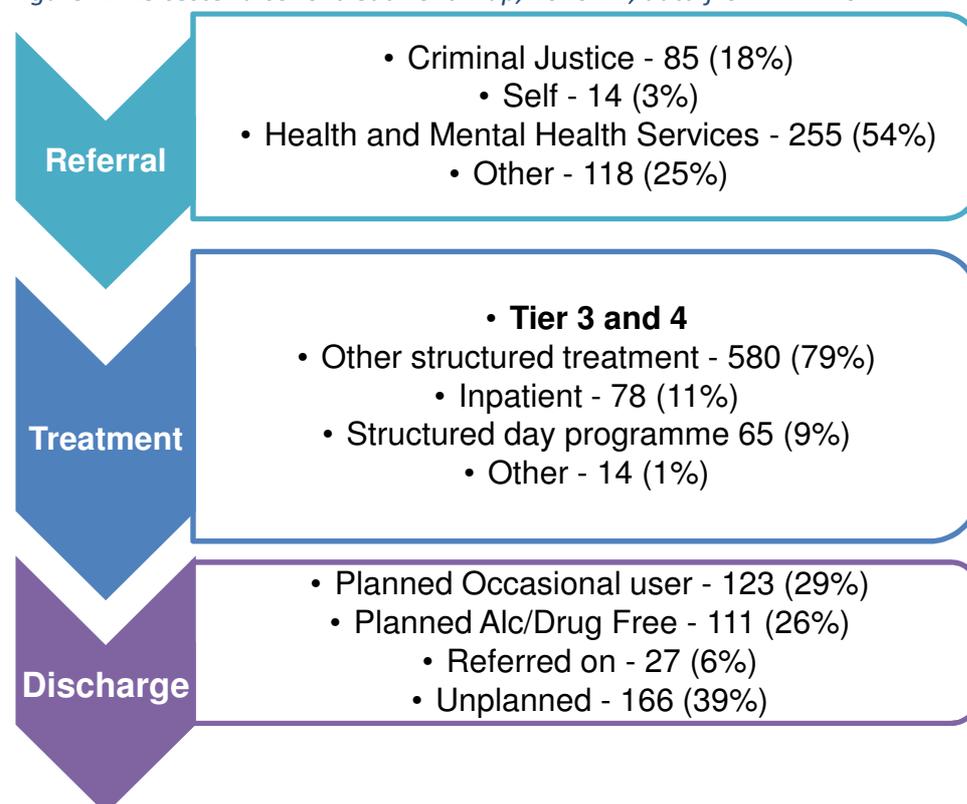
these 91% met their treatment goals on exit. The lower proportion may be a factor of the more complex needs of young people coming into treatment in Leicester.

The average time a young person spent in a programme nationally in 2010-11 was 158 days, or just over five months, compared to 129 days in Leicester. Nationally, more than 80% of the young people seeing specialist services receive a psychosocial intervention (sometimes in combination with other interventions, such as harm reduction advice and family work). Locally 100% of young people in treatment received psychosocial or harm reduction interventions and none required pharmacological interventions (which are required for those that were opiate dependent). Over April 2010 to September 2011 there were no young people in Leicester being treated who had previously or were currently injecting.

Alcohol treatment provision for adults (18 years and above)

Data from the National Alcohol Treatment Monitoring System (NATMS) provides numbers for clients referred into, treated and exiting alcohol treatment services. As stated above, it is estimated that there is almost 10,000 (3.6%) adults dependent on alcohol, of which 10% (almost 1000 adults) is the anticipated demand for treatment⁴⁶. In 2010-11 as shown in figure 42, there were 472 new referrals and 737 treatment journeys in the tier 3 and 4 alcohol treatment services in Leicester (73%, male, 27% female). The majority of referrals (54%) were from health and mental health services (much higher than nationally 28% and our peer PCTs, figure 43) and other (25%). Leicester had a much lower proportion of self-referrals than nationally (3% and 38% respectively). To note: the treatment map does not include tier 1 and 2 data i.e. brief interventions, therefore there will be many alcohol interventions that are not captured here. No records were reported for tier 2 interventions i.e. brief interventions, although this is not a compulsory to use, it would be useful to reflect the work that local services provide.

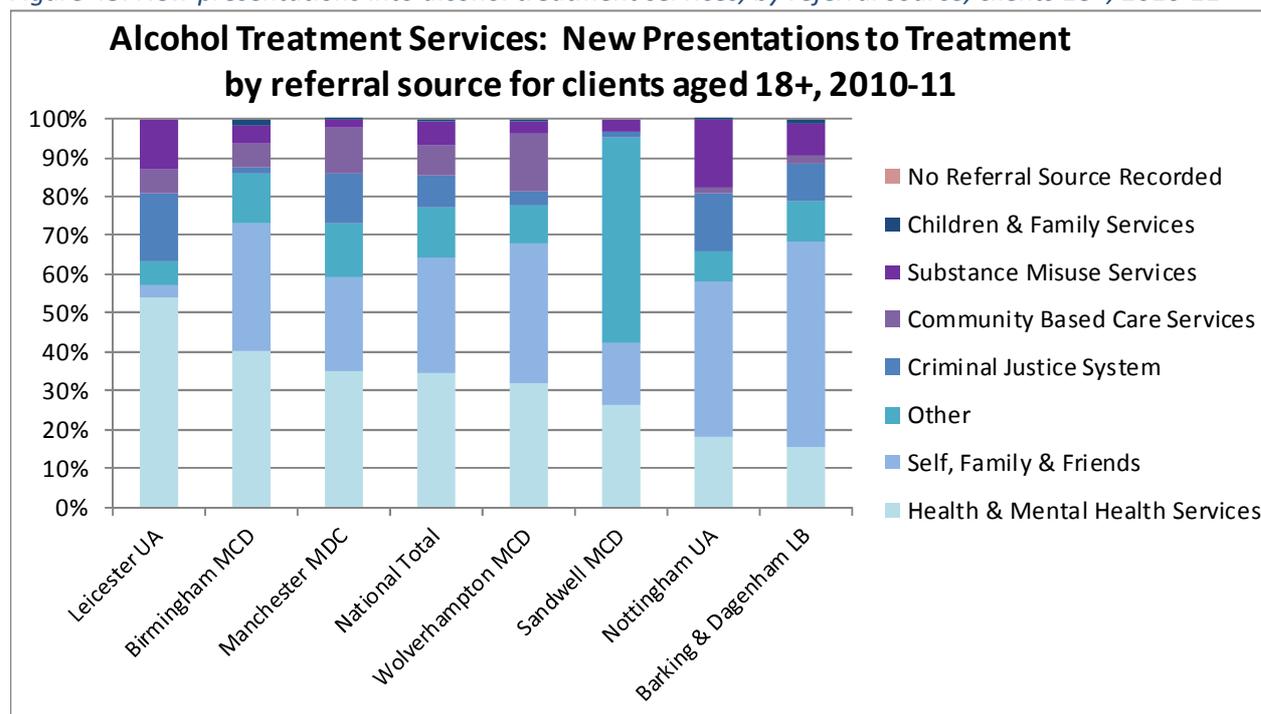
Figure42: Leicester alcohol treatment map, 2010-11, data from NATMS..



Of new referrals in tier 3 and 4 treatment, the majority were in other structured treatment (79%) (this can include key working, care management and brief packages of counselling) or inpatient detoxification (11%), there were no alcohol community prescribing or alcohol structured treatment recorded.

Comparing these figures to the national figures (2009/10 the latest available)⁴⁷, 32% were in structured psychosocial intervention, 27% in other structured treatment and the rest in a variety of interventions. Most of those in treatment had a planned exit (55% either occasional user of alcohol or drug free), and a smaller proportion who were referred on compared to the drug treatment system (6% compared to 40% in drug treatment services). These figures are very similar to the national figures (planned 54%, referred on 8% and unplanned 38%).

Figure 43. New presentations into alcohol treatment services, by referral source, clients 18+, 2010-11

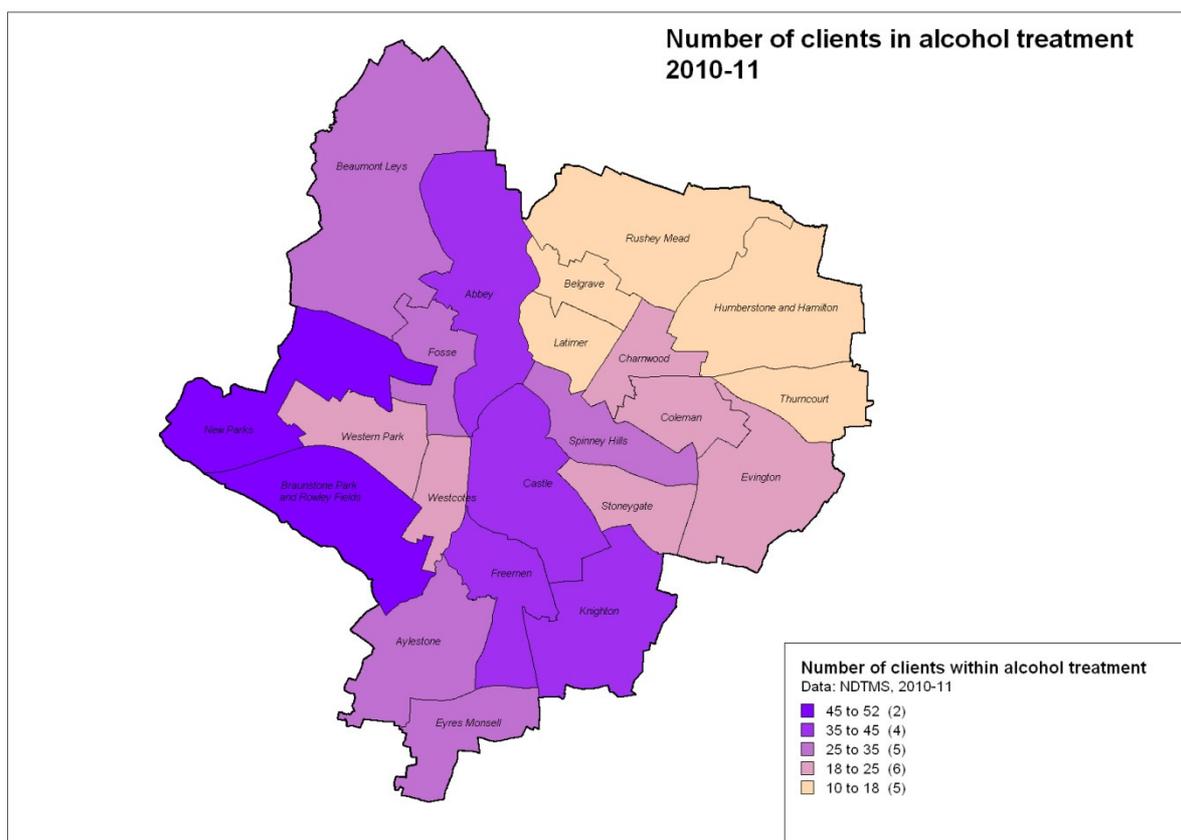


Data: NATMS

Alcohol treatment types

In 2010-11 there were 626 clients (a rise from 613 in 2009/10) of the 1,000 expected to come to treatment or 6% of dependent drinkers in structured treatment (tiers 3 and 4) in Leicester (this includes new referrals and clients already in treatment during 2010-11). Of these 463 (74%) were male and 163 (26%) female, which is slightly higher proportion of males than England (male 65%, female 35%). The data on the NATMS, does not accurately provide information on age and ethnicity of those in treatment, therefore this is not analysed.

Figure 44: Clients in Alcohol treatment, 2010-11



Data: NATMS To note: numbers are shown due to ward level data is based on partial postcode and is between 72-100% accuracy.

For alcohol users there were some differences in presenting need in the City. The five wards with the largest numbers in alcohol treatment (in descending order) were Braunstone/Rowley fields, New Parks, Freeman ,Castle, and Knighton which represented 38% of all those in treatment. The wards with the lowest number in alcohol treatment (Belgrave, Latimer, Humberstone, RusheyMead Thurncourt) represented 12% of all those in treatment. Wards in the east of Leicester have a high South Asian population with generally reported lower levels of alcohol consumption.

The amount of units drunk by each client and complexity of care needed for alcohol is assessed and recorded on the NATMS. Complexity factors include, poly-drug use, housing problems, parents, pregnant or out of employment. Those clients in the Leicester alcohol treatment system have a very similar consumption of units per month (ranging from 0 units to 1000+) as compared the National average.

Leicester has a higher percentage of clients with a 0 complexity score than the national average, 36% as opposed to 17%. Leicester also has a slightly higher percentage for complexity score of 1, 36% as opposed to 32%. Taken together, 72% of Leicester clients have a complexity score of 0 or 1 and only 28% have a score of 2- 4+. This compares well with the national average that has 49% at scores 0 or 1 and 51% at scores 2-4+, either meaning that clients seen for alcohol treatment have fewer additional issues than the national average or they are not being picked up.

Prescribing to treat alcohol dependency

Treatment for alcohol dependency includes the prescription of two drugs. Acamprosate Calcium, which helps restore the brain's chemical balance to reduce a patient's withdrawal symptoms from

alcohol and Disulfiram, which causes a severe and unpleasant reaction in the patient if they drink alcohol.

The number of prescription items dispensed to treat people for alcohol dependency in England has risen by 46 per cent since 2003. A total of 150,445, prescription items for Acamprostate Calcium and Disulfiram, were dispensed in 2009. Nearly 95,000 for Acamprostate and just over 55,500 for Disulfiram. On average 271 prescription items were issued for alcohol dependency per 100,000 of the population.

There has been a substantial increase in the number of prescriptions for Acamprostate calcium and Disulfiram in Leicester in 2010-11 compared with the previous 2 years, which reflects the increase in numbers in treatment being prescribed drugs. The total prescribing rates in Leicester are above the East Midlands, and lower than the England rate (table 13).

