

Alcohol

Introduction

Alcohol can damage nearly every organ and system in the body and is a major contributing factor to more than 60 diseases and conditions including cardiovascular disease, liver disease and cancer¹.

Alcohol use is responsible for 10% of the UK burden of disease and death, making it the third biggest lifestyle risk factor after smoking and obesity².

The impact of alcohol misuse is not confined to health outcomes. The social consequences of alcohol misuse, particularly in relation to crime, anti-social behaviour, domestic violence, road traffic accidents, and fires are significant.

**New, national safe drinking guidelines have only recently been released. These will be applied to related data in a later version of this section. Analyses undertaken in this version of the Alcohol section are based on safe drinking guidelines prior to 8th January 2016.*

Who's at risk and why?

Most people who have alcohol-related health problems aren't alcoholics, just people who have regularly drunk more than the recommended levels for some years.

In January 2016, the UK's Chief Medical Officer issued new guidelines for safe levels of drinking. The alcohol limit for men has been lowered to be the same as for women. The guideline for both men and women is as follows:

- You are safest not to drink regularly more than 14 units per week, to keep health risks from drinking alcohol to a low level
- If you do drink as much as 14 units week, it is best to spread this evenly over 3 days or more
- The risk of developing a range of illnesses (including, for example, cancers of the mouth, throat and breast) increases with any amount you drink on a regular basis
- If you wish to cut down the amount you're drinking, a good way to help achieve this is to have several drink-free days each week

Drinkers can be divided into three risk categories¹:

- lower-risk drinkers
- increasing-risk drinkers
- higher-risk drinkers

To be a lower-risk drinker, the NHS recommends that:

- Men should not regularly drink more than 3-4 units a day.
 - Women should not regularly drink more than 2-3 units a day
- ("Regularly" means drinking this amount every day or most days of the week).

Increasing-risk drinking is:

- regularly drinking more than 3-4 units a day if you're a man
- regularly drinking more than 2-3 units a day if you're a woman

¹ The descriptors of these categories are based on safe drinking guidelines prior to 8th January 2016.

If you're drinking at around these levels, your risk of developing a serious illness is higher than non-drinkers:

- Men are 1.8 to 2.5 times as likely to get cancer of the mouth, neck and throat, and women are 1.2 to 1.7 times as likely.
- Women are 1.2 times as likely to get breast cancer.
- Men are twice as likely to develop liver cirrhosis, and women are 1.7 times as likely.
- Men are 1.8 times as likely to develop high blood pressure, and women are 1.3 times as likely.

Higher-risk drinking is:

- regularly drinking more than 8 units a day or 50 units a week if you're a man.
- regularly drinking more than 6 units a day or 35 units a week if you're a woman.

Compared to non-drinkers, if you regularly drink above higher-risk levels:

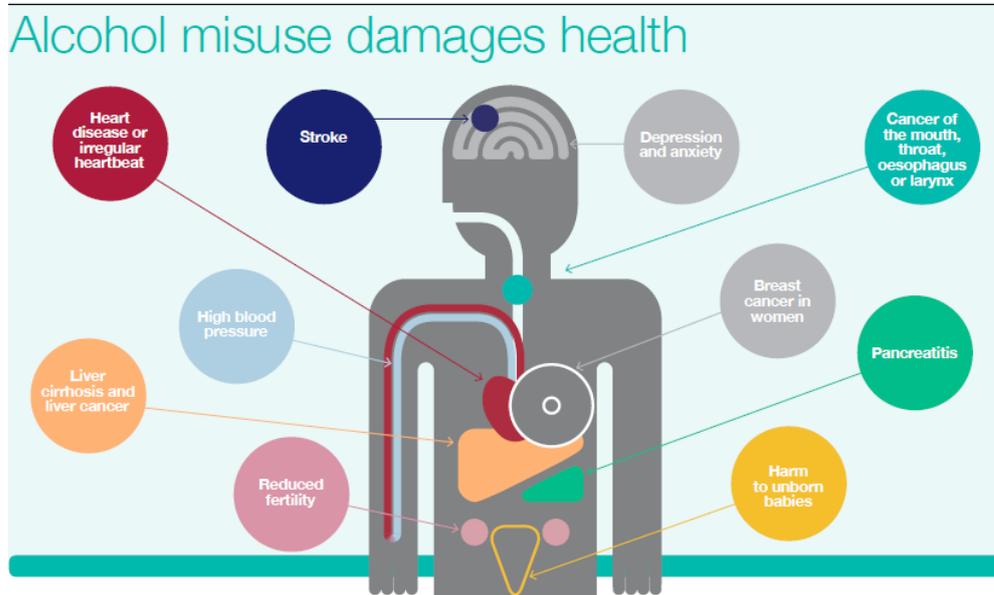
- You could be 3-5 times more likely to get cancer of the mouth, neck and throat.
- You could be 3-10 times more likely to develop liver cirrhosis.
- Men could have four times the risk of having high blood pressure, and women are at least twice as likely to develop it.
- You could be twice as likely to have an irregular heartbeat.
- Women are around 1.5 times as likely to get breast cancer.

Binge drinking

Binge drinking usually refers to drinking lots of alcohol in a short space of time or drinking to get drunk. Researchers define binge drinking as consuming eight or more units in a single session for men and six or more for women.^{3,4}

Alcohol Dependence

Alcohol dependence is characterised by a strong desire to drink alcohol and difficulties in controlling its use. Someone who is alcohol dependent may continue to drink in spite of harmful consequences. Dependent drinkers may also be increasing risk, higher risk or binge drinkers.



Source: <http://www.nta.nhs.uk/uploads/alcoholanddrugswhyinvest2015.pdf>

National Picture²

Age and Gender

The data in Table 1 and 2 show that men are more likely to drink heavily than women. 37% of men and 25% of women consume more alcohol than is recommended (for men 3-4 units per day, women 2-3 units per day).

Adults 16-64 years:

Alcohol consumption is generally higher in adults aged between 25 and 64. For men in this age range, around 40% are drinking more than the recommended daily level. In women there appears to be more variation between the age groups with fewer younger women (16-34 year olds) and older women (65+) drinking above the recommended daily levels.

Adults 65 years and over:

Alcohol consumption is lower in adults over 65 years; 34% in men 65-74 years and 15% in over 75s. In women, levels are even lower at 19% in 65-74 year olds and 7% in over 75s.

