



Leicester  
City Council

# DRUG AND ALCOHOL NEEDS ASSESSMENT IN LEICESTER CITY

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## Abbreviations

ACEs	Adverse Childhood Experiences
CSEW	Crime Survey in England and Wales
FFT-CW	Functional Family Therapy – Child Welfare
DAA	Direct Acting Antivirals
HSE	Health Survey for England
IBA	Identification and Brief Advice
L&D	Liaison & Diversion
MSOA	Middle Layer Super Output Areas
MST-CAN	Multisystemic Therapy – Child Abuse and Neglect
MST	Multisystemic Therapy Standard
MUP	Minimum Unit Price
NDTMS	National Drug Treatment Monitoring System
NICE	National Institute for Health and Care Excellence
NEET	Not in Education, Employment or Training
NPS	Novel Psychoactive Substances
OHID	Office of Health Improvement and Disparities
OST	Opioid Substitution Treatment
PHE	Public Health England
SI	Serious Incident
SHEU	School Health Education Unit
SES	Socio-Economic Status
GBL	$\gamma$ -butyrolactone
GHB	$\gamma$ -hydroxybutyrate

## Glossary

Alcohol specific admissions/mortality	Alcohol-specific conditions include alcoholic liver disease, mental and behavioural disorders and alcohol poisoning where the condition is caused primarily by alcohol
Alcohol-related admissions/mortality	Alcohol-related hospital admissions include all alcohol specific conditions, plus those where alcohol is causally implicated in some but not all cases of the outcome, for example, hypertensive diseases, various cancers and falls
Alcohol-related harm	Alcohol-related harm refers to the harmful outcomes associated with alcohol use including, but not limited to, alcohol attributable admissions, A&E visits and mortality, diseases and disorders entirely attributable to alcohol, drunk driving and alcohol-related interpersonal violence and self-harm
Deaths from drug misuse	Death classified as drug misuse must be a drug poisoning and meet either one (or both) of the following conditions: the underlying cause is drug abuse or drug dependence, defined by ICD-10 as mental and behavioural disorders as a result of use of: opioids (F11), cannabinoids (F12), sedatives or hypnotics (F13), cocaine (F14), other stimulants, including caffeine (F15), hallucinogens (F16), multiple drug use and use of other psychoactive substances (F19); The second condition is if any of the substances controlled under the Misuse of Drugs Act 1971 are involved – this includes class A, B and C drugs.
Deaths from drug poisoning	Deaths classified as a drug poisoning must have an applicable International Classification of Diseases (ICD) code assigned as the underlying cause of death. Drug poisoning deaths involve a broad spectrum of substances, including controlled and non-controlled drugs, prescription medicines (either prescribed to the individual or obtained by other means) and over-the-counter medications. As well as deaths from drug abuse and dependence, figures include accidents and suicides involving drug poisonings and complications of drug abuse such as deep vein thrombosis or septicaemia from intravenous drug use. They do not include other adverse effects of drugs, for example, anaphylactic shock or accidents caused by an individual being under the influence of drugs.

Successful completions	Number of users of drugs or alcohol that left treatment successfully (free of drug(s)/alcohol dependence) who do not then re-present to treatment again within 6 months as a percentage of the total number of drug or alcohol users in treatment.
Unplanned exists	The proportion of adults entering drug or alcohol treatment who left treatment in an unplanned way before 12 weeks, commonly referred to as early drop outs.

## 1. Introduction

Substance use refers to the use of psychoactive substances in a way that is harmful or hazardous to health and includes alcohol and illicit drugs. It is associated with a range of health conditions, such as chronic liver disease, mental and behaviour disorders and acute intoxication, and has a detrimental impact at both an individual and societal level.

It is important to note that anyone can be at risk of developing a substance problem in their lives. The use of substances can lead to dependency and addiction, which is a multi-faceted disorder that requires a multifaceted conceptualisation. Rather than pinpoint one cause of addiction, it is now understood that combination of factors contributes to a person being more or less at risk of addiction. The biopsychosocial model provides a means of considering the myriad of factors that can contribute to the risk of addiction. The “Bio” aspect of the model refers to genetics and biology. Although there is no “addiction gene” it is evident through epigenic studies that addiction has a genetic component. Individuals who are genetically predisposed have a greater risk of becoming addicted at some point in their life.