Table 13: Alcohol-dependency prescribing in Leicester GP Practices, Items per 100,000 population

| Product | | Leicester | | | East Midlands | England |
|----------------------|-----------------------|-----------|---------|---------|---------------|---------|
| | | 2008-09 | 2009-10 | 2010-11 | 2010-11 | 2010-11 |
| Acomprostate Calcium | Items | 205 | 225 | 456 | | |
| Acomprostate Calcium | Items per 100,000 pop | 57.8 | 62.3 | 124.6 | 97.4 | 189.6 |
| Disulfiram | Items | 145 | 212 | 289 | | |
| Disulfiram | Items per 100,000 pop | 40.9 | 58.7 | 79.0 | 98.2 | 100.8 |
| Total | | 350 | 437 | 745 | | |
| Total | Items per 100,000 pop | 98.7 | 120.9 | 203.6 | 195.6 | 290.4 |

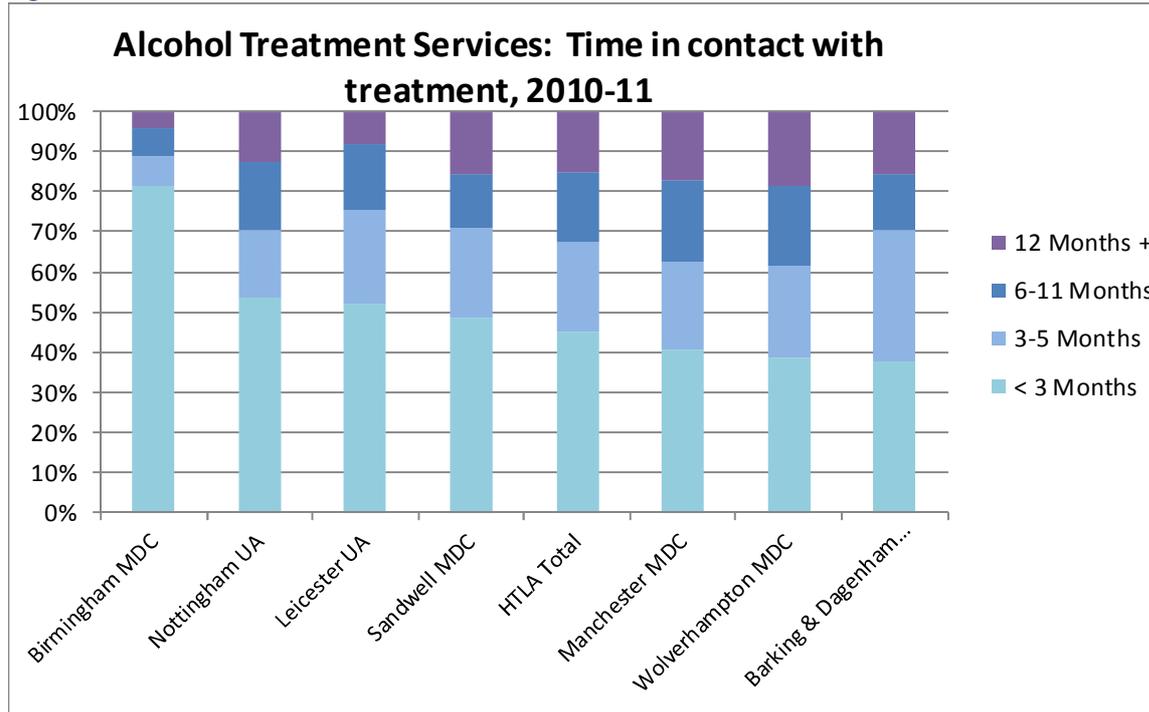
Data: Prescribing Analysis and Cost Tool (PACT), NHS IC Statistics on Alcohol, England 2011

Alcohol treatment duration and journeys

The time in contact with treatment is recorded as the client's longest episode at the agency that crosses into 2010-11. Prior contacts with treatment show the distinct treatment journeys experienced by the client in the history of formal data collection since 1st Apr 2008. 1 journey means clients whose latest journey is their first journey.

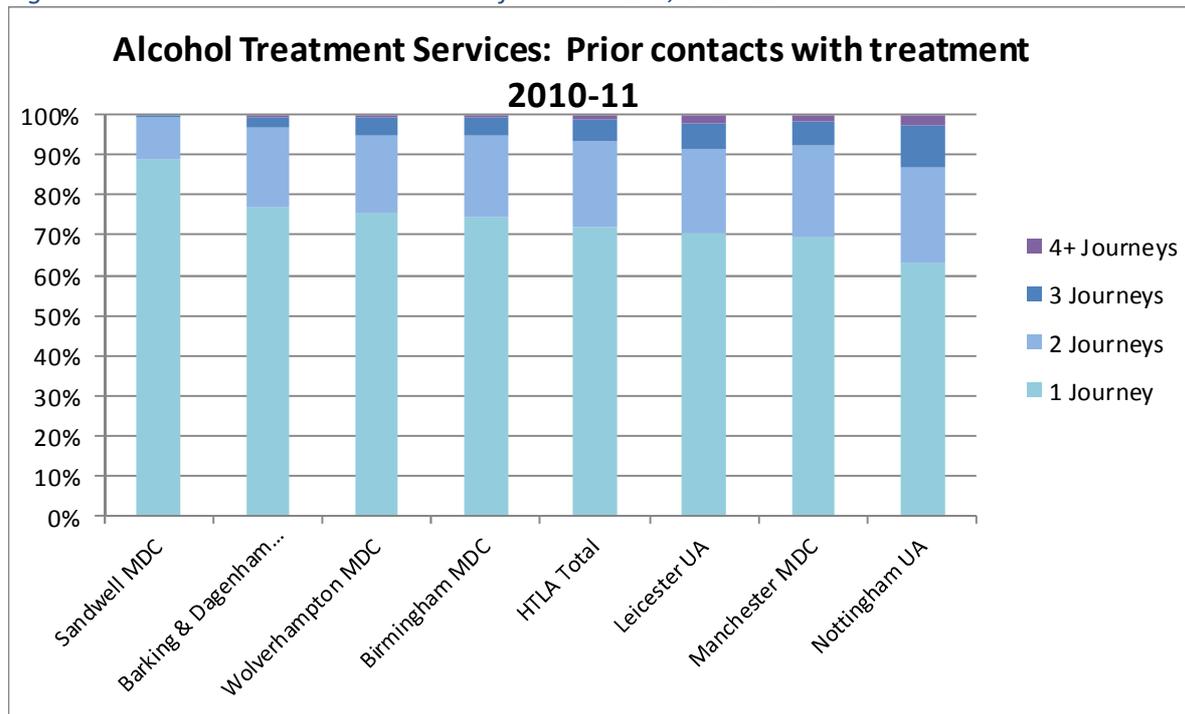
There were 763 alcohol treatment journeys in Leicester in 2010-11 (for 626 clients); of these treatment journeys, 52% were under 3 months, 23% 3-5 months, 16% 6-11 months, 8% over 12 months (figure 45). In 2010-11, 70% of clients had 1 treatment journey, 21% 2 journeys, 6% 3 journeys and 2% over 4 journeys. Leicester has the third highest proportion of clients with over 4 journeys within the peer PCTs for (figure 46).

Figure 45: Time in contact with structured treatment, clients 18+, 2010-11



Data: NATMS

Figure 46: Prior contacts with treatment for clients 18+, 2010-11



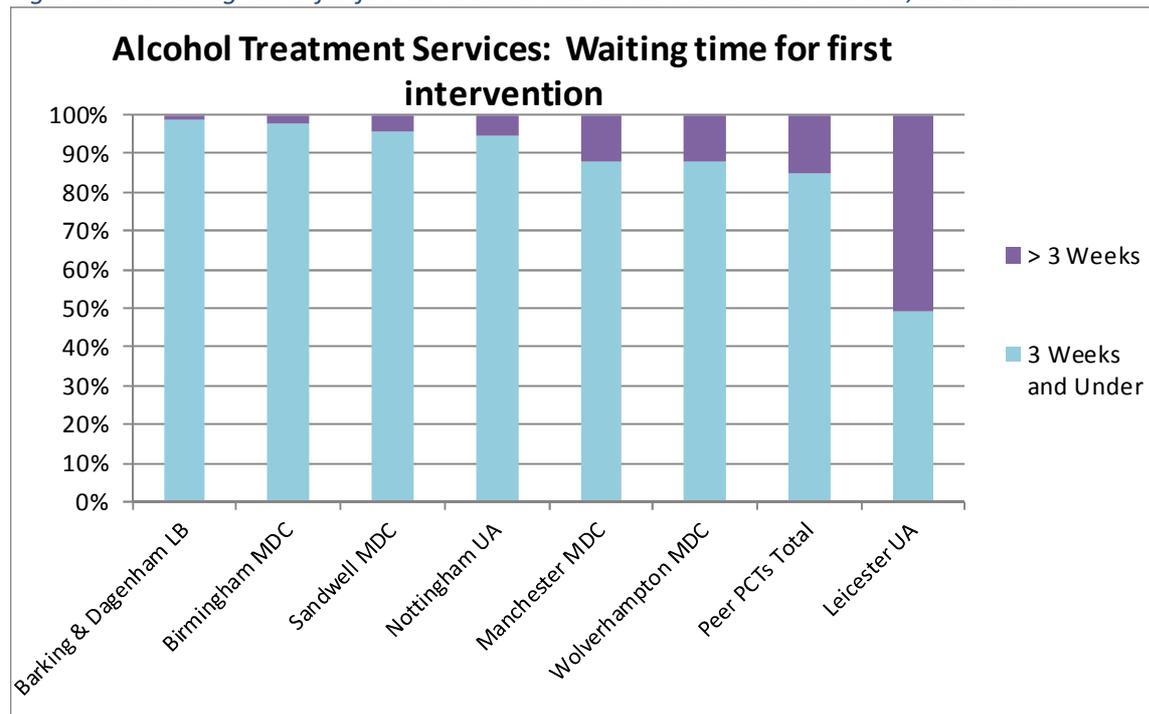
Data: NATMS

Waiting times for interventions

As with drug treatment, having a client receive treatment quickly after referral improves the chances of recovery. Figure 47 below shows the waiting times for alcohol interventions commencing within 2010-11. The first wait and subsequent waits are reported per client. The actual number of interventions will be lower than the sum of interventions as these will include interventions starting before 2010-11, but which cross into 2010-11.

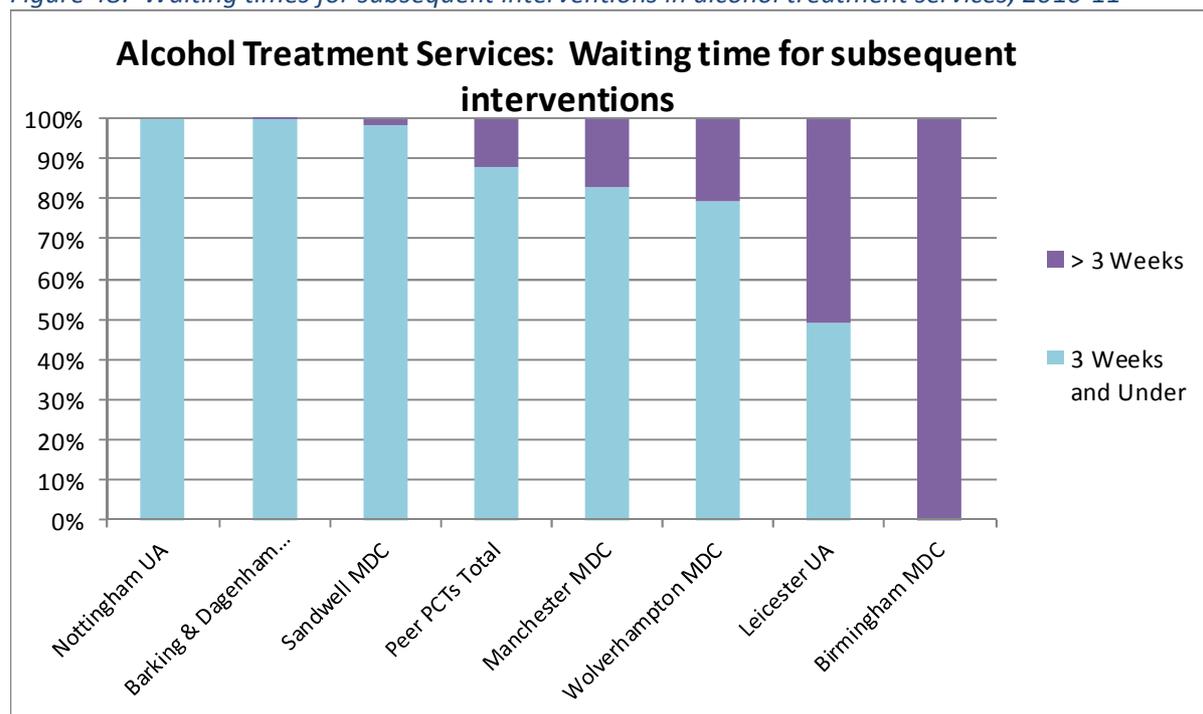
There were 579 first interventions in Leicester in 2010-11, of which 51% had a waiting time of under 3 weeks. This is the highest per cent of referral waiting over 3 weeks, some 30% greater than the next peer PCT. All other peer PCTs see over 80% of clients within 3 weeks. For subsequent interventions, only 49% of the 47 clients are seen within 3 weeks, which again is the highest proportion of waiting times over 3 weeks, with most seeing 80% of clients within 3 weeks. To note the numbers are relatively small therefore results should be interpreted with caution. Birmingham was an outlier as it only had 1 client for subsequent interventions.

Figure 47: Waiting times for first intervention in alcohol treatment services, 2010-11



Data: NATMS

Figure 48: Waiting times for subsequent interventions in alcohol treatment services, 2010-11

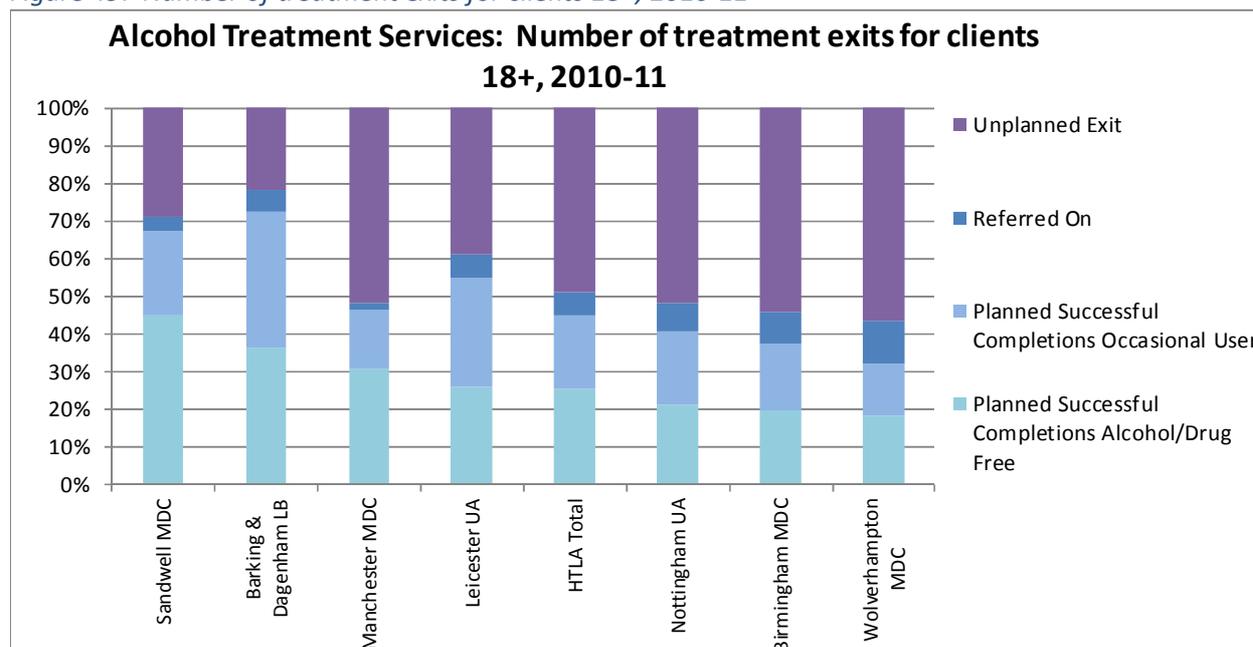


Data: NATMS

Alcohol treatment exits

This shows the exit reasons for individuals leaving the treatment system before 1st April 2011. As with drug treatment, exits are either planned, referred on planned successful with occasional use or alcohol free. Leicester had 427 treatment exits in 2010-11 of which 234 (55%) were successful exits from individuals (26% drug/alcohol free or occasional users 29%). The remainder were either referred on (6%) or had unplanned exits (39%). Leicester had the 3rd highest per cent of planned, successful treatments (55%) amongst the peer PCTs; Barking and Dagenham had the highest (72%) and Wolverhampton the lowest (32%) (figure 49).

Figure 49: Number of treatment exits for clients 18+, 2010-11



Data: NATMS

Prison and probation drugs and alcohol

The relationship between drugs and alcohol and crime is complex⁴⁸⁴⁹. For drugs, evidence suggests that problem drug users are responsible for large percentage of acquisitive crime i.e. shop lifting and burglary and as a consequence would end up in the criminal justice system. For alcohol there is little correlation between drinking modest quantities of alcohol and crime but as consumption increases, the relationship becomes stronger. Some crimes have been found to be more vulnerable to the influence of alcohol than others.