² Analyses here and going forward are all based on safe drinking guidelines prior to 8th January 2016.

Table 1: Estimated alcohol consumption on heaviest drinking day in the last week in men (2013)

Age group	None	Up to and including 4 units	More than 4 units, up to and including 8 units	More than 8 units	More than 4 units
16-24	49	16	13	21	34
25-34	36	23	17	24	41
35-44	34	26	18	22	40
45-54	31	28	21	20	41
55-64	28	32	21	18	40
65-74	33	33	20	14	34
75+	41	44	12	3	15
All men	35	28	18	19	37

Source: Health Survey for England – Adult trend tables 2014

Table 2: Estimated alcohol consumption on heaviest drinking day in the last week in women (2013)

Age group	None	Up to and including 3	More than 3, up to and including 6 units	More than 6	More than 3
16-24	55	18	11	16	27
25-34	53	21	11	15	26
35-44	48	23	16	13	29
45-54	41	27	18	14	32
55-64	42	27	21	10	31
65-74	50	31	15	4	19
75+	61	32	6	1	7
All women	49	25	14	11	25

Source: Health Survey for England – Adult trend tables 2014

Alcohol use in young people

In 2013, 39% of pupils in years 7 to 11 said that they had drunk alcohol at least once. This continues the downward trend since 2003, when 61% of pupils had drunk alcohol, and is lower than at any time since 1988, when the survey first measured the prevalence of drinking in this age group.⁵

Problematic alcohol and drug use among under-18s, rarely occurs in isolation and is frequently a symptom of wider problems. It often goes hand in hand with a range of other risks and factors, such as offending or truancy from school.⁶

Alcohol use during pregnancy

A number of risks are associated with drinking alcohol during pregnancy, including; increased risk of miscarriage, risk of foetal alcohol syndrome, alcohol related birth defects and increased risk of learning disability.

Women who are pregnant or trying to get pregnant are advised not to drink alcohol.

Ethnicity

A UK literature review conducted on behalf of the Joseph Rowntree Foundation⁷ found that most minority ethnic groups are more likely to abstain from alcohol, than people from white backgrounds and those who do drink generally drink at lower levels. Whilst abstinence is high amongst South Asians; for Pakistani and Muslim men who do drink, their alcohol consumption is higher compared to other minority ethnic and religious groups. There is some evidence to show increasing levels of alcohol consumption amongst Indian women, Chinese men and young Sikh women.

Lesbian, Gay Bisexual and Transgender People

Results from a number of small studies in the UK suggest that there are higher levels of alcohol misuse among lesbian, gay and bisexual people.⁸ It is estimated that LGBT people are twice as likely to binge drink compared to the general population.

The relationship between alcohol and health inequalities⁹

There is strong evidence that alcohol is a factor underlying higher mortality risks in more disadvantaged populations. Despite experiencing greater alcohol related harm, research suggests that low socioeconomic status groups consume less alcohol than higher socioeconomic status groups (data suggest that those with the lowest weekly incomes have lower than average alcohol consumption). This is known as the '*alcohol harm paradox*'. A range of possible explanations have been put forward for this paradox, such as differing patterns of consumption, inaccurate consumption reporting and alcohol's interaction with other unhealthy behaviours and/or socio-economic determinants of health.

The most deprived fifth of the population of the country suffer two to three times greater loss of life attributable to alcohol; three to five times greater mortality due to alcohol specific causes; and two to five times more admissions to hospital because of alcohol, than the more affluent areas.¹⁰

Mental Health

In any given year, about 25% of the population will experience a mental health problem. People with mental health problems are at increased risk of alcohol misuse. For people who are alcohol dependent, the prevalence of mental health problems is significantly higher (45%). Depression, anxiety, schizophrenia and suicide are all associated with alcohol dependence.⁸ Alcohol is frequently used to self-medicate existing mental health conditions.

Learning Disability

There is some evidence that alcohol related health problems are uncommon in people with learning disabilities.⁸

The level of need in the population

Alcohol consumption in England and In Leicester

National statistics suggest that in 2013, 15% of men and 20% of women in England did not drink any alcohol in the last year; 63% of men and 64% of women drank at levels indicating lower risk of harm; 18% of men and 13% of women drank at an increased risk of harm and 5% of men and 3% of women drank at higher risk levels.¹¹

Synthetic estimates based on the General Lifestyle Survey data and Leicester’s demographic profile, together with local admissions and mortality rates for the city, suggest that in Leicester approximately

- 28% of adults abstain from alcohol (compared with 16.5% in England)
- 74% of the population consume alcohol at lower risk levels (less than 22 units for men and 15 units for women)
- 19% of adults are drinking at increasing risk levels (22-50 units per week for males and 15-35 units per week for females)
- 6.5% of adults are drinking alcohol at higher risk levels (over 50 units per week for males and over 35 units per week for females)

With the exception of the proportion of adults abstaining from alcohol, all other levels are similar to national levels.¹²