Along with genetics, another contributing factor to the risk of addiction is the psychological component. This encompasses a wide range of traits, such as personality (e.g. sensation-seeking and impulsivity), mental health concerns (e.g. self-esteem and self-worth) and life experiences (e.g. trauma). Researchers have found strong evidence between trauma and addiction. Felitti et al. (1998) found that more adverse childhood experiences (ACEs) increased the odds of subsequent drug and alcohol use. One explanation for this trend is the toxic stress that trauma leads to the stress response. These individuals may experience constant hyperarousal, hypervigilance, anxiety and abuse of drugs may be an effective way to regulate these emotional experiences.<sup>1</sup>

The third factor in the biopsychosocial model is the social environment. Social norms, availability, accessibility, societal approval, visibility, targeting practice and cultural belief all influence the experience of addiction. For example, an individual exposed to drug use at an early age can be influenced by learning through observation. Furthermore, some communities are targeted more heavily with alcohol advertisements, particularly the more deprived communities.<sup>23</sup> The above factors provide a holistic conceptualisation of addiction that acknowledges the complexity of the disorder which requires a multifaceted solution.

Improving the wider determinants of health is essential to addressing substance issues, at a societal, environmental and economic level. Recognised risk factors of substance use include deprivation, troubled families, domestic violence and trauma in childhood. It is therefore essential to



acknowledge that substance use does not exist in isolation and treatment should be viewed as a package of integrated care across the health and social care system. Improvements in the substance use system will therefore be witnessed across a range of outcomes including physical health, mental health, social networks, employment and criminal activity.

## 2. Aims

The Drugs and Alcohol Health Needs Assessment for Leicester City aims to provide detailed analysis of current and future health needs in both children and adults and to identify health inequalities and unmet need. This will provide Public Health commissioning leads and wider partners with the information they require to continue to support those with issues with substances and rectify any gaps in service provision.

## 3. Objectives

- To describes the state of health of Leicester City residents (adults and children) related to substance use, including alcohol
- Enable the identification of the local modifiable risk factors and causes of ill health related to substance use
- To describe the policies and evidence base for substance use services
- Examine current services available and how these may need to change with current and future demand
- Understand what gaps currently exists in terms of service provision and identify recommendations to address these issues

## 4. Methodology

Local and national data sources have been examined by available variables such as time, age, gender and residence to understand the local picture. Key data sets examined were National Drug Treatment Monitoring System (NDTMS), Fingertips from Office of Health Improvement and Disparities (OHID) and the local mortality and hospital admissions files from the Public Health Intelligence team in Leicester City Council Public Health team. The Leicester Health and Wellbeing survey and School Health Education Unit (SHEU) provided the prevalence of drinking habits in the local population. The Crime Survey in England and Wales (CSEW) was used to extrapolate local estimates for drug use, as local estimates were not available.

Policy guidance was obtained from two large evidence reviews published by Public Health England on the effectiveness on alcohol control policies and the outcomes of drug misuse treatment services.

Further guidance was available from National Institute for Health and Care Excellence (NICE) and recent research.

Stakeholder engagement was carried out through semi-structured interviews with service providers and wider partners. A focus group examining the perception of substances and the prevalence of their use in young people was run with students from a local university. Service user engagement was conducted through a focus group with individuals undergoing a recovery journey. The needs assessment was reviewed through an internal gap analysis session by Leicester City Public Health team. Once internally reviewed, the needs assessment was presented at a multi-disciplinary meeting with partners across the substance use system to gather external views.

## 5. Policy Context

### 5.1. Alcohol

The government launched a national alcohol strategy in March 2012, however, there has been no refresh since then. At the time the strategy focussed on the government's commitment to tackling excessive, irresponsible drinking which has led to unacceptable levels of nuisance and harm. Challenging binge drinking and the resulting disorder, violence and health harms caused to individuals and the community are at the heart of the government's approach. This promised tougher action against offenders of alcohol related violence and disorder and businesses encouraging this behaviour, as well as support to individuals to make informed choices to change their own behaviour.