Within the whole Criminal justice system, there has been a push over the last 3 years to fully integrate services to form a cohesive end to end specialist system of drug and alcohol treatment. This has been partly achieved by joining up of what was previously known as the CARAT services within the community contract, however the Clinical IDTS interventions remain outside of the integrated pathway. This causes a confused picture of treatment within the Prison with both services assessing need differently, having poor data compliance, and a lack of co-ordination of interventions. The work in joining up the CARAT services provides continuity of care between the prison and the community.

A review of the Leicester, Leicestershire, and Rutland (criminal justice system services), covering 2010-11 found that there was a demonstrated reduction in drinking and an improvement in physical and psychological health and quality of life in those with an alcohol treatment requirement (ATR) and in treatment with the service. Although there were issues raised about data recording being inconsistent, more sensitive outcomes measures and an analysis of reoffending would help improve the understanding of the outcomes of treatment.

HMP Leicester is a local category B prison establishment in the centre of Leicester City. It has an operational capacity of 400 and serves the localities of Leicester, Leicestershire, and Rutland courts. Due to the nature of HMP Leicester being a “local” establishment it has a high population turn over or “churn” with the average length of stay within the establishment being under five weeks. Approximately 80% of current prisoners reside within Leicester city and Leicestershire County. Within the prison, 71% are categorised as White, 12% Asian, 9% Black and 8% other.

Nationally custodial substance misuse treatment services have undergone large scale change over recent years with the rollout of Integrated Drug Treatment Systems in Prisons across the UK in 2006, requiring the full range of pharmacological and psychosocial substance misuse treatment interventions being, for the first time available within custodial settings. In 2010 it was further announced that all psychosocial treatment interventions currently under the responsibility of the National Offenders Management Service would as of April 2012 move to be the responsibility of the Department of Health and along with integrated drug treatment system (IDTS) be commissioned and locally managed by local DAAT partnerships.

Treatment demand

During 2010/11 HMP Leicester had a total of 2,504 receptions, 1,840 new receptions and 664 transfers from other establishments, an increase from 2,438 in 2008-9. On reception healthcare (SERCO) assesses individuals for substance misuse need and found 537 individuals (21.4%) requiring treatment for substance misuse in 2010-11. The substance misuse team (CJDT) also assesses individuals for substance misuse treatment and according to the substance misuse treatment team a total of 762 individuals were identified as having a substance misuse need in 2010-11 this has significantly reduced from 970 in 2008-9. This means that different teams are picking up different numbers of people who needs treatment/support.

Additionally all those serving sentences of 12 months or more receive an OASys assessment from the Leicestershire and Rutland probation Trust; 1,785 individuals were identified as requiring an OASys assessment in 2010-11 and of these, it was identified that 42% (753) had a drug misuse need and 13% (228) had an alcohol misuse need a total of 981. Of these individuals, the majority were aged between 20-39 years (81%, 616), and 84% White (641), 6% Asian (43) and 10% Other (78).

Substance use

The majority of individuals (72%) would be classified as OCU's. Heroin remains the highest drug of choice (37%, 280) with alcohol second (20%, 152) and cannabis third (9%, 71). Data was missing on 121 (16%) records. Additionally it cannot be ascertained from the available data if those using methadone and Buprenorphine are in receipt of a script or are using it illicitly. The healthcare reception assessment records those who are on prescribed medication at reception and report that during 2010-11 133 receptions were on prescribed methadone and 17 receptions were on prescribed Buprenorphine. There is considerable missing data.

Blood borne virus

According to the healthcare on reception assessment data set a small number 11% (61) individuals are self-report as currently injecting, however there is significant missing data (233 records).

Information provided by SERCO health demonstrates that in 2010-11 2,204 individuals were offered HBV vaccination of which 1,239 (56%) accepted the intervention. The remaining had either already been immunised or refused. Of those 1,239 who accepted only 176 (14%) received 1st vaccination, 128 (10%) 2nd vaccination and 120 (10%) received full course and an additional 28 received a booster vaccination. In 2008-09 220 individuals consented to HBV vaccination with 74 receiving a full course and an additional 37 receiving a booster. This would indicate that although requests for the HBV vaccination have increased dramatically actual delivery of the intervention has remained fairly static since 2008-09. Fifty individuals were tested for HCV of which 20 were positive with an additional 8 being diagnosed with a HCV/HIV co-infection or HIV alone.

Testing

Within custodial environments the use illicit substances continues and there is a high demand for illicit substances creating a black market economy within the environment. However prices are

greatly inflated due to the difficulties of availability. Diversion of prescribed medication is also used as currency within custodial environments. The Prison service proactively works to reduce supply of illicit substances with a range of measures in place. For example they undertake a random drug testing programme in the prison service which randomly tests 10% of the population for illicit drug use. For year 2010-11 there were 419 random mandatory tests conducted in which 9% were positive. Prisoners are also subject to testing on suspicion and of the 68 suspicions tests conducted in 2010-11 32% were positive. Substances for those testing positive through both mandatory and suspicion testing were as follows; cannabis 25, opiates 24 and benzodiazepines 9.

These findings demonstrate that there is a trade in illicit substances within Leicester Prison, with the exception of cannabis this trade maybe both sourced from external to the establishment but also internally with diversion of prescribed medication. Clinical testing for illicit use should form part of any substitute prescribing treatment plan.

Transfer data

Onward transfer and continuity of care are essential for substance misuse offenders to have successful outcomes from substance misuse treatment services; this is equally important on reception in to custody as it is on release. In 2010/11 there were 256 (67%) inmates in treatment transferred to community drug and alcohol services to continue treatment as opposed to 28 (24%) in the previous year, compared to 42% nationally.

Drug Intervention Programme (DIP)

The Drug Intervention Programme (DIP) is an element of the national strategy to tackle drug-related crime. The drugs testing and treatment of offenders identifies those people whom are driven to commit crime through their drugs misuse. It offers offenders whose crimes are drug related the opportunity and support they need to deal with their substance misuse.

When an individual is arrested for a trigger offence (acquisitive crime) or when it is suspected that an offence is drug related (and an Inspector has given their authority) individuals are required by law to submit to a drugs test for specified Class A substances, namely cocaine and heroin if that test proves positive, the person is required by law to attend a "Required Assessment" of their substance use. This assessment establishes the degree of substance misuse issues an individual may have and provides a pathway into treatment services as required.

Across Leicestershire and Rutland the DIP is provided by a partnership of the Leicestershire Constabulary and the commissioned Leicestershire and Rutland Probation Trust's Criminal Justice Drug Team. During 2010-11 3,637 tests were conducted on individuals arrested for drug related crime, of these 1,043 (28.7%) were positive for either cocaine or heroin or both. Male positive testers accounted for 86.6% of the overall total. Of these tests, 40% were for cocaine, 35% opiates and 25% for both cocaine and opiates. The most common trigger offences are theft (51%) and burglary (17%). However there are inaccuracies in the DIP data as it is complex and sometimes does not match what is happening locally.

Drug Rehabilitation Requirement /Alcohol Treatment Requirement

The Offender Assessment System (OASys) is used in England and Wales by Her Majesty's Prison Service and National Probation areas as a complete assessment tool which measures risk areas in relation to likely re-offending and the needs of offenders under their supervision. It allows probation officers to assess how likely an offender is to re-offend, identify needs, assess harm to self and others, indicate need for further specialist treatment and measure change over the supervision period.

During 2010-11 1,081 individuals had an assessment on the Leicestershire and Rutland Probation Trusts OASys system of which 252 (23%) had an identified drugs needs and a further 240 (22%) had an identified need in relation to alcohol. There are a number of interventions available either through statutory probation provision or via the commissioned CJDT (lot 4) for those with high identified need. The CJDT deliver alcohol or drug treatment requirements both of these interventions which are mandated by the courts and individuals progress and compliance is closely monitored. Non-compliance is dealt with via breach action which returns the individual to the sentencing court.

The CJDT and statutory Probation service is monitored on the number of Commencements and completions in relation to both DRR's and ATR's. During 2010-11 in Leicester City there were 181 DRRs. The CJDT completed 81 (47%), compared to the national average of 45%. Similarly in 2010-11 Leicester City had 62 ATR commencements with a 70% completion rate. The national average was 72% in Jan 2012.

Wraparound services for drugs and alcohol

Wraparound services include support for housing, benefits, and employment etc. to support clients on the road to recovery and additionally these services can help identify individuals with substance misuse issues accessing mainstream services that are not in touch with treatment agencies. The following section covers a range of services provided in Leicester that support clients on the road to recovery or sign-post people for assessment or treatment. It is important within these services that the profile of substance misuse is raised to promote effective screening and onward referral into structured treatment. Conversely it is important that clients in treatment have access to mainstream community care services to support recovery.

The Quality of Life Service is intended to address the wraparound needs of individuals in treatment. Once fully operational, there will be a Recovery Café and gym as well as housing and employment services running surgeries on site thereby offering opportunities for individuals to be reintegrated back into mainstream society.

Support services such as the Dawn Centre provides homeless people with temporary accommodation, support, advice and assistance on health, housing, life skills and education all in one place and helps reduce the number of people who drink in the street in Leicester. Having information on the needs of these users in such services will help inform the development of services in the future.

Alcohol liaison specialist nurse

Since 2008 NHS Leicester City commissioned an alcohol liaison specialist nurse (ALSN) at UHL. Patients attending A&E/Emergency Decisions Unit (EDU) are screened by A&E Practitioners for alcohol misuse and those that screen positive are seen by the ALSN. There is currently one nurse in post and three other being recruited.

The ALSN sees the patient real-time for a "brief intervention", including triage alcohol assessment and offers advice and information e.g. how to access appropriate local services, detoxification regimes, abstinence support, controlled drinking, and withdrawal symptoms advice. If deemed appropriate, the patient would be referred on to local services for continuing care management. Alternatively or in addition, the patient may be asked to attend an outpatient clinic appointment with the ALSN for commencement / continuation of a detoxification programme (either within UHL or primary care depending on demand). This outpatient review would focus on relapse prevention.

The ALSN receives referrals for existing inpatients and would undertake real-time interventions for such patients in addition to the immediately presenting ED caseload.

A significant part of the ALSN's role is educational, in terms of promotion of the service within the Trust and the local health community. They would also undertake teaching and audit, tracking any 'missed referrals' with a view to continuously improving practice. Over 2010-11, 524 patients were seen by the ALSN, up from 494 in 2009-10. The top 5 reasons were alcohol withdrawal syndrome, alcohol dependency, hematemesis, alcohol induced-liver disease and overdose unknown.

Locally enhanced service in primary care

Excessive drinkers present twice as often as other patients in primary care and opportunistic screening and brief intervention is effective and cost effective in reducing excessive alcohol consumption in primary care. In Leicester City a Locally Enhanced Service (LES), which pays general practice for screening and offering brief interventions to registered patients (16 years and older). Over 2010-11, 33 practices (of 64) participated in the LES. There was a total of 12,363 brief interventions completed across participating practices.

Needle exchange

Needle exchange services are a crucial element in providing comprehensive harm reduction and blood borne virus prevention. There are two main methods for clients exchanging needles in Leicester; there are 13 pharmacies distributed throughout Leicester offering syringe distribution services and a needle exchange programme run through LCPT, offering targeted outreach needle exchange and through their offices in New Walk in the city centre.

The National Needle Exchange Monitoring System (NEXMS) provides data on needles dispensed. In Leicester in 2010-11 there were a total of 360,096 (projected figure) needles dispensed. Using the Harm Reduction Works Coverage Calculator⁵⁰, (which helps estimate the extent to which the number of syringes being distributed to illicit drug users within an area compares to an estimate of the potential need), there was 89% coverage in 2010-11, up from 25% in 2009-10.

Local data from LCPT (excluding pharmacies) show 697 clients using their Needle Exchange services, of which 95 (14%) were estimated to be in treatment, suggesting there are many treatment naïve people accessing this service. Data from the city council cleansing team, reported 3,327 needle finds in 2010-11, up from 2,842 in 2009-10, (a 15% increase). The wards with the majority of needle finds were; Abbey (30%, 865), Beaumont Leys (26%, 743) and Castle (14%, 402). There were no needle finds in Belgrave, Evington or Knighton.

Housing Related Support Services

Housing Related Support Services provide a range of services to Leicester residents who having housing problems. Clients of the service are asked at assessment whether they have problems other than housing. They are asked what their primary problem is, followed by any secondary problems including substance misuse. In 2010-11 Housing Related Support Services had 3,187 intervention episodes. There were 425 clients who were categorised as having a primary of secondary drug problem, lower than for the previous year (461) and 446 individuals who indicated having problems with alcohol, again lower than the previous year (459). Of these clients, 114 indicated having both alcohol and drugs problems.

Due to the stigma attached to substance misuse, a level of under reporting can be expected, however the data does provide useful information in terms of identifying unmet need. There are two housing related support services specifically configured to address the needs of clients with primary drug or alcohol problems. Heathfield House is a supported housing scheme comprising of

24 self-contained units providing support to client with a history of drug use (and following rehabilitation) for up to two years to enable them to move on to and sustain independent living.

Evesham House is a specialist supported housing project comprising 6 en-suite rooms with shared facilities to support clients with a history of entrenched rough-sleeping and chronic alcohol dependence. The service is aimed at enabling people to maintain their independence, retain choice in their lives, feel safe, secure and valued in their community; developing confidence in managing the practicalities of life minimising the reduction in independence to the individual.

Care First

Care First is the adult social care service for Leicester. Out of approximately 5,213 adults, 69 clients within adult services were shown to have substance misuse problems (of which 31 had received a review). This is an increase from 2009-10 in the number of adults (49) recorded with substance misuse problems. 22% (15) were aged 65 or older and the majority were male (46 of 55 where gender was recorded). The services they received were primarily short term residential care (27) long-term residential care (14) and home care (13).

Anchor centre

The Anchor Centre is used by alcohol dependent and often vulnerable adults. The success and reduction in street drinking across the city is partly due to the fact that street drinkers are directed to the Anchor Centre and can drink on the premises. This is a unique service with direct access to services such as; health care, housing advice as well as support. Other services such as Y Advice and Support Centre based in the Dawn Centre are open to dependent drinkers but do not allow drinking on the premises. Without the services of the Anchor Wet Day centre there would be nowhere for street drinkers to go.

The Anchor Centre had a reorganisation in September 2010 following an evaluation of service provision. The centre re-focused its role to deal with vulnerable street drinkers and homeless people with alcohol dependency while those whose main issue related to drugs would be referred on to other services.

In the first half of 2010-11, 70 users were seen, with poly-users (drugs and alcohol) the most common client type of service user. Almost three quarters (74%) were male, mainly aged over 40 (60%), 83% of clients were white and 38% of clients were of NFA or living in hostels.

In the second half of 2010-11 there was an increase in the number of clients seen to 95 (40 new users of the service) and an increase in the number Eastern European nationals using the service, which may be a reflection in the increased proportion of the Leicester population coming from the east Europe. Clients were older, with 64% of clients older than 40 and 80% male. The proportion of clients of NFA or in hostels had also increased from 38% to 59%. These changes may reflect the difference in the demographics of those dependent on drugs and alcohol.

New Futures

New Futures is a voluntary organisation that provides support to girls and women, boys and men involved in or at risk of exploitation through prostitution in Leicester. In 2010-11 they saw 416 clients. New Futures do not record how many of their clients are in treatment, yet are aware of an increase in women going into treatment. Of the women they see 70% are using drugs with the majority of those being poly-users. The majority of women are under 25 years old (60%) and of those 80% use drugs (substances unknown).