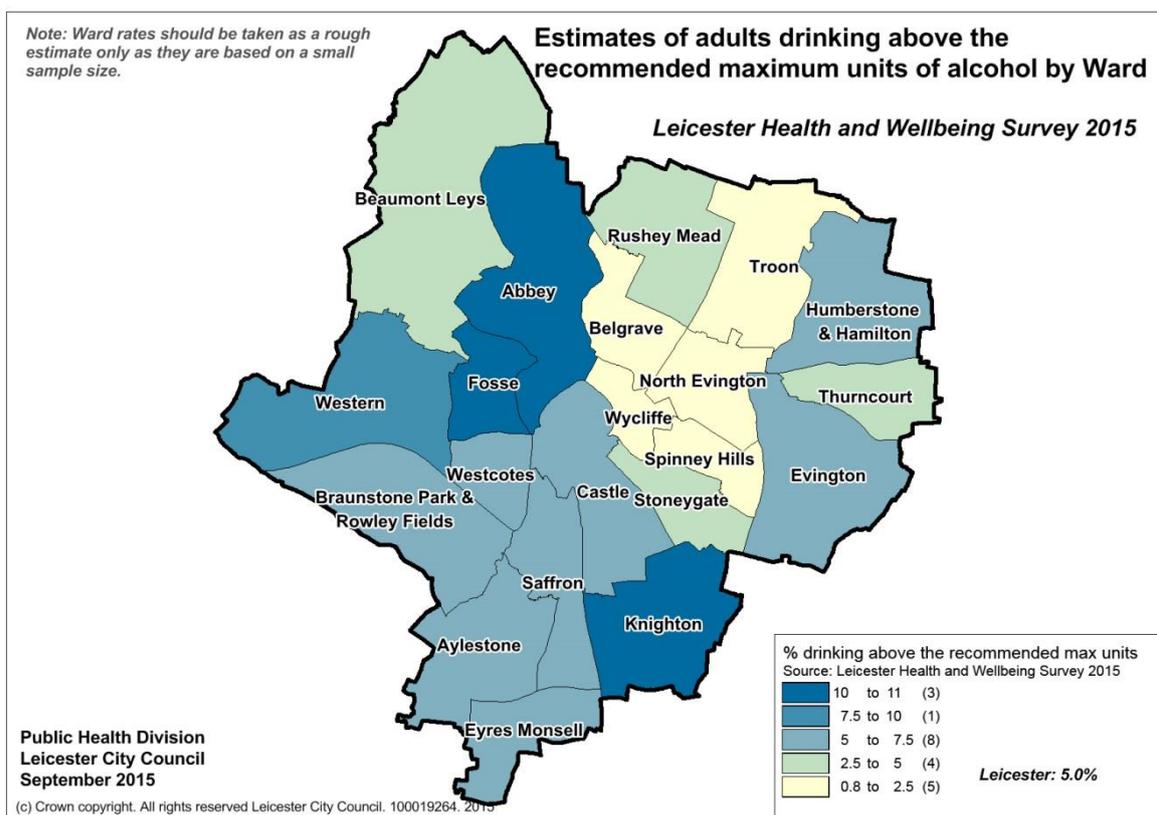
Table 3: Alcohol consumption data in Leicester, 2015

Category	Alcohol consumption	% Non-drinker	% Within recommended max limits	% Above recommended max limits
Gender	Male	45%	48%	7%
	Female	56%	41%	3%
Age group	16-24	52%	43%	5%
	25-34	49%	48%	3%
	35-44	54%	43%	3%
	45-54	52%	42%	6%
	55-64	48%	47%	5%
	65+	47%	46%	7%
Ethnic group	White	31%	61%	7%
	Asian or Asian British	74%	24%	2%
	Black or Black British	67%	31%	2%
	Mixed	40%	59%	2%
	BME Other	85%	15%	0%
	Total	50%	45%	5%

Data: Leicester Health and Wellbeing Survey 2015

- Overall, the Leicester Health and Wellbeing Survey 2015¹³ showed 50% of Leicester’s adult population are non-drinkers, 45% drink within the recommended limits and 5% drink above the recommended limits.
- More women than men are non-drinkers and men have higher drinking levels than women, with around 7% of men and 3% of women drinking above the recommended weekly units.
- Highest levels of non-drinkers are found in Asian ethnic groups (74%), followed by Black ethnic groups (67%), Mixed groups (40%) and lowest in White groups (31%).
- White population groups have the highest levels of drinking above the recommended daily levels (7%), with similar levels in Asian, Black and mixed ethnic groups (2%).
- Abbey, Fosse, and Knighton wards show the highest levels drinking more than the recommended maximum alcohol units.

Figure 1: Proportion of the Leicester population drinking above the maximum recommended alcohol units



Data: Leicester Health and Wellbeing Survey 2015

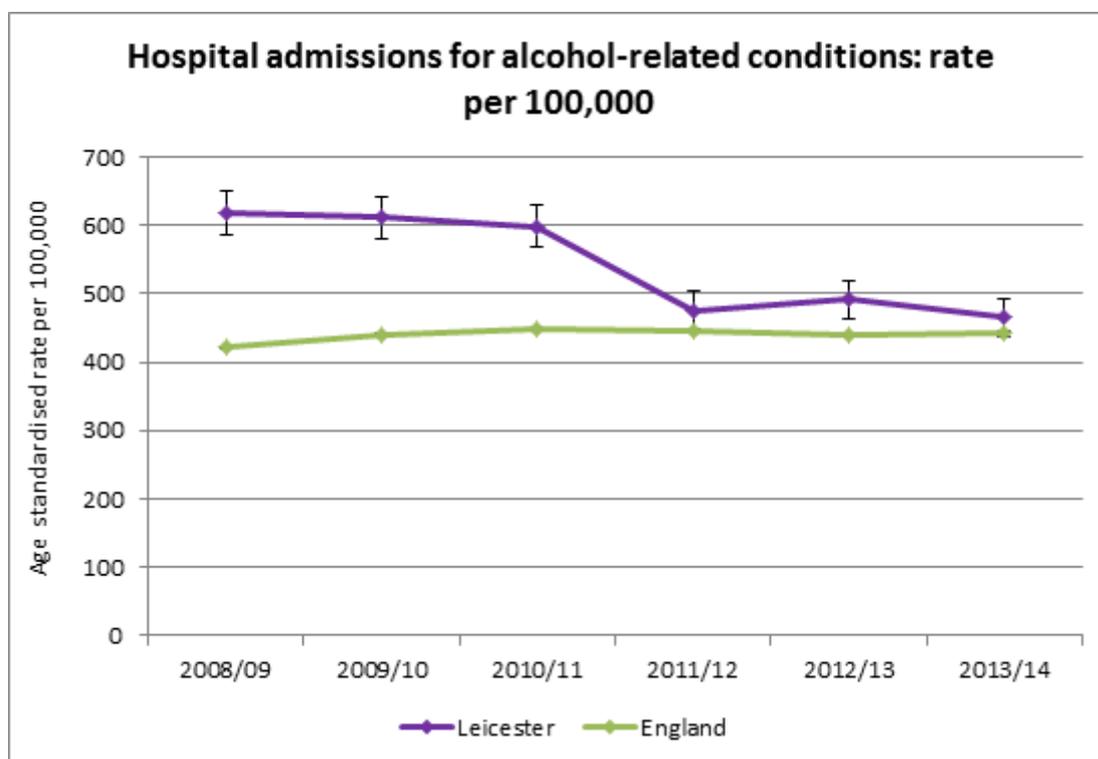
Note: Data is presented at ward level in the map above as the numbers are too small to show at lower geographies such as the Census 2011 lower or middle super output areas

Alcohol related hospital admissions

Alcohol-related hospital admissions (narrow* - shown in and below Figure 2) have fallen in Leicester over the past 5 years. However, rates are significantly higher for men in Leicester than men in England (2013/14). In women, alcohol-specific (directly caused by alcohol) hospital admission rates are significantly lower than in England and alcohol-related hospital admissions are similar.