The government made a commitment to tackle low pricing of alcohol through the introduction of a minimum unit price for alcohol. In March 2020, the Government said there were "no plans for the introduction of MUP in England<sup>4</sup>" although it would continue to monitor the progress of MUP in Scotland and consider the evidence of its impact. Both Scotland and Wales have introduced Minimum Unit Pricing.

In September 2022, Leicester City Council published their Alcohol Harm Reduction Strategy<sup>5</sup> which lays out how to support people to drink responsibly and reduce the harm that excessive drinking causes. Working with partners across the city, the strategy aims to:

- Promote a culture of responsible drinking
- Protect children and young people and families
- Improve early identification and treatment
- Promote responsible selling
- Reduce alcohol related crime

- Respond to emerging issues

Actions include promoting non-alcoholic alternatives, supporting retailers to responsibly promote and sell alcohol, and ensuring that people have access to early intervention and treatment services.

## 5.2. Drugs

Addressing substance use remains a key national priority. The National Drug Strategy 2021, “From Harm to Hope: A 10 Year drugs plan to cut crime and save lives<sup>26</sup>” builds on the findings from the Dame Carol Black review. The strategy aims to combat illegal drugs by breaking the supply chains of drugs, develop a world class treatment and recovery system with streamlined integration and reducing the demand for recreational drugs. The strategy is underpinned by investment of over £3 billion over the next three years. Locally, the requirements of the new national Drug Strategy “From Harm to Hope<sup>26</sup>” creates new substance use governance arrangements with overall responsibility sitting in the Leicester, Leicestershire and Rutland Combatting Drugs Partnership.

## 6. Evidence Review

### 6.1. Alcohol

A whole population approach is required to produce the most effective results due to the large proportion of the population who are exceeding the recommended low risk drinking guidelines. 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.

There are three key influencers of alcohol consumption: price (affordability), ease of purchase (availability) and the social norms around its consumption (acceptability). There has been an array of public health interventions developed to reduce the wide-ranging burdens from alcohol. Public Health England undertook a rigorous evidence review examining the effectiveness and cost effectiveness of such interventions. This review found that reducing the affordability of alcohol as the most effective and cost-effective approach to promoting prevention and health improvement. This could be through tax increases and/or Minimum Unit Price (MUP) is likely to lead to substantial

reductions in harm and increases in government revenue. The advantage of a MUP is it targets the heaviest drinkers who are at risk from the greatest risk of harm.<sup>6</sup>

The evaluations of MUP are encouraging for the majority of the population where a decline in alcohol consumption has been witnessed. However, the effects of alcohol consumption among people drinking at harmful levels show there is no clear evidence for a reduction in consumption, in fact, in one study alcohol consumption increased following MUP introduction. Please note, this interrupted time series analysis highlighted a number of limitations such as a small number of data points post intervention and recall bias from collection of the outcome data.<sup>7</sup> Of particular importance will be future analyses of the impact of the policy on morbidity and mortality from health conditions closely associated with harmful drinking (e.g. liver cirrhosis or alcohol poisoning). This will provide a more direct and objective indicator for whether MUP is affecting those at greatest risk of harm.

Availability is largely influenced by licencing. The review found policies that sufficiently reduce the hours during which alcohol is available for sale, particularly in the night time economy, can substantially reduce the harms of alcohol and are cost-effective when targeted at the areas with the highest alcohol outlet density. Robust marketing regulations are strongly supported by the evidence base. It was consistently reported that exposure to alcohol marketing increases the risk that children will start to drink alcohol, or if they already drink, will consume greater quantities. Emerging research has focused on specific mechanisms to do this, such as watershed bans or online age verification filters.<sup>6</sup> In a further bid to de-normalise alcohol consumption, it has been argued that alcohol sponsorship and advertising needs to cease in the traditional radio, TV and newspapers but also on social media and web advertising. A further step is to propose sporting and cultural events to be alcohol free.