Street Drinking

Street drinking has been an issue in the city centre castle ward and remains a challenge during spring and summer months in Leicester. Street drinkers experience multiple social exclusion issues including substance misuse, homelessness, mental and physical health issues. Many of Leicester's street drinkers have a history of abuse, trauma or loss. Leicester has had 5 deaths in the past two years out of the 30 persistent street drinkers.

The street drinking initiative started in January 2010 and has developed a database of the identified street drinkers since April 2010. This has reduced street drinking in Leicester. It's success is based on the collaboration and commitment of the nine projects from DAAT, housing, health, police and voluntary sector.

Between January 2011 and December 2011 a total of 218 street drinkers were recorded by the project. 75% of these were new cases and 25% had previously been on the list. Only 11% (24) of the total number of street drinkers were persistent. The rest, 89%, were seen only once or twice.

The project is multi-agency and with over 9 agencies involved in sharing information and working together to tackle the issue it is an acknowledged example of good practice in working with multiple and complex needs particularly in relation to homelessness.

The co-ordinating aspect of the street drinking management project has been critical in ensuring better communication across agencies and therefore more informed decisions are made to support and address the issues underlying the street drinkers' life.

Qualitative review of needs and services: Service providers, users, parents and carers of users and wider stakeholders

The Public Health and the Drug and Alcohol Action Team (DAAT) commissioned Qa Research to conduct seven group discussions to gather qualitative data for the annual drug and alcohol needs assessment⁵¹. Sixty-one stakeholders were involved in the focus groups including drug and alcohol service providers; Tier 1 agencies; drug and alcohol service users and parents and carers of users. All group discussions were carried out in January 2012.

By commissioning an external agency to facilitate discrete group discussions enabled stakeholders to discuss their experiences and thoughts in an honest and open environment. In previous years participants may have been wary of what they said in front of the DAAT team and they may have had less opportunity to have their say in what were larger consultation workshops. A limitation of using an external agency is that due to very tight timescales this work has by necessity been approached with little contextual knowledge of drug and alcohol services in Leicester.

This research has generated a wealth of qualitative data regarding the views and experiences of a range of stakeholders regarding the local drug and alcohol system in Leicester City. Whilst mainstream services; specialist providers; services users and parents/carers of users have contributed to this consultation it should be noted that there may still be perspectives missing, such as GP's and judges. Whilst the input of service users and parents/carers has undoubtedly been valuable, care should be taken when deciding how to use the information going forward as the groups were not designed to generate a representative view of these groups, with the services users group, in particular, being made-up of pro-active individuals heavily involved in local services.

The key strengths, weaknesses, opportunities and threats of the current system according to the professionals taking part in the consultation can be summed up as follows:

| | |
|--|--|
| Strengths: <ol style="list-style-type: none"> 1. Links between services 2. Range of services/interventions 3. Positive comments on specific services | Weaknesses: <ol style="list-style-type: none"> 1. Awareness of need/ability to engage specific groups 2. Services/funding for dual-diagnosis clients 3. County links & lack of local residential rehab |
| Opportunities: <ol style="list-style-type: none"> 1. Better joint-working 2. National focus on involving families 3. Community work & targeted work with specific groups | Threats: <ol style="list-style-type: none"> 1. Commissioning cycle 2. Resources/funding issues 3. Alcohol agenda/funding & competition |

Within the focus groups stakeholders discussed many positives of the system as it stands. Although there were areas for development and improvement the links between services was discussed as a real positive and strength of the local system. It was indicated however that Tier 1 agencies could be better informed about the range of specialist agencies available, not purely those specialising in drug and alcohol work but also wider issues such as housing and employment to ensure appropriate support and referrals reach the service users. Whilst competition arising through the commissioning process and tighter resources across agencies was considered to be a threat to effectively supporting drug and alcohol users, further joint-working between services was considered a real opportunity going forward.

The research has explored gaps in knowledge and resources to work with specific groups less likely to engage in services such as South Asian communities. These gaps in knowledge were considered to be one of the main weaknesses of the present system although there are positives to note in terms of engagement in complementary therapies and funding to work with A-10 groups which provide real opportunities.

Within the report particular issues in terms of supporting dual-diagnosis clients have been raised, with funding stream difficulties and communication between services being an issue. A key discussion point concerned the alcohol agenda being lost within an integrated team when demand for specialist services, and work to address non-engagement in terms of alcohol, is felt to be extremely important.

The range of services and interventions available locally was generally considered to be strong, particularly in relation to psychosocial interventions and the range of prescribing medication available. Individualised and client-driven care-plans were also considered to be a strength, with stakeholders welcoming the fact that despite the recovery agenda, people are not being pushed unnecessarily towards abstinence from substances. Stakeholders considered the recovery agenda to be an opportunity to work differently with those newly presenting to services, particularly younger users.

It was identified that there is a lot of positive work taking place in terms of developing peer mentoring and support groups. Whilst family support groups are established in organisations such as AA and now through Quality of Life, there is an identified need to begin further dedicated work with families, including children of service users. Taking services and support out further into the community is also a priority going forward and services should be supported to do so. Having the resources and dedication to support this process will be key for ongoing engagement of non-users during times when resources for paid staff are stretched across services.

NICE Guidelines on drug and alcohol misuse

This section provides a summary of the NICE guidelines in relation to drug and alcohol misuse. This includes the actions and appropriate care that should be provided to reduce drug and alcohol misuse in the community. A further review of the evidence for drug and alcohol interventions can be found in appendix 4.

Community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people⁵².

Community-based interventions are defined as interventions or small-scale programmes delivered in community settings, such as schools and youth services. They aim to change the risk factors for the target population. Substance misuse in the guideline includes; the harmful use of any psychotropic substance, including alcohol and either legal or illicit drugs and vulnerable young people include; those whose family members misuse substances, those with behavioral, mental health or social problem, excluded or truants from school, young offenders, looked after children, homeless, those involved in sex work and some from BME groups.

The guidance recommends that local areas develop and implement a strategy to reduce substance misuse in this group based on local profiles supported by local service model that defines the role of local agencies. These include practitioners and others who work with vulnerable and disadvantaged children and young people in the NHS, local authorities and the education, voluntary, community, social care, youth and criminal justice sectors. In schools teachers, support staff, school nurses and governors, should use existing screening and assessment tools to identify vulnerable and disadvantaged children and young people aged under 25 who are misusing or who are at risk of misusing substances. They should also work with others to provide support, and refer children to appropriate services. Family based structured support over 2 or more years, behavioural based therapy and motivational interviewing should be offered. More intensive support should be offered if required.

Drug misuse: Psychosocial interventions⁵³

This guideline makes recommendations for the use of psychosocial interventions in the treatment of people who misuse opioids, stimulants and cannabis in the healthcare and criminal justice systems. Opportunistic brief interventions should be offered to people with limited contact with drug services if concerns about drug misuse are identified. Staff should routinely provide people who misuse drugs with information about self-help groups and drug services should introduce contingency management programmes to reduce illicit drug use. These can include; incentives on presentation of a drug negative test, incentives with completion of hepatitis B/C and HIV testing, hepatitis B immunisation, TB testing. Drug services should ensure that staff are trained in contingency management.

Drug misuse: opioid detoxification⁵⁴

The guideline makes recommendations for the treatment of people who are undergoing detoxification for opioid dependence arising from the misuse of illicit drugs. Pharmacological approaches are the primary treatment option for opioid detoxification, with psychosocial interventions providing an important adjunct. The guideline should be read in conjunction with drug misuse and dependence – guidelines on clinical management: update 2007⁵⁵. It is important that effective key working systems are in place as they are an important element of care. Keyworkers have a central role in coordinating a care plan and build a therapeutic alliance with the service user.

The guide recommends that detoxification should be a readily available treatment option for people who are opioid dependent. Methadone or buprenorphine should be offered as the first-line treatment in opioid detoxification and staff should routinely offer a community-based programme to all service users considering opioid detoxification, except with exception.

Psychosis with coexisting substance misuse: assessment and management in adults and young people⁵⁶.

This guideline covers the assessment and management of adults and young people (aged 14 years and older) who have a clinical diagnosis of psychosis with coexisting substance misuse. The term psychosis is used to describe a group of severe mental health disorders characterised by the presence of delusions and hallucinations that disrupt a person's perception, thoughts, emotions and behaviour. The main forms of psychosis are schizophrenia, bipolar disorder or other affective psychosis. Substance misuse is defined the same as the above.

Approximately 40% of people with psychosis misuse substances at some point in their lifetime, at least double the rate seen in the general population. Substance misuse among individuals with psychiatric disorders is associated with significantly poorer outcomes than for individuals with a single disorder.

The guidance recommends that treatment and care should take into account people's needs and preferences. People with psychosis and coexisting substance misuse should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. Time should be taken to engage the person and build a relationship. Communication should be direct, yet flexible and motivational.

Healthcare professionals in all settings, including primary care, secondary care mental health services, child and adolescent mental health services (CAMHS), accident and emergency departments, and those in prisons and criminal justice mental health liaison schemes, should routinely ask adults and young people with known or suspected psychosis about their use of alcohol and/or prescribed and non-prescribed (including illicit) drugs. In addition, conduct an assessment of dependency detoxification⁵⁷ and 'Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence'.

Healthcare professionals working within secondary care mental health services should ensure they are competent in the recognition, treatment and care of adults and young people with psychosis and coexisting substance misuse. Adults and young people with psychosis should not be excluded from mental healthcare because of their substance misuse and those with psychosis should not be excluded from substance misuse services.

Joint working arrangements between specialist substance misuse and service for psychosis should be sought and those commissioning services should ensure that age-appropriate mental health services are available for those young people with psychosis and transition arrangements are in place. The guide provides detailed guidance on how to implement these recommendations.

Alcohol-use disorders: preventing the development of hazardous and harmful drinking⁵⁸

This guidance recommends that nationally the Chief Medical Officer should coordinate an alcohol harm-reduction strategy for England across government, including making alcohol less affordable by considering introducing a minimum price per unit, reducing availability by reducing the number of outlets to buy alcohol, and minimise advertising exposure to young people.

Local action should be taken on licensing, using data to map the extent of alcohol related problems before reviewing licensing policy. Local areas should ensure sufficient resources are available to prevent under-age and to those intoxicated sales, taking action in partnership, to those premises who regularly sell to under-age drinkers, and ensure sanctions are fully applied to businesses.

Local areas should prioritise alcohol-use disorders as an ‘invest to save’ measure, commissioners should ensure a local joint needs assessment is carried out, and ensure plans include screening and brief interventions, properly resourced tier two and tier three services ensuring at least one in seven dependent drinkers get treatment locally. Formal evaluation should be included in the commissioning framework and ensure staff are appropriately trained, and resources available to support implementation of evidence based practice.

For children aged 10 to 15 years who are thought to be at risk from their alcohol use, obtain detailed history of alcohol use and use professional judgement to decide appropriate course of action. Consider referral to CAMHS if there is reason to believe significant risk of alcohol related harm and ensure discussions are sensitive to the child.

For young people aged 16 and 17 years, a validated questionnaire i.e. AUDIT, should be used for screening with focus on key groups i.e. those who regularly attend sexual health clinics, involved in crime, truant, at risk of self-harm, looked after children and those involved in child safeguarding agencies. Extended brief interventions can be offered to children aged 16 and 17 years old.

For adults, professionals should routinely carry out alcohol screening to those at risk, be offered brief advice and extended brief advice to those who have not responded to brief advice. For those aged 16 years and over, who may be alcohol dependent consider making a referral to specialist treatment.

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence⁵⁹

This guideline makes recommendations on the diagnosis, assessment and management of harmful drinking and alcohol dependence in adults and young people (10-17 years). The principle of care should be about building a trusting relationship with those who misuse alcohol taking into account stigma and discrimination and provide information about appropriate to their level of understanding. Encourage families and carers to be involved to support the individual, and provide information to families and carers about how they can support the service user.

When the needs of families/carers have been identified, offer guided self-help, and provide information about support groups and if needed provide information and education about alcohol misuse, explore sources of stress and effective coping strategies. For those who have contact with parents who misuse alcohol, consideration of the impact to the child-parent relationship and the children’s development should be made and comply with the requirements of the Children Act (2004).

Staff should be competent to identify harmful drinking and alcohol dependence. In the initial assessment, extend to any associated health and social problems and need for assistance, this should be conducted using formal assessment tools i.e. AUDIT, SADQ or LDQ, CIWA-Ar and APQ.

Specialist alcohol services should agree goals with patients that are tailored to their needs. For all people who misuse alcohol a motivational intervention should be carried out as part of initial assessment, promoting abstinence or moderate drinking. All interventions should be delivered by appropriately trained staff. For those with moderate to severe alcohol dependence intensive structured community-based support should be offered. Those that are homeless consideration of residential rehabilitation for a maximum of three months and help to find the user stable accommodation before discharge should be made.

Care coordination should be part of routine care; consider case management to increase engagement and this should be delivered in the context of tier three interventions. Harmful drinkers

and those with mild alcohol dependence should be offered psychological intervention, and for those with partners who are willing, offer couples therapy. Harmful drinkers and those with mild to moderate dependence who have not responded to psychological interventions, pharmacological intervention (acamprosate or oral naltrexone) in combination with psychological intervention should be offered.

Those who need assisted withdrawal should usefully be offered treatment in the community which should vary in intensity according to the severity of the dependence. Consider inpatient or residential assisted withdrawal for those who meet specific criteria.

Drug regimens for assisted withdrawal should use fixed dose regimens and after successful withdrawal for moderate and severe alcohol dependence consideration of acamprosate and oral naltrexone in combination with psychological intervention should be given. There are special considerations for children and young people in treatment and those with comorbidities.

*Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications*⁶⁰

This guideline examines the key areas in investigation and management of a number of alcohol related conditions (acute alcohol withdrawal, alcohol-related seizures and delirium tremens, Wernicke's encephalopathy, liver disease and acute and chronic pancreatitis) in adults and young people (aged 10 and over).

For people in acute withdrawal or assessed as high risk, administration to hospital should be offered, with healthcare professionals who are able to care for people in acute alcohol withdrawal for 24 hour assessment and monitoring. Those with alcohol related liver disease; patients should be referred and should be considered for assessment for liver transplantation if they have decompensated liver disease after best management and 3 months abstinence from alcohol and otherwise suitable candidate. For alcohol related pancreatitis refer people with pain to a specialist centre for multidisciplinary assessment.

*Interventions in schools to prevent and reduce alcohol use among children and young people*⁶¹

The guidance is for schools, although it looks at how to link interventions in schools with community initiatives. As there were no national guidelines on safe and sensible alcohol consumption for children the guidance focuses on encouraging children not to drink, delaying the age which young people start drinking and reducing harm it can cause.

Schools should ensure alcohol education is an integral part of the curricula, ensuring education is tailored to different age groups, increasing knowledge, exploring attitudes, help decision making, develop self-esteem and increase awareness of how others influence alcohol consumption. This should be a whole school approach to alcohol and where appropriate, offer parents or carers information where they can get help to develop parenting skills.

Schools should, where appropriate, offer brief advice, direct to external agencies, and follow best practice on child protection. Partnerships should be developed between schools, other services and healthcare to ensure integration of the school interventions with community activities.

Other NICE guidance that encompasses substance misuse

Guidance for pregnancy and complex social factors⁶² includes those women who misuse substances (alcohol and/or drugs). It recommends that commissioners should record the number of women presenting for antenatal care and their use (or non-use) with complex social factors, and record satisfaction with services. Consider undertaking a multi-agency needs assessment including safeguarding issues, and have a coordinated antenatal care services including joint care plans across agencies, co-locating services and offering women information about services.

The guidance on methadone and buprenorphine (oral formulations) are recommended options for maintenance therapy in the management of opioid dependence⁶³. The decision on which drug to use should be made on a case by case basis and should be administered daily under supervision for at least the first three months of treatment. Supervision should be relaxed only when a patient's compliance is assured and both drugs should be given as part of a programme of supportive care.