Important: Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition, for example, alcohol-induced behavioural disorders and alcohol-related liver cirrhosis. Alcohol-related conditions include all alcohol specific conditions, plus those where alcohol causally implicated in some but not all cases of the outcome, for example, hypertensive diseases, various cancers and falls.¹⁴

Figure 2: Hospital admissions for alcohol-related conditions*



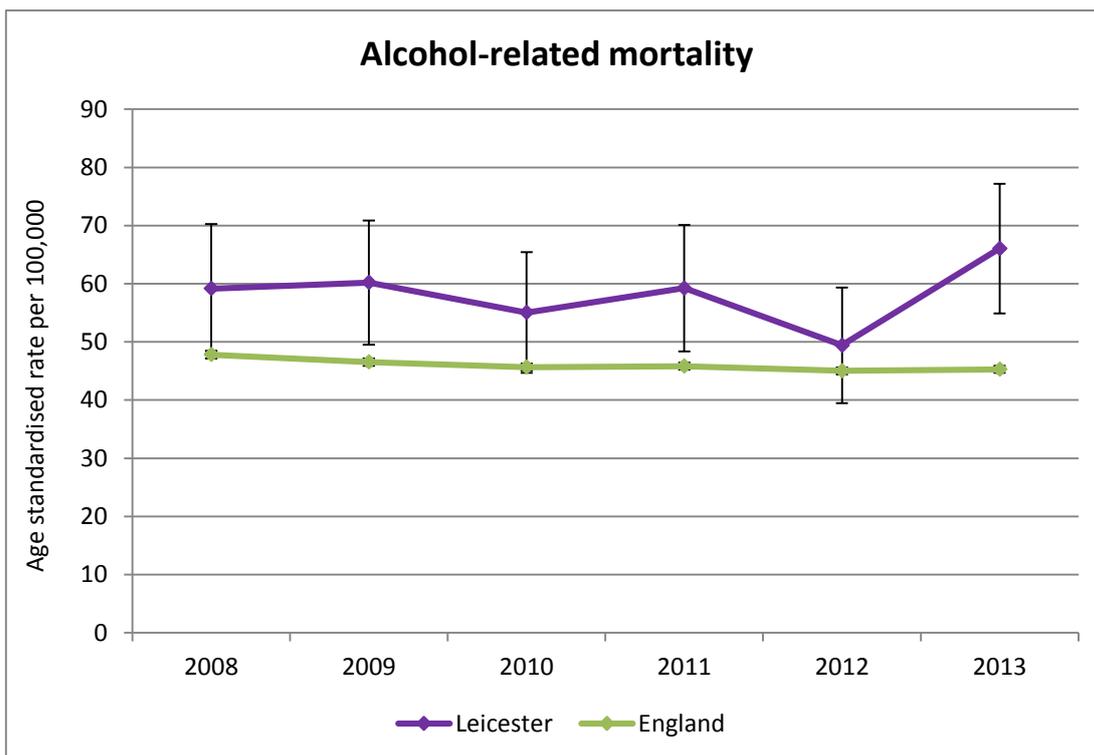
Data: <http://fingertips.phe.org.uk/profile/local-alcohol-profiles>

*NB. This relates to ‘narrow’ hospital admission, that is, persons admitted to hospital where the primary diagnosis is an alcohol-attributable code or one of the secondary codes is an external alcohol-attributable code

Alcohol-related Mortality

Overall rates of alcohol related mortality (Leicester 66.1, England 45.3 per 100,000), alcohol-specific mortality (Leicester 19.7, England 11.9 per 100,000) and mortality from chronic liver disease (Leicester 17.6, England 11.7 per 100,000) are all significantly worse than the national rate. Rates are worse in men than women (mortality rates for women are similar to the national average).¹⁴

Figure 3: Alcohol related mortality rates



Data: <http://fingertips.phe.org.uk/profile/local-alcohol-profiles>

Mortality from chronic liver disease including cirrhosis

There were 133 deaths from chronic liver disease in Leicester between 2011 and 2013, of which nearly 75% were in men. This equates to a significantly higher mortality rate than nationally (17.6 deaths per 100,000 in Leicester, compared with 11.7 deaths per 100,000 in England). Mortality rates from chronic liver disease in Leicester have been rising, from 14.9 deaths per 100,000 (2006-2008) to 17.6 deaths per 100,000 (2011-2013).¹⁴

Adults 16-64 years: 80% of deaths from chronic liver disease in Leicester are in under 65 year olds. In England 69% of deaths are in the under 65s.¹⁵

Adults 65+ years: 9% of deaths from chronic liver disease are in 65-74 year olds and 11% in over 75s (18.5% and 13% in England).¹⁵

Social Impacts

Alcohol-related recorded crime

Nationally 53% of violent incidents involving adults are alcohol-related. In Leicester there has been a continued reduction in the level of alcohol-related recorded crime since 2008/09. In 2012/13 there were around 2,700 crimes recorded relating to alcohol and over 1,900 alcohol related violent crimes. There were also 64 crimes recorded as alcohol-related sexual offences. The rates of alcohol-related violent crime in Leicester, although falling, remain higher than the national average.¹⁶

Street Drinking

A street drinker is someone who drinks heavily in public places and appears, in the short term, to be unable or unwilling to stop or control their drinking. Street drinkers often have a long history of alcohol misuse, and frequently drink in groups for companionship. Street drinkers often have multiple vulnerabilities including drug use, mental health issues, physical health problems and homelessness. Street drinkers are at risk of arrest for; public drunkenness, shoplifting, begging and other public order offences as well as being at increased risk of being the victim of assault. The street drinking population is not static and there is often a seasonal variation in the number of street drinkers, this makes quantifying the levels of problematic street drinking difficult.

In Leicester there is a multiagency approach to managing street drinking which involves treatment services, police, community wardens, and the homelessness outreach team. Currently we estimate that there are in the region of 70 individuals who are street drinking, although many of these are intermittent. We have identified 26 individuals whose street drinking can be described as prolific and who have additional complex health and social care needs.

Current services in relation to need

There is a body of evidence supporting the effectiveness of a range of alcohol interventions. Services in Leicester are commissioned in line with national guidance and good practice.