In terms of acceptability, the focus tends to be around education. Health interventions aimed at drinkers who are already at risk, such as Identification and Brief Advice (IBA) and specialist treatment for those with harmful drinking patterns and dependence, have been found to be effective and cost-effective if delivered at scale. IBA involves the administration of a short screening questionnaire about current drinking patterns, followed by personalised advice and information. It has been found to be most effective in Primary Care settings.<sup>6</sup> Research has aimed to understand if IBA is effective in an adolescent sample. A NICE review reported that among adolescents, there is limited evidence that electronic IBA effectively reduces alcohol consumption compared with minimal or no intervention controls.<sup>8</sup>

Alcohol liaison nurses within acute hospital settings have key role in the systematic early identification of alcohol misuse in people admitted to hospital and in co-ordination of ongoing support, tiered depending on the level of misuse. Published evidence is available for the effectiveness and cost-effectiveness of alcohol care teams in reducing hospital admissions and attendances at emergency departments and readmissions.<sup>6</sup> However, commissioning of such services at a national level is not uniform and patchy. There is also national shortage of addiction psychiatrists to oversee the management of those with dependency.

## 6.2. Drugs

Public Health England (PHE) undertook an evidence review to examine the drug treatment and review system. They used a mixed methods approach to review the evidence, drawing on statistical information, engagement with stakeholders including experts by experience, and commissioning external reviews by academic experts. The review makes clear that drug treatment systems should continue to address a broad range of outcomes including: harm reduction, reduced drug use and social integration and recovery.<sup>9</sup> This should be accomplished through evidence-based treatment interventions, recommended in the NICE drug misuse guidelines and the 'Drug Misuse and Dependence: UK Guidelines on Clinical Management'. Findings show that drug treatment affects a broad range of outcome domains. Opioid Substitution Treatment (OST) is associated with a marked reduction in heroin use (66% abstinence) and is associated with a marked reduction in illicit drug injecting and sharing of injection equipment and substantially reduces the risk of an overdose and the risk of bloodborne viral infection. Evidence also points to OST being an effective means of bringing people into contact with treatment and bringing stability to lives.<sup>9</sup>

A wide range of international, peer-reviewed evidence demonstrates the efficacy and effectiveness of mutual aid and its potential role in improving service users' community integration, their social networks and recovery outcomes, along with the health and wellbeing of their families and relatives. The further development of mutual aid should be encouraged in local communities, including access to a range of peer-based recovery support options, including 12-step, SMART Recovery and other community recovery organisations. Currently in Leicester, Dear Albert holds a sub-contract with the community treatment provider.<sup>10</sup>

In the criminal justice system, it has been found prison diversion initiatives are effective at reducing drug use and the evidence points to opioid substitution treatment as an important driver of crime reduction, with reduced offending compared to the time people spend in treatment. It is important that local areas ensure that there are robust and integrated pathways between treatment and all

points of the criminal justice system, including pathways between prison and community-based treatment, to ensure the crime reduction benefits of treatment can be realised.<sup>9</sup>

It is imperative as a Public Health system we examine how to minimise the factors which predispose people to use drugs in harmful ways. Problematic use and harm are associated with upstream factors including socioeconomic deprivation<sup>11</sup> and adverse childhood experiences<sup>12</sup>, which predispose individuals to a range of health and social disadvantages. Social factors, including housing, employment and deprivation, act as moderators of drug treatment outcomes, with clear negative associations between outcomes and neighbourhood deprivation, housing problems and unemployment have been found to exist. It is important to recognise that integrated support is required to navigate through these complex systems of support for housing, treatment, health care and social care. There is evidence that housing insecurity may contribute to an increased risk of relapse.<sup>9</sup> Prevention programmes delivered through a multitude of partners in various settings (e.g. home, school, workplace, throughout the community) are most likely to lead to positive outcomes. These interventions may not be substance use specific and may specially target the wider determinants of health. It is therefore important to recognise the impact a successful drugs and alcohol service has on the wider public health system e.g. homelessness, unemployment, premature mortality.