Naltrexone is recommended as a treatment option in detoxified formerly opioid-dependent people who are highly motivated to remain in an abstinence programme and only administered in adequate supervision⁶⁴. Discontinuation of Naltrexone should be considered if there is evidence of misuse.

Needle and syringe programmes provide sterile injecting equipment to people who inject illicit drugs. They may also support adults who inject non-prescribed performance and image-enhancing drugs. The aim is to reduce the harm caused, particularly the spread of viruses such as hepatitis and HIV. NICE recommends⁶⁵ that local drug partnership should collect and analyse data to estimate the prevalence of infections related to injecting drug use, collect the number and demographic characteristics of drug users, the coverage of the programme and those in regular contact with the programme.

Generic and targeted (i.e. specific groups i.e. homeless people who inject drugs) services should be commissioned to meet the local need, ensuring increased proportion of those who inject drugs in contact with the service, offer a range of equipment, advice and information on treatment services. Integrated care pathways, audit and monitoring of services should be commissioned. A range of settings should be available, with a balanced mix of service levels (1-3) offered and available for a significant time during any 24 hour period. Those delivering the services should dispense based on need, ensure safe working practices and be appropriately trained.

Recognised gaps in analysis

Whilst the report covers many aspects of drug and alcohol misuse in Leicester City, there are known gaps in the analysis within the report. These include;

- Families with multiple problems (multiple social, economic and health problems)
- Needs of children whose parents are within the treatment system
- Main underlying issues in relation to those in the criminal justice system, a symptom or cause of offending
- Substance misuse and domestic violence
- Insight into the attitudes in relation to novel drugs
- Mapping of assets or services across the community
- Comparison on spend on drugs and alcohol with other areas.

These areas would need further investigation in the future to understand their needs.

Summary and key findings

The self-reported drug use is lower than that nationally; however there are significantly more drug admissions than nationally, although there are differences across the city. Self-reported alcohol consumption is also lower than nationally, however there is a statistically significantly higher rate of hospital admissions, deaths for alcohol specific and related disease, as well as alcohol related crime and sexual crime. This may reflect the high rates of alcohol consumption and admissions in the west of the city and low levels in the east. There is some evidence to suggest that behaviour around alcohol in the South Asian community, who are predominately based in the east of the city, may be changing.

Those that report misusing drugs and alcohol are likely to be male, White and 16-24. Additionally they are more likely to have poor mental health, diets and smoke, highlighting the importance of having more integrated interventions. There is a clear east/west split in substance misuse, with the west being higher than the east. The consequences of this are seen in hospital admissions and those in treatment, however with changing attitudes and behaviours in South Asian communities in relation to drugs and alcohol this picture may change.

There is a clear link between mental health problems and drug and alcohol misuse (dual-diagnosis), with many clients being seen in treatment that have been identified as having mental health problems. The Intercept project has started to identify more people within the criminal justice system, however further work is needed in the mental health and substance misuse treatment services to identify and treat these people.

Local Police data indicates that young people (16-24 years) are much more likely to have an alcohol and drug related offence, Black and other BME groups are more likely to have a alcohol and drug related offences, respectively. Asian groups show much lower lever rates. There is a small number of drug related and alcohol specific deaths each year, with the majority of drug related deaths being caused by opiate use.

Treatment services for adults and children, for both drugs and alcohol have recently been redeveloped and the data presented in this HNA covers the period before the reconfiguration in 2011. However the data does provide some indicators of the health issues relating to drugs and alcohol in Leicester.

For adults there are a relatively high number of referrals that come from the criminal justice system, compared to nationally and our comparator DAAT partnerships. Consequently there are a high proportion of those in treatment that are referred on, rather than exiting from the services. Successful completions as a proportion of all those in treatment is also lower than nationally, suggesting further work is needed to intervene at an earlier stage rather than when someone is picked up through the criminal justice system. This may reduce the proportion referred on and increase the proportion successfully completing. Some data indicates that health outcomes of those in treatment have improved, although much of the data is incomplete and improvements in initial assessment are required.

The picture is similar for substance misuse treatment for young people. There are a higher proportion of referrals coming from the criminal justice system, those in treatment appear to have a greater complexity of need when in treatment compared to nationally and comparator partnerships and therefore there is a lower proportion of successful exits from treatment. There have recently been an increasing number of young people in treatment, which may be a reflection of the improvement in access,, services meeting the need or an increasing need. This will need further exploration.

Alcohol consumption is reported to be lower than nationally, however Leicester has a higher rate of hospital admissions and deaths related to alcohol, and much greater rate in males. There also appears to be a greater proportion of males being admitted for alcohol specific mental health problems than England and East Midlands. There are longer waiting times for alcohol treatment and a lack of reporting of certain types of interventions compared to the national picture. There are a higher proportion of referrals from health and mental health services compared to nationally, with similar outcomes, although a lower complexity of clients than nationally. With all these services, there were a low proportion of self/family referrals, which in some aspects may reflect how clients can access services i.e. referral through healthcare or another service, or may indicate the lack of knowledge of the services in the local community or the feeling of a lack of access.

Within the Criminal justice system, much work has been undertaken over the past 3 years to fully integrate services to form a cohesive end to end specialist system of drug and alcohol treatment that meets the complex needs of offenders. Within the local prison (HMP Leicester) this has partly been achieved by joining up of what was previously known as the CARAT services within the community contract, yet the Clinical IDTS interventions remain outside of the integrated pathway. This causes a confused picture of treatment within the Prison with both services assessing need differently, having poor data compliance and a lack of co-ordination of interventions.

There are a range of 'wraparound' services providing support for those who misuse drugs and alcohol, with the QoL service pulling together some wraparound services and support families to support recovery; however there is not a coherent systematic process on identification and assessment of drug and alcohol misuse, nor a systematic collection of data from these services. Therefore some needs and opportunities to refer/signpost people into treatment are being missed.

For all services that provide support and treatment, improved data collection, assimilation, analysis and interpretation is needed to provide a comprehensive picture of the needs and emerging needs of those in Leicester with substance misuse problems and provide a strategic overview of the issues.

Many of the issues identified within the quantitative aspect of the report were echoed in the qualitative findings. The strengths included; that there were links across services and a range of interventions offered to clients, however engaging with specific groups e.g. South Asian populations, funding for dual-diagnosis and access to residential rehabilitation were seen as weaknesses. Proposed opportunities included better joint working across Leicester, involvement of families and targeted work in specific groups/communities.

There are a range of effective and cost effective prevention and treatment options for drug and alcohol misuse. To increase the chances of recovery for someone who is receiving treatment, a model that focuses on support from the community and the family and assesses the wider context should be implemented. This would include care coordination for the individual and support from 'wraparound' services to aid recovery. The majority of young people do not need prescribed substitute drugs, and as with adults, a holistic approach to the individual is needed to support them in their recovery. This should be implemented in a partnership way across the city.

There are some areas of substance misuse which this report does not cover, these include; families with multiple problems, the needs of children whose parents misuse substances, offending and substance misuse, the role of substance misuse and domestic violence, novel drugs, mapping strengths and services location of services in relation to need, the needs of the student population, homeless population and comparative spend on treatment services. These areas would need further investigation in the future to understand their needs.

Recommendations

Leicester wide recommendations

1. A clear systematic approach to collating, analysing and interpreting data (and softer intelligence) for all tiers of treatment and broader action on drugs and alcohol misuse on a regular basis in one location locally is required to better understand the issues relating to the substance misuse. For example from 'wraparound' services (inc. 3rd sector), hospital, treatment services, police, social care, other LA, UHL (including; A&E assessment, and midwifery) and other healthcare data i.e. ASSIST. It is recommended to implement a system which reports into the appropriate structures i.e. the Safer Leicester Partnership.
2. Ensure that partnership working between health services, drug and alcohol treatment services and wider 'wraparound' services for both adults and young people is developed to better meet the needs of drug and alcohol users, which can include multi-disciplinary treatment and greater understanding of different pathways. Improved coordination, assessment/screening, referral between teams and flexible delivery of services i.e. the development of a care pathway (including support post treatment), improved data collection and collation with shared data agreements and training/development of staff is required to ensure there is efficient use of resources and increase successful completions/recovery.
3. There are some signs of changing behaviour in South Asian communities around substances., There is also an overall change in the type of drug misuse i.e. poly-misuse and use of legal-highs. Local services need to be able to understand (i.e. undertake specific research in communities such as South Asian and Somalis, the use of legal highs and Khat), be compliant with diversity requirements, adapt to changing demand, and engage with those groups not readily accessing services to ensure needs are being met. Additionally we need to further understand if we are providing services to the right people, at the right place, at the right time i.e. through health equity audits.
4. The relatively low proportion of those with dual-diagnosis in the treatment system (compared to national figures) and low proportion of referrals from mental health teams across the city for drugs indicates that there may be a number of clients in the mental health system and/or the drug/alcohol treatment system and wraparound services that are not being picked up with dual-diagnosis. Building on current practice, further screening, assessment, and collaborative working for dual-diagnosis with further exploration of the issue is required.
5. There are a low proportion of referrals into services from self or family and friends, which may be a reflection on the current treatment system set up. However there appears to be a lack of knowledge of services in the community. A clear communications strategy across the whole of Leicester will help partnership working between services, improve education across the community, discourage substance uptake, aid access and encourage uptake of services to those in need.
6. Of those in the drug treatment system, 23% had a child living with them. Further work is needed to explore the needs of the children whose parents misuse substances (alcohol and drugs) to enable holistic support for the family i.e. further exploration of the whole family needs and families with multiple problems.
7. Access to support and information at times of crises was expressed as a concern within the service user and parent/carer groups, as well some CJS services. This needs further

exploration. It may be that extension of peer-mentoring across family groups and services users, as well as raising awareness of national or local support helplines, could help to address some of this need rather than opening local services out of hours.

8. It is important for clients to be seen quickly for treatment as it improves their chances of recovery. From the 2010-11 data, Leicester has a relatively lower proportion seen within three weeks of referral (compared to nationally) and there have been long waits for psychosocial treatment and residential rehabilitation. Having low waiting times is important to aid recovery and should be a priority.
9. Coding of services in the NDTMS and NATMS do not reflect the work that the treatment agencies are currently delivering both in adult and young people's services i.e. community detoxification and tier 2 work. Proposed changes in the national systems provide an opportunity for greater insight into treatment regimes, completeness and reporting of data from services across the city so a better understanding of the need and therefore action is provided.
10. Substance misuse treatment services for offenders have undergone much development over the past few years. There is a robust treatment pathway for both drug and alcohol misusing offenders that spans first Criminal justice contact through to community reengagement following sentence finishing. However there is still a mixed picture of provision within HMP Leicester with psychosocial and clinical interventions being delivered separately. There appears to be a duplication of effort, poor data quality and an unclear care coordination process. To ensure that substance misusing offenders receive the best available chance at recovery a fully integrated pathway within the prison should be developed with clear leadership, defined roles and responsibilities and data capture.
11. There was a reported lack of housing support for those leaving custody, and lack of detailed information of no formal abode cases, although the QoL services provides some support. This should be considered a priority area in terms of helping to facilitate a stable and secure environment. To aid this, links between the CJS and specialist housing support should be strengthened.
12. Raised in the qualitative interviews, when commissioning services the DAAT team should strive to mitigate any negative effects of the commissioning cycle, by working with services across the city to ensure a continuation of high quality service provision.
13. Local Police data suggests that younger populations (16-34 year) and Black ethnic groups are more likely to have an alcohol and drugs related offence. Further investigation of why this might be is required.
14. The report does not cover families with multiple problems, the needs of children whose parents misuse substances, offending and substance misuse, the role of substance misuse and domestic violence, novel drugs, mapping strengths and services, location of services in relation to need, the needs of the student population, homeless population and comparative spend on treatment services. These areas would need further investigation in the future to understand their needs.

Drug recommendations

15. Leicester has the highest proportion of referrals into drug treatment from the criminal justice system, a high proportion of those in treatment referred on and a relatively low

proportion of successful completions. Further work is needed to understand why this is i.e. is it eligibility criteria or awareness of services and what mechanisms there are to gain a higher proportion of referrals into treatment from community based services before they enter the criminal justice system. This may have an impact on successful exits from treatment. This will require an on-going review and appropriate plans in place to improve the outcomes.

16. Those injecting drugs and sharing needles have a high chance of acquiring blood borne viruses. Building on improvements in the coverage and treatment of those being offered and taking up vaccination to reduce the spread of blood borne viruses is required.
17. Emerging drug trends such as legal highs and steroid users are putting pressure on certain aspects of the treatment system, gaining better insights into the attitudes and behaviours of those at highest risk will need further exploration.
18. Outcomes of drug treatment are recorded through the TOP system. Low compliance at initial assessment has prohibited meaningful analysis of the outcomes of treatment. An increase in compliance of TOP starts is required.
19. Leicester has an average proportion of those in treatment who have problematic use of prescription and over-the-counter drugs. Leicester partnership should continue to develop services to ensure that all people, including those who develop addiction or substance dependence problems with prescription only and over the counter medicines, can achieve recovery.

Alcohol recommendations

20. There is a low level of reported drinking in the city (through survey data), yet there is a high rate of admissions to hospital and deaths. This may reflect the high rates of consumption and admissions in the west of the city and low levels in the east and the potential intervention coming when substance alcohol problems are deep-rooted. This need for alcohol treatment should be investigated further.
21. Within the alcohol-related admissions, Leicester has a much higher proportion of alcohol specific mental health admissions for males, a statistically higher rate of alcohol related recorded violent and sexual crimes and higher proportion of hospital admissions for violence. The reasons for this high proportion needs further investigation.
22. There are a much lower proportion of referrals for alcohol treatment that come from self-referral in Leicester compared to nationally and a higher proportion coming from health and mental health services. The complexity of clients in alcohol treatment also appears to be lower than nationally, although with similar outcomes from treatment. This may reflect current referral pathways, stigma attached to accessing treatment or how the services are marketed. Education, marketing i.e. using Mosaic, outreach and a review of access to services would be required to increase the proportion of those who self-refer.
23. The proportion of those in alcohol treatment services (roughly 6%) is much lower than the estimated national proportion of dependent drinkers and the aspiration set out by the Department of Health (15%). Understanding why this is needs further exploration.
24. Those in alcohol treatment had relatively higher proportion of 3+ treatment journeys compared to our peers, which are shorter, with a higher proportion of clients waiting longer

for treatment and similar outcomes. An understanding of why there are more treatment journeys in Leicester treatment system would need further investigation.

Young people recommendations

25. There appears to be an increased number of young people coming into treatment, which could be a reflection of the improvement of access. Targeting the younger population of Leicester needs to be continued.
26. As with adults, a high proportion of referrals come through the criminal justice system. Leicester has a relatively high proportion of younger people in treatment with complex issues and as with adults' further work is needed to understand why is this and the mechanisms to gain a higher proportion of referrals into treatment from community based services before they enter the criminal justice system. The relatively high levels of need recorded at treatment entry also suggest the need to continue to target services that work with at risk groups of young people-for instance those who are NEET and with mental health difficulties.
27. Four wards (Braunstone/Rowley Fields, Beaumont Leys, Eyres Monsell and New Parks) in the city have a high number of young people in treatment and in treatment with the criminal justice team. Targeted work may be needed in these wards in order to prevent drug and alcohol related offending with young people.
28. There is limited local evidence on issues related to the transition of young people moving from young people's services to adult services. Further investigation of this is required to consider whether a young adults' service could be implemented for 16-25 year old.
29. There is an indication of the changing drug use, particularly with young people. Understanding the attitude and behaviours will need further investigation to help develop and adapt services for young people in the future.