Primary prevention/awareness raising

Awareness raising campaigns are run throughout the year, often linking with national campaigns such as Alcohol Awareness Week. Campaigns are generally co-ordinated between strategic partners including the police, health, the local authority and treatment providers to maximise the impact. Materials to support teachers to deliver safe alcohol use messages are available in schools. During fresher's week a campaign is delivered on alcohol and keeping safe at both local universities.

Early identification (brief interventions)

Evidence suggests that a brief intervention delivered by a healthcare professional can be successful in moderating people's behaviour in relation to alcohol. According to the research 1 in 8 people will moderate their drinking in response to a brief intervention¹⁷.

Brief interventions consist of a 5 minute conversation between a health professional and an individual regarding their understanding of alcohol intake/units and simple advice on how to cut down. The intervention is offered to individuals identified at risk following completion of a simple alcohol questionnaire. In Leicester, the questionnaire is offered to new patients (over 16)

registering with a GP, patients undergoing a NHS cardiovascular health check, or patients consulting a GP or pharmacist regarding certain “trigger” conditions such as gastritis.

The alcohol nurse liaison service identifies people who attend A&E or are admitted to hospital where alcohol may have been a contributory cause. The alcohol liaison nurse team can offer a range of interventions including brief and extended brief interventions, referral to specialist treatment services and referral for detoxification as required.

Specialist Treatment and Support Services

The National Treatment Agency (NTA) models of care of adult drug misusers and models of care for alcohol misusers, describes a tiered system of treatment:

Tier 1 includes information advice screening and referral to specialist services.

Tier 2 includes drug/alcohol related information and advice triage referral to structured treatment harm reduction.

Tier 3 includes provision of community-based care coordinated specialised assessment and co-ordinated care, planned treatment.

Tier 4 includes specialist inpatient detox and residential rehabilitation.

A range of specialist treatment and support services are commissioned within Leicester.

Community based integrated adult drug and alcohol services

A full range of services covering Tiers 1 – 3 are provided for adult service users in the community. This includes psychosocial interventions, substitute prescribing, needle exchange, community based detoxification, and support services to facilitate recovery. The provider of these services is the Leicester Recovery Partnership.

Specialist criminal justice adult pathway

A full range of services covering Tiers 1 – 3 are provided for adult service users in contact with the criminal justice system from arrest through prison services and into probation services. This service is provided by the LiFt partnership.

Treatment resistant drinkers

The Anchor Centre supports treatment resistant, entrenched drinkers who are often also street drinkers. This service is provided through the LiFt partnership.

Young People’s services

Specialist integrated drug and alcohol services to support young people and their families. This service is provided by Lifeline.

Inpatient detoxification services

Specialist drug and alcohol detoxification services for service users where community detoxification is not suitable. This service is provided by Nottinghamshire Healthcare Trust at their Woodlands Centre.

Residential rehabilitation services

Residential services to support maintenance of recovery for people who have completed detoxification. The Substance Misuse Community Care Assessment Team is commissioned by Leicester City Council to undertake the Community Care Assessments, which determine the eligibility of clients to residential rehabilitation services. It is not a provider of rehabilitation services.

Housing related support

This service for people in recovery includes accommodation and ‘floating’ support (that is, workers who support clients in their own tenancy) and is provided by the Home group.

Project Intercept

A specialist project providing advocacy support for services users with dual diagnosis (mental ill health and alcohol/drug ill health).

Table 4: Numbers of adults in Leicester in alcohol treatment, 2010/11 to 2013/14

Adults in alcohol treatment	2009/10	2010/11	2011/12	2012/13	2013/14
Successful completions	203	230	234	280	206
Numbers in treatment	613	626	685	774	765
Waiting times < 3 weeks	207	257	429	488	488
% Waiting < 3 weeks	44	53	80	86	89

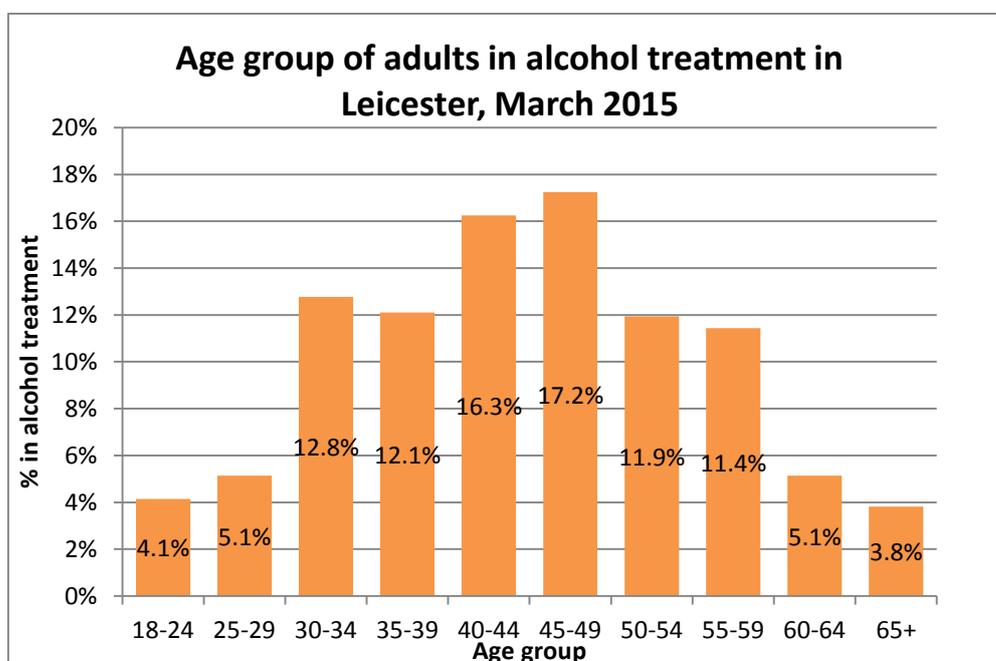
Source: National Drug Treatment Monitoring System (NDTMS)

Table 4 above details National Drug Treatment Monitoring System (NDTMS) data for numbers of individuals in treatment in Leicester for alcohol dependency over the past 5 years.