It is important that treatment services are able to be responsive to changing or new patterns of drug use. The development of new referral pathways and partnerships to reach new and emerging groups of users will be essential, as will a workforce with the competences to work with new users and patterns of use.<sup>9</sup>

The Public Health community is united in the opinion that current legislation may create barriers to the provision of innovative, evidence-based harm reduction interventions. Interventions including overdose prevention centres, heroin assisted treatment and drug checking services have promising association with reducing riskier drug taking behaviours and drug related harm.<sup>131415</sup>

- **Overdose prevention centres:** This is a centre where the most vulnerable can use drugs under the supervision of trained professionals who intervene in the event of an overdose. These services are currently provided in at least 15 countries and an unsanctioned service operated in Glasgow in 2020-2021.<sup>16</sup> Available evidence demonstrates various benefits of the sites, including reductions in drug related deaths where they were introduced and increased engagement with drug treatment services.<sup>1317</sup> More research is needed to evaluate the impacts and cost-effectiveness of the sites, however worries that providers

would be committing offences under the Misuse of Drugs Act create a barrier to introducing pilots and conducting research in the UK.<sup>18</sup>

- **Heroin assisted treatment:** This comprises of the prescription of diamorphine for people with opioid dependence who did not respond to methadone and buprenorphine. Heroin assisted treatment is provided in various countries, notably including Switzerland, where the approach has been embraced since legislative change in 1998.<sup>19</sup> Studies in the UK and internationally have demonstrated the benefits of heroin assisted treatment, including reductions in illicit heroin use and increased retention in drug treatment.<sup>14</sup> Provision of heroin assisted treatment remains limited in the UK despite the successful implementation of pilot services.<sup>20</sup> This may be related to its significant costs; however, evidence demonstrates these are compensated by savings for other services, including related to reductions in acquisitive crime.<sup>21</sup>
- **Drug checking services:** This is where people who use drugs can test their substances before consuming them, to ascertain whether they are adulterated or particularly dangerous. These services provide an opportunity to engage people not in contact with drug treatment services and provide harm reduction advice. Whilst limited drug checking services are provided in the UK, they are more widely available in other countries, notably including the Netherlands, where the nationally funded Drugs Information Monitoring System (DIMS) has operated across a network of sites since 1992.<sup>22</sup> Available evidence demonstrates drug checking services can influence the behaviour of people who use drugs to deter the use of more dangerous substances, whilst providing an opportunity to monitor the substances in circulation.<sup>15</sup> Provision of public facing drug checking services has decreased in the UK since a Home Office licensed serviced briefly opened in 2019.<sup>23</sup>

It would be possible to increase the provision of heroin assisted treatment and drug checking without changing existing legislation in the UK, whilst the provision of overdose prevention centres would require minor changes to existing legislation or the institution of new legislation giving statutory protection to providers.

## 7. Emerging Issues

### 7.1. Chemsex

“Chemsex” is used to describe intentional sex under the influence of psychoactive drugs, mostly among men who have sex with men. It refers particularly to the use of mephedrone,  $\gamma$ -hydroxybutyrate (GHB),  $\gamma$ -butyrolactone (GBL) and crystallised methamphetamine.<sup>24</sup> These drugs are often used in combination to facilitate sexual sessions lasting several hours or days with multiple

sexual partners. Due to the sexually disinhibiting nature of the 'high' provided, it is often associated with a sense of invulnerability to harm or risk. This can translate into reduced concern for safer sex practices and feelings of confidence, being sexually adventurous, heightened sense of pleasure, stamina, and endurance that may last for days without sleep. Unwanted side effects while under the influence can include aggression, paranoia, hallucinations and overdose.

In relation to ChemSex interventions, there is no gold standard for treatment. Anecdotal evidence suggests there is a reluctance of users to use drug treatment services as they are seen as “not relevant” and may face additional stigma from these services. It is necessary for ChemSex interventions to be delivered in partnership with the recognition that sexual health and substance use will need to work together to deliver early and potentially different interventions for these users.