Glossary

BBV – Blood Borne Virus

BCS – British Crime Survey

BME – British Minority Ethnic

CADT – Community Alcohol and Drug team

CAHMS – Child and Adolescent Mental Health Services

CBT – Cognitive Behavioural Therapy

CJDT – Criminal Justice Drug Team

Co-morbidity – To have two or more coexisting medical conditions or disease processes that are additional to an initial diagnosis

DAAT – Drug and Alcohol Action Team

GLS – General Lifestyle Survey

Health and Well-being Board (HWB) – A forum for local commissioners across the NHS, public health and social care, elected representatives, and representatives of HealthWatch to discuss how to work together to better the health and wellbeing outcomes of the people in their area.

HES – Hospital Episode Statistics

HNA – Health Needs Assessment

HSE – Health Survey for England

LA – Local Authority

LLS – Leicester Lifestyle Survey

LTLC – Long term limiting conditions

NDTMS/NATMS – National Drug Treatment Monitoring System/National Alcohol Treatment Monitoring System

NEET - not in education, employment, or training

NFA – No fixed abode

NICE – National Institute for Health and Clinical Excellence

NIT – Numbers in Treatment

NTA – National Treatment Agency

OCU – Opiate and/or crack user

ONS – Office of National Statistics

PCO – Primary Care Organisation

PCT – Primary Care Trust

PDU – Problem Drug Users

SCAN – Specialist Clinical Addiction Network.

SLP – Safer Leicester Partnership

Tier 1/2/3/4 Services – The various levels of drug treatment services offered. Tier 1 being the most general (such as a GP) and tier 4 being the most specialised (such residential rehabilitation services).

TOP – Treatment Outcomes Profile

VSA – Volatile Substance Abuse

YOS – Youth Offending Service

Z Drugs - Medicines called zaleplon, zolpidem and zopiclone are commonly called the Z drug. They are primarily prescribed for short periods to ease symptoms of anxiety and sleeping difficulty.

Appendix 1. Methodology for qualitative aspect of HNA

The research aims were achieved through the use of focus group discussions. The research was conducted to the guidelines set out by the international market research standards, ISO:20252.

Seven groups took place involving 61 stakeholders, each group had a different focus:

1. Specialist Alcohol Services (10 attendees)
2. Specialist Drug Services (8 attendees)
3. Criminal Justice Services (7 attendees)
4. Young People Services (12 attendees)
5. Mainstream Stakeholders (13 attendees)
6. Service Users (7 attendees)
7. Parents/carers of drug/alcohol users (4 attendees)

The DAAT team recruited and organised these groups. A handful of stakeholders attended more than one group discussion. A member of the DAAT team introduced the context and rationale for the group discussions at the beginning of each session before withdrawing. Briefing materials were also sent to the participants by the DAAT team ahead of the groups.

Tailored discussion guides were developed by Qa in conjunction with the DAAT team. These were intended as guides rather than to be religiously adhered to, it was not possible to cover every question within the groups and some of the sizes of the groups and competing priorities amongst participants influenced the flow of the discussions although the key themes were always covered. A lot of discussion was prompted through undertaking the SWOT analysis exercises and such exercises could be a useful tool to use in future consultation by the DAAT team.

All of the focus groups took place during the daytime and lasted between two and two and a half hours. The Service Users and Parents/Carers groups took place at the Quality of Life building. All groups were audio-recorded (with permission) to ensure accuracy of analysis and quotes used within the report.

By commissioning an external agency to facilitate discrete group discussions the DAAT team have enabled stakeholders to discuss their experiences and thoughts in an honest and open environment. In previous years participants may have been wary of what they said in front of the DAAT team and they may have had less opportunity to have their say in what were larger consultation workshops. Qa would like to emphasise however that a limitation of using an external agency is that due to very tight timescales this work has by necessity been approached with little contextual knowledge of drug and alcohol services in Leicester. This should be remembered when viewing this report. The work should be treated as Qa presenting the pertinent issues for stakeholders rather than Qa being able to offer clear recommendations for what should be taken forward locally. Whilst we have made suggested recommendations it will be for the DAAT to determine the feasibility of these as some issues discussed may not fall within the remit of the DAAT team nor be within the team's powers to overcome.

Appendix 2. Output from the JSpNA drugs and Alcohol Dissemination and discussion event 17th April 2012

List of attendee's

| Name | Organisation |
|-------------------|--|
| Karen Rees | LPT |
| Dr Anna Hiley | Inclusion Healthcare Social Enterprise CIC |
| Andrew Chivers | SPO Offender Management Drugs Team |
| Wayne Henderson | Inclusion Healthcare Social Enterprise CIC Ltd |
| Karen Purewal | Action Homeless |
| Sarah Whittle | YOS |
| Anna Barradell | Young People's Service |
| Anna Maudsley | YMCA |
| Ram | YMCA |
| Kate Beaumont | YMCA |
| Yunus Zamakda | New Direction |
| Helen Robson | New Direction |
| Hazel Wilson | The New Futures Project |
| Cat Rooms | The New Futures Project |
| Nuala Facey | YMCA |
| Charlotte Talbott | CJDT |
| David Beaumont | Leicestershire PNN Police |
| Sally Flanagan | LCPT |
| Supt Stuart Prior | Leicestershire PNN Police |
| Zubair | Build |
| Dr Basim Farid | |
| Sarah Styles | Inclusion Healthcare |
| Dale Deacon | YOS |
| Jo Hall | QoL |

Criminal Justice group

Check and challenge points of clarity

- Pg 89 This should more clearly reflect that this disjoint of service provision only affects the Prison element of the pathway and that the entire rest of the pathway now sits under one provider.
- Needs to do further analysis of what the main underlying issues are in relation to the CJ cohort is drug / alcohol use a symptom or cause of offending.
- Gap in relation to Domestic violence offenders substance misuse
- To note inaccuracies with reported DIP data
- There are some assumptions made in relation to diversity data and trends how does this impact on Leicester as a dynamic population.
- High proportion of CJ referrals – there seems to be an assumption made in relation to this as being problematic – deeper analysis needs to be done to understand this trend – i.e. are CJ referrals treatment naïve, how many previous episodes??
- Examination of relationship between drug of choice and fluidity of substance use.
- Recent work with Dual-diagnosis and CJ services not reflected

- Caseload complexity and women specific issues not addressed i.e. there is not women specific prison locally therefore women not accessing services, are there childcare issues, parenting issues, domestic violence either by partners or pimps.

Areas for action

- Police awareness in relation to Alcohol treatment pathway and options
- More robust alcohol pathway and referral eligibility criteria
- Prison – integration of IDTS with Psychosocial and community treatment is essential
- Raise the profile of alcohol treatment/ alongside raising capacity
- Hospital admissions – alcohol – we need a better understanding of the needs and issues a round this data.
- Dual-diagnosis – sustainability of intercept and integration with other initiatives eg. Police custody screening
- Accommodation remains an unresolved issue with significant implications for outcomes.
- Awareness raising across all areas of substance misuse - education/ awareness raising for YP – is this happening what are the messages. Wider public campaigns in relation to substance misuse – why do these not get done locally?

Three Top priorities (four)

1. Prison – commissioning – integration of service provision
2. Dual-diagnosis remains problematic – not integrated
3. Alcohol – responsibilities of partners within wider strategy
 - a. Funding
 - b. Capacity
 - c. Eligibility criteria
4. Establish the need for a local residential rehab facility specifically for people with children

Young Person’s substance misuse group

BME communities

The group acknowledged the recent increase in YP from BME backgrounds in touch with New Direction, yet the need for longer term investment in this area was emphasised alongside the capacity to work with families, market the services and use language skills.

Earlier Intervention

The need for earlier intervention was recognised, whilst ensuring the needs of those who need treatment are met. The role of schools and the transition age are important here-young people moving from primary to secondary. Support for agencies on the ground will be key and opportunities should be explored for a ‘two-way’ sharing of information between specialist services and front-line services around drug/alcohol trends/issues. The YOS will be looking to do some work soon on examining why some young people develop drug/alcohol issues-will try to look at some of the antecedents in the lives of the young people in the YOS cohort. This may shed some light on what interventions may help steer young people away from problem alcohol/drug use.

Parents

The need for work with parents is acknowledged-they need support-they are living with the everyday issues. The work can be challenging in its own right. Also acknowledged that supporting young people to reduce alcohol or drugs can be difficult when parents are using regularly.

Outcomes

There was a discussion around what kind of outcome we should be looking for with young people who misuse substances. Is being drug free realistic for all young people-some of whom have quite severe needs and are using substances to cope-some may achieve reductions in substance use and improvements in other areas, but may not be 'drug free'.

Young Adult Services

The need for relevant and tailored specialist services for young adults(18+) was raised.

Adults and Drugs group

Accessibility

- Treatment system undergoing reduction in opiate use although there is still an opiate bias.
- Difficult to canvass the opinion of those that are hard to engage and these are non opioid users.
- Emerging drug trends are putting pressure on certain parts of the system eg steroid use
- Police are attempting to broaden out the scope of drug testing to provide complete picture of need but there are funding constraints.
- At the Dawn Centre full tox screening is carried out which flags up concurrent use of other drugs including prescription medication.
- Consensus was that an understanding of different substances was invaluable but practitioners possessed the relevant skills to engage different cohorts and structured, psycho social interventions were deemed important for engagement purposes.
- Low level interventions at Baseline were crucial in engaging chaotic clients ie toast, tea and welcoming atmosphere. This is a vital first step in engaging those clients that are reluctant to access structured treatment. This approach seems to work and merits further consideration.
- Once the recovery café and gym are operational there will be an alternative venue for clients to access services.
- Services needed to be less restrictive and needed to examine their eligibility criteria to encourage more clients into treatment.
- Too much emphasis has been placed on out of hours provision to the detriment of weekday services. Need to be convinced that out of hours services are cost effective.

Recommendation

- Any future developments need to be consolidated on existing good practice.
- Group felt there was a need for a partnership wide communications strategy to address accessibility issues.

Families

- Support for families acknowledged by the group as a service deficit
- Need for a dedicated families service to be commissioned
- Strategic Board being formed to explore opportunities for strategic partners to collaborate.
- Community Drug & Alcohol Services are now part of Families, Young People and Children Services which provides a valuable opportunity to integrate substance misuse into the wider context eg role of health visitors, school nurses etc.
- Group confident that the majority of practitioners were confident in developing and delivering family based interventions.
- Troubled families were being picked up but there was no robust mechanism for onward referral and enlisting the support of mainstream services.

Recommendation

- There needs to be a service mapping exercise to identify resources in the community.
- To promote a multi disciplinary approach specialist workers need to come together to share information, review cases and agree on a co-ordinated response.

Recovery

- Abstinence based interventions are not new to the local treatment system.
- Pace of expectation towards successful completions has accelerated in recent months.
- There is too much emphasis on planned closures at the expense of other treatment goals.
- Harm reduction delivers valid health gains for the individual and the wider community.
- Mutual Aid groups are acknowledged as alternative means of support to users.
- Peer mentors also offer positive role models for existing service users.
- Performance management of planned closures is not conducive to fostering partnership based approach.
- The Quality of Life Service has an important role in cascading recovery based approaches to the rest of the treatment system.
- Should not assume that unplanned discharges are a negative feature as its hard to re-establish contact with these individuals.

Recommendation

Evidence based approaches to developing recovery capital must be a priority for the partnership.

Adults and Alcohol group

Initial Thoughts

- Comparable resources – how is this reflected in current data – what do other PCT's give financially (can only support low numbers if low on resource, therefore gap in reporting)
- GP's are an important link in the pathway for alcohol treatment. The community alcohol team (CAT) work with GP's, and alcohol treatment workers are based in large surgeries in certain areas in the city. CAT have looked at levels of referrals from GP's and are targeting GP's to increase referrals from those that do not refer or have few referrals on to alcohol services.
- Feedback from GP consortium was underlying assumption that alcohol treatment not successful and that people have little motivation to change.

Recommendation

It was acknowledged that better communication was required to raise the awareness of the success of brief interventions in reducing the harm of alcohol on a patient, and improve GP's and other's understanding of alcohol treatment availability, its health and financial benefits and recognition of the impact of not referring clients on for help when needed i.e.: hospital related admissions.

Discussion around numbers of estimated people with alcohol dependence in the city (10k) and records show that 700 were in treatment. This shows a number of concerns (1) Only 7% of dependent drinkers received treatment from services, (2) lack of data from other services that carry out treatment and intervention with dependent drinkers – such as psychiatry/mental health services, wrap around services (such as housing providers, social services, day centres).

Audit tool is a blunt tool and can be misleading. Issue of how to measure success from a client perspective as it is usually subjective.

Agreed to explore ways that we can capture interventions from tier 1 and 2 services to illustrate the breadth of work undertaken around alcohol harms reduction and show a bigger picture. 25% of referrals are from the category "Other" and this needs to be explored – pathway of movement in to and out of services needs to be understood to improve the recovery journey with on going support.

Discussion took place on numbers of self-referrals having seemingly low levels. This was rationalised by fact that data only based on tier 3 and 4 services and this would not show self-referrals. Better understanding of this would be achieved through data collection of tier 1 and 2 services.

South Asian Community discussion around lack of clear evidence around increasing levels of alcohol harm in range of communities within Leicester. Acknowledgement that success was achieved in services when specialist treatment worker/s employed with knowledge of specific needs including cultural understanding and relevant language skills. (Concern around existing resources and lack of continuity and understanding and expense of interpretation resources needed when language skills not available).

Recommendation

A model of care/pathway needs to be understood in order to provide appropriate support to those people who are not yet getting alcohol treatment There is anecdotal information about what the community want , and this differs from what is actually available.

Dual-diagnosis

Still a gap in provision, especially the need for on-going talking therapies and alternative therapies in general. Really need to tap in to mutual aid peer support and support groups as a way on continuing the treatment journey once leaving specialist services. Issues of under reporting in other services such as mental health and learning disabilities.

Recommendation

Need to research dual-diagnosis provision within region and beyond to see if a model of care can be adopted. Also look at numbers with reported dual-diagnosis to understand the issues more deeply.

Family agenda

Will be coming in the future re: Troubled families. Work is in progress between public health, CYPS and the DAAT.

Appendix 3. Experian Mosaic types

Further information about the top 10 Mosaic types across Leicester in relation to drugs and alcohol.

1. Type E20 is characterised by a lower than average prevalence of drug taking and a much very lower than average visits to pubs/wine bars.
2. Type I42 is similar to E20 but with actually a higher percentage having never taken drugs than E20 and an even higher percentage having never visited a pub/wine bar as compared to the national average.
3. Type O69 had a higher than national average percentage of taking Ecstasy but lower than national average in other drugs and in visits to a pub/wine bar.
4. Type K50 are typified by a lower than national average prevalence of drug taking in all drugs and also a lower than national average of visits to a pub/wine bar.
5. Type G32 has a much higher than national average in both drug taking in all drugs, and also a much higher than national average in visits to pubs/wine bars, with the largest difference between the national average and the type on visits almost every day.
6. Group E21 has a lower than average prevalence of drug taking compared to the national average and a higher than national average in visits to pubs/wine bars in both the less than once a week and three times a week categories.
7. Type N61 is characterised by a higher than national average in all drug taking, with the highest prevalence in Ecstasy. Also for type N61 however, visits to pubs/wine bars is lower than the national average.
8. Type I44 has a higher than national average prevalence of drug taking in all drugs, with Ecstasy being a much larger discrepancy from than national average than either cocaine or cannabis. Type I44 also has a higher than national average in visits to pubs/wine bars in all multiple visits a week categories.
9. Type O67 are typified by a very slightly higher than average incidence of taking Ecstasy but lower than average prevalence of taking other drugs. Visits to pub/wine bars were lower than national average in all visits.
10. Type I43 were higher than national average in taking cannabis and Ecstasy, with Ecstasy being far greater than cannabis, but prevalence of taking cocaine was as with the national average. Visits to pubs/wine bars were lower than national average for visiting once, twice or three times a week, but higher for visits almost every day.