The profile of clients in alcohol treatment at March 2014 showed:

- 603 clients had alcohol treatment
- 70% were male, 30% female
- 4% were aged 18-24, 18% aged 25-34, 28% aged 35-44, 29% aged 45-54, 17% aged 55-64 and 4% over 65 years (Figure 4)

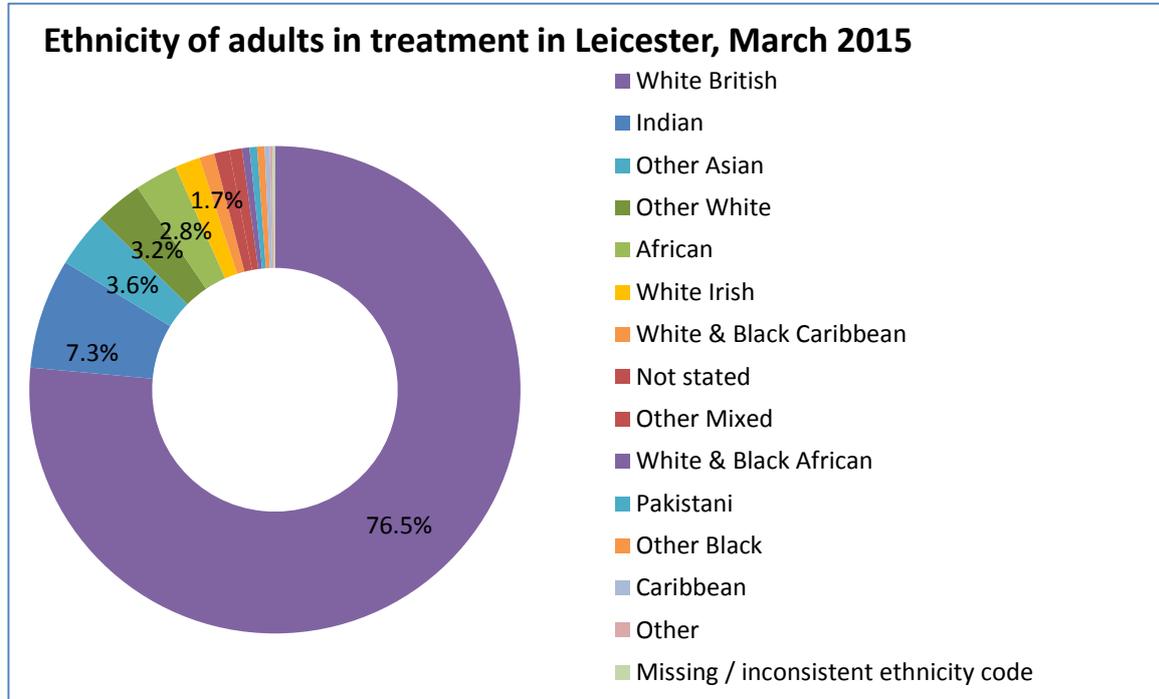
Figure 4: Age group of adults in alcohol treatment in Leicester, March 2015



Data: NDTMS Quarterly Partnership report: <https://www.ndtms.net>

The profile of clients in alcohol treatment at March 2014 showed that in terms of ethnic group (Figure 5), White British make up 76.5% of clients, followed by Indian (7.3%), Other Asian (3.6%) and other White (3.2%).

Figure 5: Ethnicity of adults in treatment in Leicester, March 2015

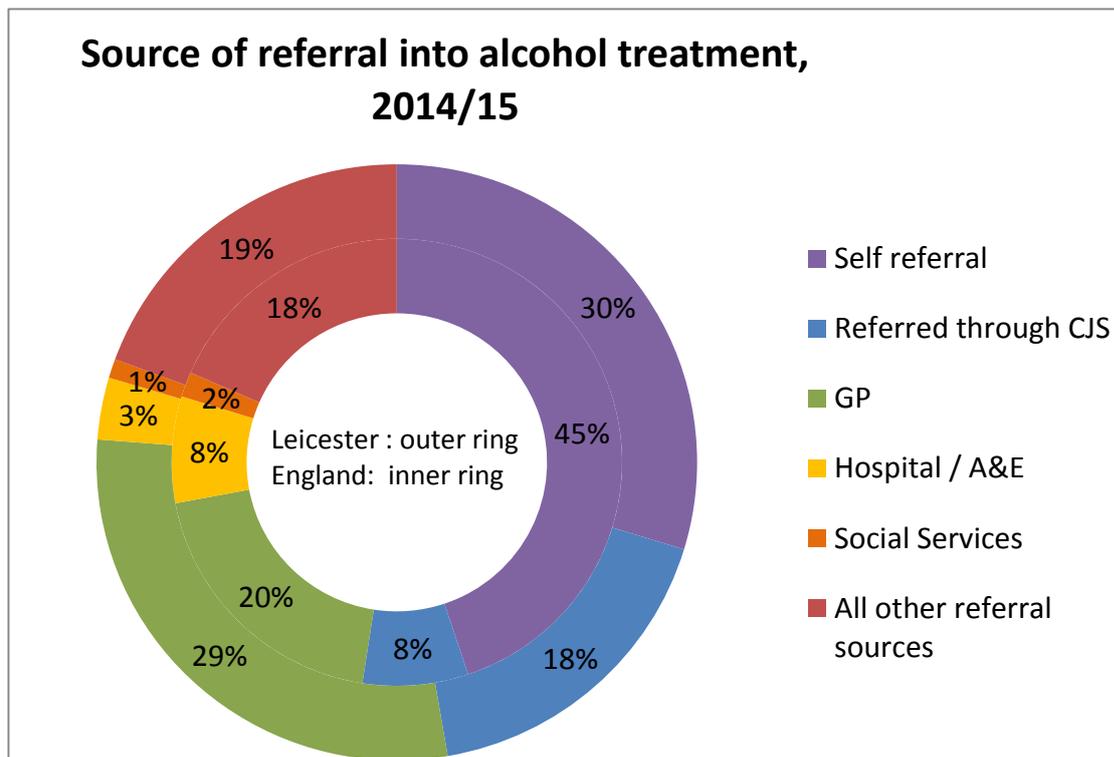


Data: NDTMS Quarterly Partnership report: <https://www.ndtms.net>

Sources of referral into alcohol treatment (2014/15)¹⁸

Figure 6 shows that self-referral rates are 30% in Leicester, compared with 45% nationally. The largest referral routes are self-referral and via GPs. Referrals from GPs stand at 29%, compared with 20% nationally. Referrals via the Criminal Justice System are also higher locally than nationally (18% locally, compared with 8% nationally).