Appendix 4. A review of the evidence for drug and alcohol interventions

Background

A drug is a chemical substance that acts on the brain and nervous system, changing a person's mood, emotion or state of consciousness (stimulants, depressants and hallucinogens). Drug misuse is when a person regularly takes one or more drugs to change their mood, emotion or state of consciousness⁶⁶ and under British law, most drugs are illegal (appendix 5).

Drug services

The aim of this section is to review the evidence for key areas of drug services. White and Best (2010)⁶⁷ reviewed the international evidence around recovery and the role of treatment services. The review provided information on the link between the evidence base on addictions and the wider context of social inclusion, public health and economic development.

The UK Drug Policy Commission has developed a UK 'vision' of recovery, which was characterised as a process of:

'voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.'

The report states that: *'recovery is most effective when service users' needs and aspirations are placed at the centre of their care and treatment...an aspirational and person-centred process', making the client the centre of treatment on the road to recovery.*

The review found strong and supportive evidence for the transition from models of acute care to recovery based care on international evidence and extrapolations from the mental health field, alcohol research and growing UK research on recovery from drug dependence. However, the review acknowledges that there remain many unanswered questions relating to long-term changes to sustain recovery, the role of treatment and other forms of community intervention and engagement, and the catalysts and mediators for change.

There is little UK-based research and the international evidence base on recovery is limited as much of the evidence is dated, most is based on alcohol rather than illicit drugs and almost all the evidence originates from the United States. There are a number of cohort studies assessing the short-, medium- and in some cases the long-term outcomes of a range of mechanisms of delivery of drug treatment which consistently show significant improvements across a range of indicators, including health, offending, risk-taking, substance use and social functioning.

Differences in effectiveness between modalities of treatment (such as community detoxification, methadone maintenance and residential rehabilitation) have been less consistently reported in the evidence base, although the Scottish outcome study, DORIS undertaken between 2001- 2004,⁶⁸ reported low rates of sustained abstinence from stabilisation-focused community treatment in Scotland. More recent USA outcome studies have switched focus from overall effects to the mechanisms of change with increased emphasis on the importance of service functioning and delivery, on therapeutic alliances and the process of client engagement and participation in treatment process.

The review found that there is a consistent evidence base supporting methadone substitution treatment in maintenance settings, based on meta-analytic data, this requires not only prescribing

but adequate psychosocial support and links to ‘wraparound’ care. Scottish outcome research has shown that while methadone maintenance leads to improved outcomes in a range of domains, it is associated with low rates of sustained abstinence. Continuity of care is a critical component of effective treatment systems, and there is a strong supportive evidence base around linkage to 12-step and other community ‘aftercare’ supports and there is an on-going problem with psychosocial interventions. While there is a strong evidence base from trials, there is little evidence that these are routinely translated into everyday clinical practice.

Learning from the mental health recovery movement, some key principles that could be translated to drug recovery; empower of the person in recovery, focus on the enabling role of the professional and a much greater role for family and community engagement in recovery. However there remain concerns⁶⁹ about the lack of ‘hard’ evidence and that the mental health recovery movement is at an early stage in its knowledge base and practical implementation, as much of the evidence to date in this field has been drawn from personal experiences.

The key finding from the review emphasises the importance of on-going support after structured treatment, the positive outcomes associated with mutual aid and peer support in the community and the importance of assertive follow-up support and aftercare.

The evidence suggests that a switch in focus to a model that is focussed less on the individual in isolation and more on the community and the family and so assesses outcome in this wider context including quality of life of children and partners and active engagement in local community affairs. For sustained recovery the pathways involved are highly individualistic, therefore a narrow, ‘diagnostic’ definition of recovery is not advisable. The best predictor of the likelihood of sustained recovery is the extent of ‘recovery capital’ or the personal and psychological resources a person has, the social supports that are available to them and the basic foundations of life quality, i.e. a safe place to live, meaningful activities and a role in their community (however this is defined), barriers to recovery include psychological problems (mental illnesses and the absence of strengths, such as self-esteem and self-efficacy), significant physical morbidities (including blood borne viruses), social isolation and on-going chaotic substance use, while structured treatment has a key role to play, it is only part of the support that most people will need. On-going support in the community is essential for the on-going recovery journey and often includes mutual aid and other peer support as recovery is not just about the individual, but impacts on families and communities.

The report concludes that recovery is a philosophical approach to addressing drug problems based on personal choice, empowerment and strengthening communities, and has a growing evidence base. However, it was apparent there is a need for more strategic, programmatic approach to developing the drugs recovery evidence. There was a lack of clear evidence from the UK about the long-term pathways to recovery and their impact on families and communities, as sustained recovery is estimated to be 5-7 years after achieving abstinence from on-going street drug use.

Young Peoples Specialist Substance Misuse Treatment

This section examines the recent development and expansion of treatment services for under-18s, as well as provision for young adults in their late teens and early 20s. This section considers the need to support young people and particularly the most vulnerable, in the transition from adolescence to adulthood.

Most young people who enter specialist drug or alcohol treatment have other, often multiple needs, such as mental health issues, involvement with the criminal justice system, social exclusion, or lack of education, training or employment opportunities.⁷⁰

Most young people who access specialist drug and alcohol services do not need to be prescribed substitute drugs and very few indeed would benefit from residential treatment. Some do not even need structured therapy related to their substance use. Almost all, however, need support on other issues in their lives, as young people's treatment needs to be holistic.

It is clear that the drugs that cause the most problems for young people and young adults are, cannabis and alcohol, and younger substance users are mixing and matching different (and new) drugs. This creates a new challenge for services. Additionally the adult and young people's treatment systems work with two different notions of substance misuse problems, different interventions, with different targets and outcomes. This can lead gaps for someone leaving young people's drug treatment aged 18 who needs further support with adult services frequently not the right place.

The same things that make young people vulnerable to problems with drug use can make them vulnerable to involvement in the supply of drugs. Workers need to be able to recognise and support young people at risk of offending and to help create exit strategies for those who are already involved in drug supply or gang-related activity. It is important not to frame young people's substance misuse in exclusively individual and therapeutic terms, and fail to invest in community resources. Employment and meaningful activity, decent accommodation and access to leisure activities for young people are all vital.

A review by the NTA⁷¹ brought together the evidence for effective treatment of substance misuse among young people aged under 18 years. The review found that although young people's substance misuse is a relatively new area of academic study and that evidence is scarce to make strong statements about definitive treatment decisions some suggestions were drawn.

Young people's services should have universally accessible, should target those who are considered vulnerable, and have specialist services to meet the needs of those whose needs cannot be met by universal and targeted services.

Specialist services should always offer; assessment before treatment, young people should have an individual care plan, multi-professional services may be required to meet the complex needs of some young people, and care should be coordinated across services by a lead professional. Child protection issues should be explored and addressed if required, some young people can consent, while others may require their parents to consent prior to treatment, young people should be encouraged to allow parents/carers to participate in their care plans and their views should be considered in their care plan.

Substance misuse treatment in young people is consistently shown to be effective in reducing substance misuse in the medium-term outcomes. In the long-term no intervention was significantly better than any other, although sticking to an intervention model based on theoretical and empirical effectiveness has been shown to increase retention in substance misuse programmes compared to the amount of time spent with a young person. As well as reducing substance misuse in young people, a number of other outcomes have been demonstrated including; reduced problem behaviour, increased involvement in positive activities, confidence and self-esteem, academic attainment, reduced criminal activity and improved mental health, family relationships and attendance at school.

In addition to tackling the substance misuse issue in young people, having support services around misuse services can help support children into recovery and prevent other consequences such as

going into care, yet these services need to be persistent, reliable yet flexible to be a greater success⁷².

Alcohol interventions

(This section is largely adapted from Kent PCT Alcohol Health Needs Assessment 2009 and County Durham and Darlington Alcohol Health Needs Assessment June 2011)

This section examines a range of effective interventions from prevention to specialist treatment of alcohol problems. For completeness, some common interventions with a weaker evidence-base have also been included for information. Treatment approaches have been categorised into 'brief interventions', 'specialist interventions' and 'less intensive treatment interventions', which fall between the two.

In June 2006 the Department of Health's National Treatment Agency published *Models of Care for Alcohol Misuse (MoCAM)*⁷³. This document has the force of a National Service Framework in the health service and provides a standard to judge the adequacy of the range of local services.

MoCAM divides services into four Tiers:

1. Tier 1 Non-specialist services which see substance misusers e.g. social services and primary care
2. Tier 2 Open access, low threshold, substance misuse services
3. Tier 3 Structured community-based substance misuse services
4. Tier 4 In-patient and residential substance misuse services.

MoCAM describes Tier 1 interventions as being central to the development of an integrated local alcohol treatment system. Delivered by front line workers in generic services to people not actively seeking alcohol treatment they can identify people at risk which is essential to the prevention of alcohol problems. Tier 2 interventions as a platform in which people with alcohol related problems require the following local interventions which offer simple and swift access to help with the aim of engaging and retaining them in treatment and care:

- advice, information and referral services for drinkers, their families and carers;
- easy access or drop-in facilities that include services to reduce alcohol related harm;
- self-help groups such as Alcoholics Anonymous.

MoCAM recognises that recovering problem drinkers require aftercare. This is seen as a possible role for Tier 2 services. Low threshold specialist services should also offer assistance to family members and other carers. MoCAM and ANARP identify a need to establish mutual aid services to complement existing provision (e.g. Alcohol Advise). Facilitated self-help groups as an alternative to Alcohol Advise offer a range of potential advantages and opportunities:

- services can be delivered economically outside usual hours and in existing community services' premises;
- opportunities to provide support to others as well as receive support;
- relapse prevention and rapid re-entry to treatment;
- help to sustain change for people who choose controlled drinking;
- stable groups of service users who can be consulted by commissioners and other stakeholders
- facilitated services for others affected including family members and carers.

MoCaM Tier 3 services comprise specialist alcohol interventions delivered in the community; Tier 3 favours community based assisted alcohol withdrawal (detoxification). Assisted withdrawal in the community is a well evidenced intervention. Many Community Alcohol Teams would expect

routinely to provide home visiting in assisted withdrawal while GP's prescribe. This is good practice, manages risk effectively and is an economic intervention. Tier 3 practice should be reviewed to establish whether there is increased scope for community based assisted withdrawal. In-patient assisted withdrawal may be needed more often if the treatment population has entrenched problems. MoCaM recommends that Tier 3 practice should be reviewed to establish whether there is increased scope for community based assisted withdrawal.

MoCAM Tier 4 include inpatient detoxification and residential rehabilitation and there are issues about Tier 4 evaluation and value for money. Tier 4 is the most costly intervention in alcohol treatment and there is relatively little research and evaluation of Tier 4 interventions.

In-patient assisted withdrawal is expensive. However, it can be argued, it is necessary because alcohol withdrawal is more dangerous than withdrawal from most other drugs. Some evidence suggests that hybrid regimes, commencing withdrawal on an in-patient basis and where safe, completed in the community could be developed.

A combination of interventions are needed to reduce alcohol-related harm – to the benefit of society as a whole.⁷⁴ Population-level approaches are important because they can help reduce the aggregate level of alcohol consumed and therefore lower the whole population's risk of alcohol-related harm. They can help:

- those who are not in regular contact with the relevant services
- those who have been specifically advised to reduce their alcohol intake, by creating an environment that supports lower-risk drinking
- prevent people from drinking harmful or hazardous amounts in the first place.

Interventions aimed at individuals can help make people aware of the potential risks they are taking (or harm they may be doing) at an early stage. This is important, as they are most likely to change their behaviour if it is tackled early. In addition, an early intervention could prevent extensive damage.

The Department of Health has identified a number of High Impact Changes to reduce alcohol-related harm⁷⁵; those which are calculated to have the greatest impact on health commissioned outcomes. The report suggests some actions which are calculated as being likely to have the best impact for areas where tackling alcohol-related harm has been identified as a priority:

1. work in partnership
2. develop activities to control the impact of alcohol misuse in the community
3. influence change through advocacy
4. improve the effectiveness and capacity of specialist treatment
5. appoint an alcohol Health worker
6. IBA – Provide more help to encourage people to drink less
7. amplify national social marketing priorities

The High Impact changes for alcohol are linked. The temptation to see them as completely separate activities from each other would be the wrong approach. While changes 4 through 7 are supported by clear evidence of their impact, changes 1 through 3 are changes that set the scene for progress.

The bullet points below identifies those which have the greatest impact on health commissioned outcomes and suggests some recommended actions for areas where tackling alcohol-related harm has been identified as a priority.

- **Improve the effectiveness and capacity of specialist treatment:** Ensure the provision and uptake of evidence-based specialist treatment for at least 15% of estimated dependent drinkers in the PCT area
- **Appoint an alcohol Health Worker(s):** Commission an adequate number of Alcohol Health Workers or Alcohol Liaison Nurses to work across the acute hospitals
- **Identification and Brief advice (IBa) – Provide more help to encourage people to drink less:**
 - In primary Care:
 - **new registrants;** Commission identification and brief advice as per the Directed Enhanced Service (DES) for all newly registered patients
 - **at risk groups;** Consider extending coverage through a Local Enhanced Service (LES) in primary care to additional at risk groups such as all men aged 35-54 or those patients on existing QOF registers
 - In hospital settings:
 - **IBA in A&E and specialist units (e.g. fracture clinics):** Commission a specialist alcohol nurse linked to every accident and emergency unit where there is apparent local need
- **Amplify national social marketing priorities:** Commission local social marketing activity which builds on the evidence, strategy and tools provided by the national social marketing programme. Ensure this promotes the local available service response.

Prevention

Interventions Targeting Young People

Evaluations and review-level evidence of alcohol prevention programmes targeting young people within and outside the school setting have produced relatively weak results of effectiveness. Studies have shown no firm conclusions about the effectiveness of prevention interventions in the short- and medium-term. Over the longer-term, the Strengthening Families Programme has shown promise as an effective prevention intervention for alcohol use in young people. However, further research, based on a randomised controlled trial design, with adequate sample size, is required to fully evaluate the potential of the programme in the UK.^{76,77,78}

There is good research evidence that Social Norm Marketing (SNM) campaigns, intended to correct misperceptions of subjective drinking norms and reduce alcohol consumption, can have a positive impact on lowering alcohol consumption by college students.^{79,80} SNM relies on the assumption that one's perceptions of others' attitudes and behaviours are the key components in attitude and behaviour change.

Interventions in Service Settings

Review-level evidence indicates that intensive, good quality, face-to-face server training, i.e. bar staff accompanied by strong and active management support, is effective in reducing intoxication levels in customers.⁸¹ There is review level evidence that interventions administered in the server setting, to facilitate sensible alcohol consumption and reduce the occurrence of alcohol-related harm, do improve server behaviour. However, there is a lack of robust evidence to indicate that these interventions reduce alcohol-related injury risk.⁸²

Interventions in Work Place settings

Analysis of literature reporting studies on the impact of workplace interventions on alcohol consumption and alcohol-related behaviour, has shown evidence that worksite interventions, including core components of employee assistance programmes, are effective in rehabilitating

employees with alcohol problems.⁸³ One study, which included training of employees, reduced drinking by about 50 per cent.⁸⁴ Another multi-level study (including 5,338 workers in 137 workgroups across 16 American worksites) identified strong associations between workgroup social drinking norms and drinking outcomes: workgroups with more restrictive social norms influencing lower alcohol consumption. This suggests public health efforts at reducing drinking and alcohol-related injuries, illnesses and diseases should target social interventions at worksites, although further research within UK workplaces would be valuable.⁸⁵

Mass Media Campaigns

Whilst there are difficulties in measuring the effectiveness of public messages because of limited baseline and outcome data, evaluation research suggests that most mass media campaigns, warning against the risks of excessive drinking, affect knowledge and attitudes rather than behaviour. However, mass media campaigns can be successful if they model specific behaviours or target particular risks, such as drink driving.^{86,87}

Interventions to Reduce Alcohol Impaired Driving

There is review-level evidence that 80mg/100ml Blood Alcohol Concentration (BAC) laws are effective in reducing alcohol-related crash fatalities. Lower BAC laws are effective in reducing alcohol impaired crash fatalities among young or inexperienced drivers.⁸⁸ There is review-level evidence that minimum drinking age laws, particularly those that set the minimum drinking legal age at age 21, are effective in preventing alcohol related crashes and associated injuries.⁸⁸ There is strong review-level evidence that random breath testing, selective breath testing and sobriety checkpoints are effective in preventing alcohol-impaired driving, crashes, and associated fatal and non-fatal injuries.^{89 90}

Recent review-level evidence suggests that increased police patrol programmes are beneficial in reducing traffic crashes and fatalities, however, because of study weaknesses, this evidence does not firmly establish whether increased police patrols, implemented with or without other intervention elements, reduce the adverse consequences of alcohol-impaired driving.⁹⁰ There is review-level evidence for the effectiveness of ignition interlock devices in reducing habitual recidivist intoxicated driving. There is no evidence for longer-lasting effectiveness, once the device has been removed.⁹¹

Self-Assessment of Drinking

There is some research evidence, although not consistent, that reported drinking by patients correlates with blood tests and is similar to that reported by their families. However, there is some doubt as to whether this is true for UK primary care consultations, particularly in relation to heavy drinking, where GPs may be seen as having several roles, and where fears of employment, legal or insurance consequences may affect disclosure.⁹¹

Self-help Interventions

Review-level evidence suggests that bibliotherapy (self-help literature), especially based on cognitive behavioural principles, can be effective in decreasing at-risk drinkers, particularly those seeking help for their drinking, and to a lesser extent with drinkers identified through screening for harmful drinking.^{92,93} There is inconsistent evidence on the effectiveness of electronic screening and brief intervention (eSBI) for alcohol use. However, a variety of pilot studies support the potential of interactive computer approaches, including a rigorous trial in New Zealand targeting university students.⁹⁴

In the NTA 2006 review of the effectiveness of treatment for alcohol problems, Twelve-Step Facilitation (TSF) was identified as an effective form of treatment for alcohol. This was supported by evidence from Project MATCH, a multi-site clinical research carried out in 1993.^{95,96,97,98,99,100} However, more recent review-level evidence of eight randomised controlled 89 trials (total of 3,417

adults) comparing Alcoholics Anonymous, or alternative TSF, to other psychological treatments or no treatment were unable to unequivocally demonstrate the effectiveness of AA or TSF approaches for reducing alcohol dependence or problems. However, one small study suggested that AA may help patients to accept treatment and keep patients in treatment more than alternatives.^{101,102} It is clear that more efficacy studies on TSF are needed in the UK.

Harm Minimisation and Screening

Screening and Identification

There is good evidence to show that appropriate screening helps the detection and treatment of alcohol problems. A number of screening tools exist, but the Alcohol Use Disorder Identification Test (AUDIT) is considered the most effective instrument for detecting hazardous and harmful drinking among people not seeking treatment within primary care settings.¹⁰³ CAGE (abbreviated for cut down, annoyed, guilty eye opener) is more appropriate for detecting alcohol abuse and dependency. FAST (an abbreviated form of AUDIT) works well as a rapid tool within the A&E setting, and TWEAK and T-ACE are effective in antenatal and preconception consultations.^{87,95,96,76}

Brief Interventions

Brief interventions are delivered by non-specialist staff, such as general medical practitioners and other primary care staff, in the general community settings. A brief intervention typically occurs and comprises a single 5-15 minute session, and up to a maximum of four sessions and the provision of information and advice designed to achieve a reduction in risky alcohol consumption or alcohol-related problems. A brief intervention has five essential steps: assessment of drinking behaviour and feedback; negotiation and agreement of goal for reducing alcohol use; familiarisation of the patient with behaviour modification techniques; reinforcement with self-help materials; and follow-up telephone support or further visits.

There is growing review-level evidence that brief interventions in primary care can be cost effective in reducing total alcohol consumption and episodes of binge drinking in hazardous drinkers, and lessen the demand for accident and emergency department services. There is less evidence that this effect may be sustained for longer periods, beyond a year. Very brief interventions (5-10 minutes) may have a similar effect to extended interventions (20-45 minutes or several visits), although the evidence is not consistent. Although there is some evidence of the impact of brief interventions lasting up to four years, evidence is generally mixed on the longer-term effects and needs further research.^{87,95,96,76}

Previous research suggests that brief interventions are equally effective on men and women. However, the most recent meta-analysis of 22 randomised controlled trials (RCTs) from various countries¹⁰² found a clear effect in men at one year of follow up, but the benefit was not so clear for women. The return on investment for brief intervention in primary care to tackle alcohol misuse has been estimated as 428%.^{104,105}

Less Intensive Treatment

Psychosocial Interventions by GPs

Review-level evidence has not found effectiveness (or ineffectiveness) of psychosocial interventions delivered by general practitioners. Of the psychosocial interventions reviewed, problem-solving treatment for depression seems the most promising tool for GPs, although its effectiveness in daily practice remains to be demonstrated.¹⁰⁶

Cognitive Behavioural Therapy (CBT)

CBT seeks to identify and modify maladaptive thinking, prescribe specific coping strategies, teach coping behaviours and problem-solving strategies through instruction. There is good evidence that a condensed form of cognitive behavioural therapy (three sessions) is effective, especially among female alcohol service users with a mild or moderate level of dependence.¹⁰⁶

Motivational Interviewing (MI)

This client-centred intervention is based on a set of therapeutic principles and counselling techniques closely linked with the stages of the Cycle of Change model. There is review-level evidence that MI and its adaptations can be effective as a preparation for more intensive treatment of different. MI also seems to increase the effectiveness of more extensive psychosocial treatment. However, there further advantages and disadvantages compared to other forms.¹⁰⁷

Motivational Enhancement Therapy (MET)

MET begins with the assumption that the responsibility and capacity for change lie within the patient. MET provides individualised feedback about the effects of drinking and benefits of abstinence. It reviews treatment options, and designs a plan to implement treatment goals. MET has been evaluated in two major multi-centre trials: Project MATCH and the United Kingdom Alcohol Treatment Trail (UKATT). Analysis indicates that, over four sessions, MET is as effective as more intensive treatments such as Twelve Step Facilitation (TSF), Cognitive Behavioural Therapy (CBT) and social behaviour and network therapy. It is a cost effective intervention, which works well as a standalone specialist treatment for service users with moderate alcohol dependence. The NTA (National Treatment Agency) advocate that MET should be considered as the first step in a stepped care programme of care in specialist agencies, provided there are no reasons for immediately intensive forms of treatment.⁸⁴

Conjoint Marital Therapy

There is evidence that a single session of conjoint marital therapy can result in improvements on all marital adjustment and alcohol related outcome measures after 18 months of follow up. Offering more than one session appears to be no more effective.⁸⁴

Specialist Treatments

The underlying principle of Social Behaviour and Network Therapy (SBNT) is for clients to develop positive social network support for the modification of drinking and sustained change. This can be carried out in group or individual formats, and can also be conveyed by self-help manuals. SBNT has been evaluated in a major multi-centre trial, UKATT. It has been found to be a cost effective intervention: no less effective than MET although more intensive. Currently, there is no research to indicate what types of service users may benefit most from SBNT.⁸⁴

Coping and Social Skills Training (CSST)

This intervention is often combined with assertiveness training and/or communication skills training to help alcohol misusers adopt a common set of techniques to address important coping skills for daily living. Evaluative research has identified CSST as an effective treatment modality among moderately dependent alcohol misusers, but is less suited to clients with psychiatric morbidity or high levels of anger.⁸⁴

The Community Reinforcement Approach (CRA)

There is evidence of the effectiveness of this intervention, particularly in relation to service users with severe alcohol dependence, especially those that are socially unstable and isolated. Broadly, this intervention aims to manipulate the alcohol misuser's social environment (including the family and vocational environment) so that being sober is rewarded and intoxication is unrewarded. Supervised Oral Disulfiram (SOD) treatment is a vital component of this approach.

Behaviour Contracting

This effective intervention requires the therapist to negotiate agreement between the service user and their significant other to a system of mutual expectations and obligations. Rather than a standalone, it is more appropriate to consider this as an integral component of other successful treatment methods and an essential part of the community reinforcement approach.

Behavioural Self-Control Training / Self-Management Training (BSCT)

BSCT can be carried out in group or individual formats or self-help manuals. It includes setting limits for drinking; self-monitoring of alcohol consumption; methods to control the rate of drinking; drink-refusal skills training; self-reward systems for successful behaviours; analysis triggers to excessive drinking. At present, this intervention is considered to be the most effective treatment modality available for alcohol misusers considered suitable for a moderation goal: it is estimated that 60–70% of treated alcohol misusers with low to moderate dependence showed clear improvement up to two years after treatment.^{84,108}

Cue Exposure Training (CET)

This relatively new approach exposes service users to alcohol-related cues (the sight or smell of alcohol), thereby allowing the patient to practice responses to such cues in real-life situations. CET teaches a variety of coping skills for dealing with urges caused by such cues. Few studies have examined the effectiveness of CET, but the existing results shows CET to have promise as a treatment method, particularly when combined with coping skills or communication skills training and as part of a broader CBT programme.^{84,109}

Detoxification

This is a planned process of rapidly achieving an alcohol free state in service users with alcohol dependency. It is commonly undertaken in the early part of an alcohol misuser's action stage of change, and should be seen as the first step towards achieving abstinence. Alcohol detoxification typically involves the prescribing of medication to minimise withdrawal symptomatology. It carries risks and requires careful clinical management and patient commitment. Rigorous pre-planning (as part of a medium term plan) is essential for reducing failure rates, as multiple detoxifications are known to result in poorer treatment response.⁸⁴

Evidence from uncontrolled trials indicates that detoxification of alcohol dependent patients within community centres or the home setting is as effective as inpatient treatment, although home-based treatment is more costly, unless considering meeting the needs of clients in rural locations.⁸⁴ However, strict criteria to select patients for home, community or inpatient detoxification are needed, as it is estimated that for a small number of patients (1:100) with very severe dependency home detoxification may not be suitable.¹¹⁰ There is a body of evidence, based on RCTs, that benzodiazepines are the best drug group for alcohol dependence detoxification: Chlordiazepoxide is currently the drug of choice for uncomplicated detoxification, with diazepam as an acceptable alternative.

Relapse Prevention

Relapse prevention should not be viewed as a treatment in itself, but rather as the building block for the longer-term success of all alcohol treatment interventions. Indeed, preventing patients from relapsing to destructive drinking patterns is much more of a challenge than achieving initial abstinence or reductions in drinking.

Psychosocial

MET, BSCT, CBT, Marital/Family Therapy and Coping/Social Skills Training are all clinically and cost effective psychosocial interventions and are recommended treatment options for the prevention of relapse in alcohol dependence.

Pharmacological

There is evidence to show that Disulfiram - which produces an unpleasant reaction when taken with alcohol, thus aiming to change the psychologically expectations of the drinker when faced with alcohol - is an effective component of relapse prevention. Acamprosate and Naltrexone, both anti-craving therapies which block pleasant effects of alcohol, have been shown to have minor positive effectiveness in relapse prevention, when used in combination with psychosocial treatment. Evidence suggests that Naltrexone helps individuals who have lapsed, and Acamprosate is most useful for those who are worried that cravings will lead to a lapse in abstinence.⁸⁴

Extended Case Monitoring

There is review-level evidence that maintaining therapeutic face-to-face or telephone contact for extended periods of time, with individuals with alcohol and other drug disorders appears to promote better long-term outcomes than 'treatment as usual'. Even low-intensity continuing contact may have a beneficial effect.¹¹¹ This has implications for the reallocation of resources in the cost-effective delivery of care over time, as one trial showed statistically significant cumulative outpatient cost savings (US \$240 per ECM case relative to controls).^{84,112} However, further UK-based research on extended case monitoring would be useful.

Alcohol Learning Centre

The Alcohol Learning Centre provides online resources and learning for commissioners, planners and practitioners working to reduce alcohol-related harm. These include the latest guidelines, evidence, online training and examples of good practice. Details can be found at:

<http://www.alcohollearningcentre.org.uk/>

Overall Cost Effectiveness

Given that the cost burden of alcohol-related problems falls not only to the NHS, but more substantially to the criminal justice system, there is some debate about whether generic healthcare measures such as QALYs are suitable for the evaluations of alcohol treatments.

There are a few good quality economic reviews of alcohol services, and the majority have been undertaken outside the UK, particularly in the USA. However, research suggested that the cost of treatment for alcohol is often totally or partially offset by future short and long-term reductions in healthcare costs. Indeed, findings from the UKATT study suggest that evidence-based alcohol treatment in the UK could result in net savings of £5 for every £1 spent for the public sector. NICE recommend that Chief executives of NHS and local authorities should prioritise alcohol-use disorder prevention as an 'invest to save' measure.

Appendix 5. Classification of drugs

The Misuse of Drugs Act (1971) classifies illegal drugs into three categories (Classes A, B and C) according to the harm that they cause, with Class A drugs considered to be the most harmful. Table A2.1 displays the drugs that respondents were asked about in the 2010/11 BCS and their current classification under the Misuse of Drugs Act.

Emerging psychoactive drugs which have been classified under the Act recently, such as mephedrone, are not included in the table below because they are not currently presented within the overall extent of BCS drug misuse. Drugs included in the main BCS trend measure and their classification under the Misuse of Drugs Act (as at July 2011) (table below).

| Classification | Drug |
|----------------|--|
| Class A | Powder Cocaine Crack Cocaine Ecstasy LSD Magic Mushrooms Heroin Methadone Methamphetamine |
| Class A/B | Amphetamines |
| Class B | Cannabis (since January 2009; due to reclassification) |
| Class B/C | Tranquillisers |
| Class C | Anabolic steroids Ketamine (since April 2006) |
| Not Classified | Amyl nitrite |

Following the Drugs Act 2005, raw magic mushrooms were classified as a Class A drug in July 2005. Prior to this change in the law, only prepared (such as dried or stewed) magic mushrooms were classified as Class A drugs. However, the BCS does not distinguish between the different preparations of this drug, so the trend in magic mushroom and Class A drug use presented here has not been affected by the change in the law.

Amphetamines can be classified as either Class A (when prepared for injection) or Class B (in powdered form). Since BCS questions do not distinguish between the forms of the drug taken, amphetamine use has not been included in estimates of overall Class A drug use in this report. The BCS included a question on methamphetamine (which is classified as Class A) for the first time in 2008/09.

Similarly, tranquillisers can either be classified as Class B (such as barbiturates) or Class C (such as benzodiazepines). Consequently, Class B and Class C drugs cannot be aggregated reliably because the survey does not identify which specific tranquilliser respondents used. Cannabis was reclassified from a Class B to a Class C drug in January 2004. However, the Government decided to reclassify cannabis as a Class B drug under the Misuse of Drugs Act with effect from January 2009. Reclassification does not affect BCS estimates, but cannabis is presented as a Class B drug within BCS reports.

The category 'not classified' indicates that possession of these substances is not illegal but it is an offence to supply these substances if it is likely that the product is intended for abuse. The 2006/07 BCS was the first year that questions on ketamine were included in the survey; ketamine use is reported according to its classification (Class C).

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