Figure 6: Source of referral into alcohol treatment, 2014/15



Data: NDTMS Quarterly Partnership report: <https://www.ndtms.net>

*Percentages may not add up to 100 due to rounding

CJS – Criminal Justice System (that is, referred though an arrest referral scheme, via an Alcohol Treatment Requirement (ATR), prison or the probation service).

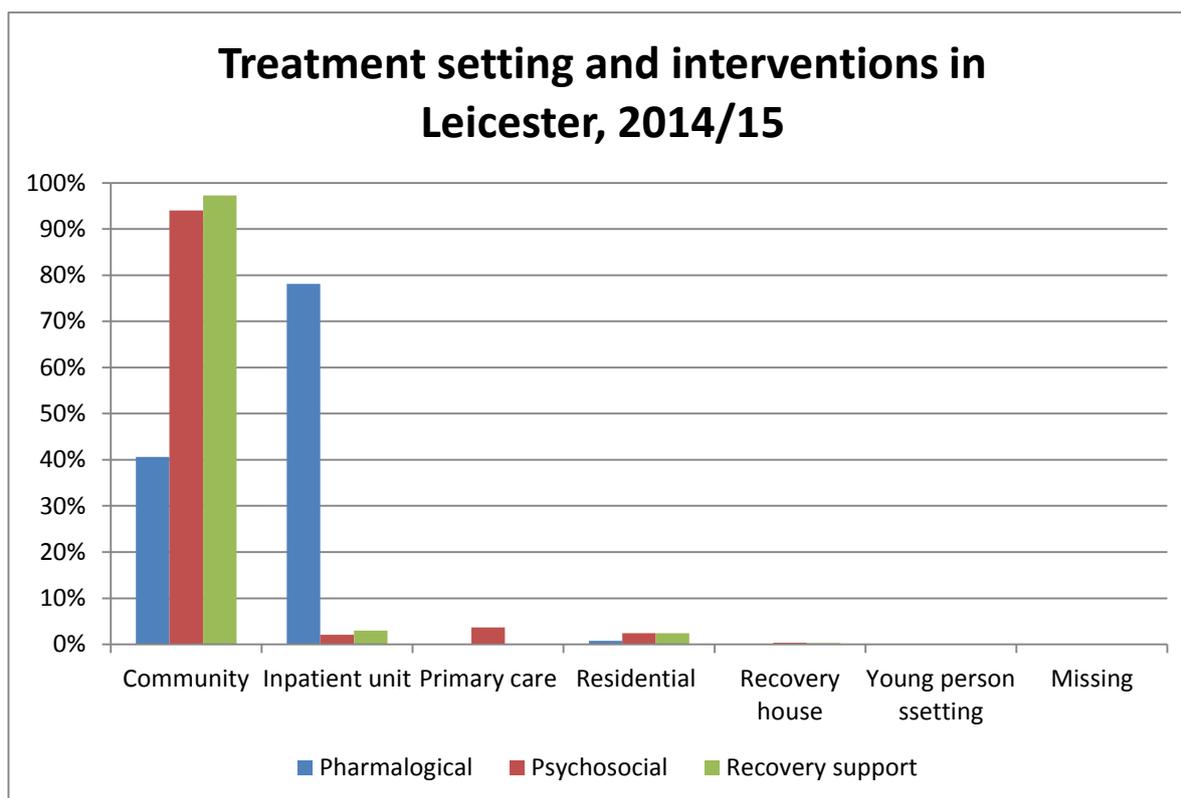
Key statistics about those in treatment (2014/5 unless otherwise stated):

- 73% of all those in treatment were drinking at higher risk levels in the 28 days prior to entering treatment.
- 23% were living with children.
- Self-reported housing status of adults at the start of treatment showed that 7% had a housing problem (not urgent) and 3% had an urgent housing problem (no fixed abode [NFA]).
- Self-reported employment status at the start of treatment showed that 18% were in regular employment, 50% were unemployed/economically inactive and 22% were long term sick or disabled.
- 10% of those in treatment were also receiving care from mental health services for reasons other than substance misuse (compared with 20% nationally).

- Nearly two-thirds of the treatment population are on benefits (63%) which compares to 54% nationally (individuals in alcohol treatment on 31st March 2012, recorded as being on benefits of any type on 31st March 2012).

Figure 7 illustrates the proportion of individuals accessing a range of interventions delivered within treatment services by setting.

Figure 7: Treatment setting and interventions in Leicester, 2014/15



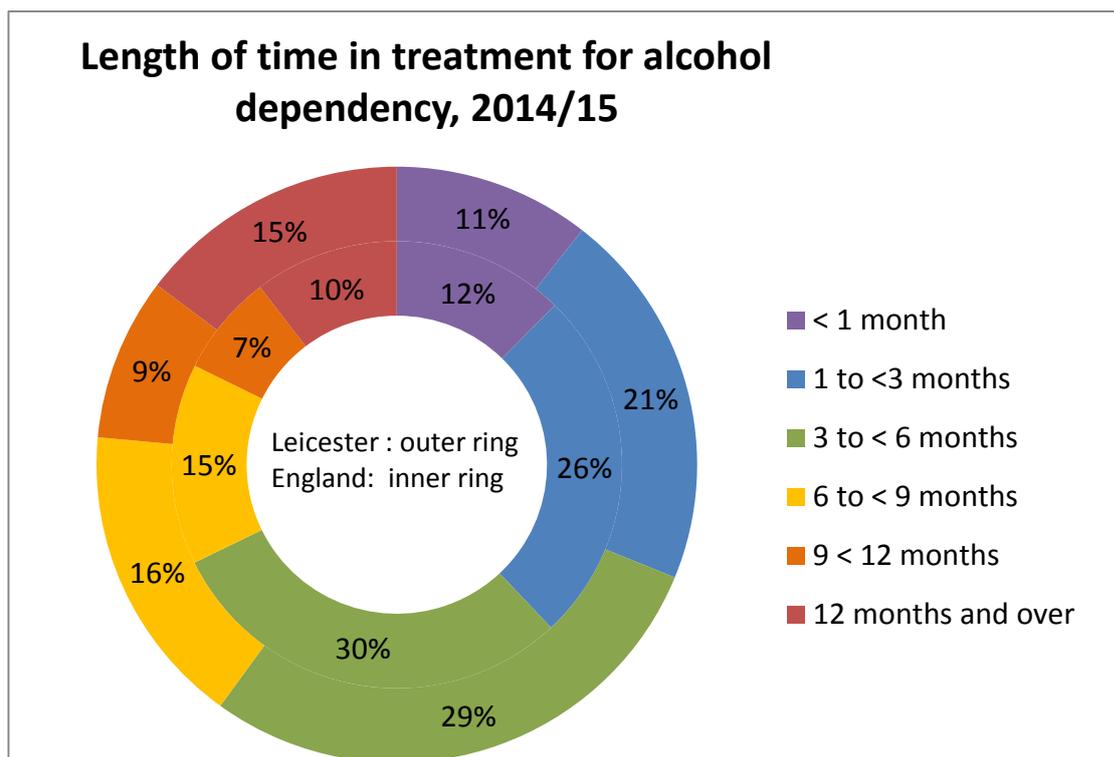
Data: NDTMS Quarterly Partnership report: <https://www.ndtms.net>

* Figure 7 shows the proportion of individuals receiving each intervention type and not a summation of the setting in which the intervention was delivered

** Figure 7 shows the proportion of individuals receiving each intervention type and not a summation of the pharmacological, psychosocial or recovery interventions

Figure 8 illustrates length of time spent in treatment for alcohol dependency (2014/15). The recommended length of treatment varies according to the level of alcohol dependence. Retaining clients for their full course of treatment is important, in order to increase the levels of successful treatment completion and reduce rates of early treatment drop out. Conversely, having a high proportion of clients in treatment for more than a year may indicate that they are not moving effectively through and out of the treatment system.

Figure 8: Length of time in treatment for alcohol dependency, 2014/15



Data: National Drug Treatment Monitoring System Quarterly Partnership report:
<https://www.ndtms>

* Proportion of treatment exits by length of time in treatment

*Proportions may not add up to 100 due to rounding

Projected services use and outcomes in 3-5 years and 5-10 years

The population of Leicester City is predicted to increase as indicated below in Table 5. If we assume that there is no change in the proportion of people drinking at the specified risk levels, then we can expect to see a rise in hospital admissions and death rates associated with alcohol consumption.

[Crude calculations applying latest prevalence and rates of admission/mortality to the ONS population projections:](#)

Table 5: Risk of alcohol consumption and projected numbers in Leicester to 2030

	Prevalence %	2015	2020	2025	2030
Leicester Population 16+		265,160	271,260	278,880	289,000
Low risk	74.1	196,431	200,950	206,595	214,092
Increasing risk	19.4	51,423	52,606	54,084	56,046
High risk	6.5	17,306	17,704	18,201	18,862

Data: LAPE 2014 (synthetic estimates from 2009), ONS mid-2012 population projections

Table 6: Projected number of alcohol-related hospital admissions in Leicester (based on 2013/14 rate)

Year	2013/14	2015	2020	2025	2030
Projected alcohol-related hospital admissions	1,305	1,320	1,358	1,391	1,430
Admission rate per 100,000	465	465	465	465	465

Data: Alcohol admissions projections based on keeping the rate constant and using increases provided in the population projections (ONS-mid 2012 population projections)

Table 7: Projected number of alcohol-related mortality rates in Leicester (based on 2013 rate)

Year	2013	2015	2020	2025	2030
Projected alcohol-related deaths	161	163	168	172	177
Mortality rate per 100,000	66	66	66	66	66

Data: LAPE 2014 (synthetic estimates from 2009), ONS mid-2012 population projections

Unmet needs and service gaps

The Leicester Health and Wellbeing Survey 2015 showed variation in knowledge regarding alcohol units between different groups:

- 33% of respondents had not heard of alcohol units
- Certain cultural/religious groups were less likely to have heard of units (these are the same groups who are less likely to drink (including Hindus, Muslims, Sikhs and those of a Black and Minority Ethnic Group [BME])
- Women were more accurate than men, when asked about the official recommended maximum number of units they can drink per day (50% of women got this correct, compared with 41% of men)¹⁹

A local study within South Asian communities conducted in 2015, demonstrated a lack of awareness of the services available locally to support individuals with drug and alcohol problems.

Recommendations for consideration by commissioners

Commissioners are recommended to:

- Ensure that treatment services are designed to reflect the needs of the whole population at risk, including equity of access for under-represented groups in the current treatment model.
- Continue to target known priority groups and identify additional priority groups at high risk of alcohol related harm, as a focus for prevention activity.
- Highlight the need for prevention of alcohol misuse across all age groups and ensure health promotion interventions are fully commissioned.
- Enhance provision of identification and brief advice for alcohol problems across a wide range of health and social care front line staff.
- Ensure referral pathways between all alcohol health promotion, treatment and aftercare services are fully integrated and effective.
- Ensure robust referral pathways between substance misuse services and mental health services, for clients with dual diagnosis.
- Ensure continued provision for change resistant drinkers, including problematic street drinkers.

Key contacts

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- ⁴ <http://www.nhs.uk/Livewell/alcohol/Pages/Bingedrinking.aspx>
- ⁵ <http://www.hscic.gov.uk/catalogue/PUB17712>
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- ¹² Mid 2009 synthetic estimates, Local Authority alcohol indicators for crime and consumption only, available from: <http://www.lape.org.uk/data.html>
- ¹³ Leicester Health and Wellbeing Survey 2015, <http://www.leicester.gov.uk/your-council/policies-plans-and-strategies/health-and-social-care/data-reports-and-information/leicester-health-and-wellbeing-survey-2015/>
- ¹⁴ LAPE 2015 User Guide available to download from: <http://fingertips.phe.org.uk/profile/local-alcohol-profiles>
- ¹⁵ HSCIC Indicator portal (NHS and Public Health-internal access only): <http://www.indicators.ic.nhs.uk/webview/>
- ¹⁶ Leicester LAPE Profile 2014 <http://www.lape.org.uk/data.html>
- ¹⁷ Moyer, A., Finney, J., Swearingen, C. & Vergun, P. (2002). Brief Interventions for alcohol problems: A meta-analytic review of controlled investigations in treatment-seeking and non-treatment seeking populations. *Addiction*, 97, 279–292.
- ¹⁸ Alcohol data: JSNA support pack. Key data to support planning for effective alcohol harm prevention, treatment and recovery in 2016-17
- ¹⁹ <http://www.leicester.gov.uk/media/180392/leicester-health-and-wellbeing-survey-2015.pdf>