## 7.2. Local Intelligence

Leicestershire Police, Turning Point and members of the Leicester, Leicestershire and Rutland Substance Misuse Community Safety Partnership contribute to a Drug Alert System that aims to share information regarding areas of concern, emerging threats and current issues regarding drugs to relevant local partners quickly and efficiently. The latest emerging threats (as of September 2022)<sup>25</sup> have been prioritised as:

- Adverse reactions from Cannabis Edibles
- Counterfeit Alprazolam (Xanax)
- Lean (Purple Drink/Syrup)

# 8. Population at Risk of Substance Use

## 8.1. Children and Young People

The Government’s Drug’s Strategy, *From Harm to Hope*<sup>26</sup>, focuses on preventing the onset of substance use by building resilience in young people and supporting young people and families at risk of substance use. The data below examines the key indicators increasing the likelihood of misusing substances.

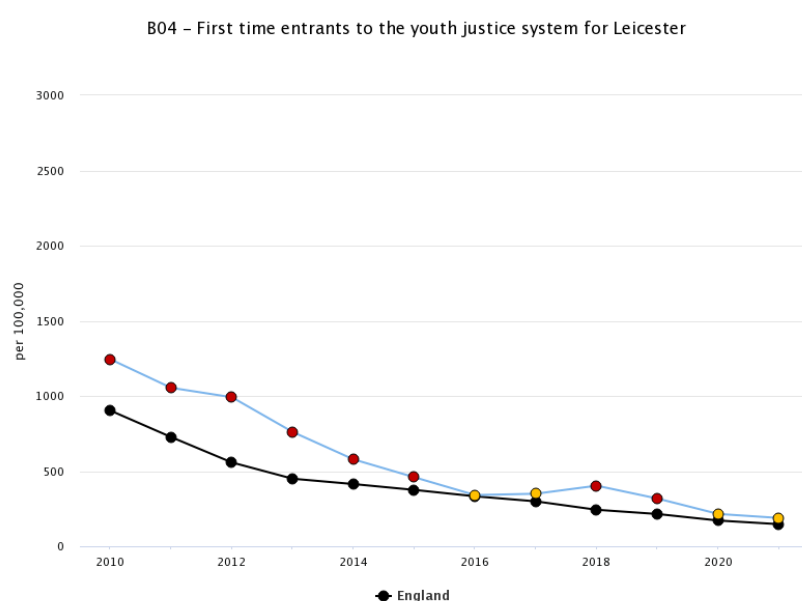
### 8.1.1. Youth Justice

First time entrants to the youth justice system are children aged 10-17 who receive their first youth caution or court sentence. Approximately 13% of offences committed by these young people were drug offences, and substances may be a factor in other offences. Youth justice, particularly Youth Offending Teams, are a major source of referrals into drug and alcohol treatment for young people.



Figure 1 shows both nationally and locally the trend in first time entrants to the youth justice system have significantly declined over the last five years. The rate for Leicester City has remained higher than the national average since recording but performs similar to the national average for the latest two data points. In 2021, 67 juveniles receiving their first conviction, caution or youth caution equating to a rate of 188.2 per 100,000 population aged 10-17 years. Nationally the latest rate is 146.9 per 100,000 population.

*Figure 1: Rate of 10 to 17 year olds receiving their first reprimand, warning or conviction per 100,000 population in Leicester and England*



### 8.1.2. Looked After Children

Looked after children are a vulnerable group who are at higher risk of substance use. In Leicester, there were 489 looked after children 2020/21, with 4% identified as having a drug and alcohol problem. Nationally, 44% of children looked after with an identified drug and alcohol problem received an intervention which includes non-structured interventions. In Leicester City, the percentage was 100%.<sup>27</sup> Nationally, 8% of young people in community structured substance use treatment are children looked after.

*Table 1: Looked after children identified for their substance use problem and receiving an intervention, Leicester and England, 2020-21<sup>27</sup>*

Area	Number of LAC	No. identified as having a SM problem	% identified as having a SM problem	No. who received an intervention	% who received an intervention
Leicester	489	22	4%	22	100%
England	59,050	1760	3%	770	44%

### 8.1.3. Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences, or ACEs, are potentially traumatic events that occur in childhood such as experiencing violence, abuse, or neglect; witnessing violence in the home; and having a family member attempt or die by suicide. Also included are aspects of the child's environment that can undermine their sense of safety, stability and bonding such as growing up in a household with substance abuse, mental health problems, or instability due to parental separation or incarceration of a family member.

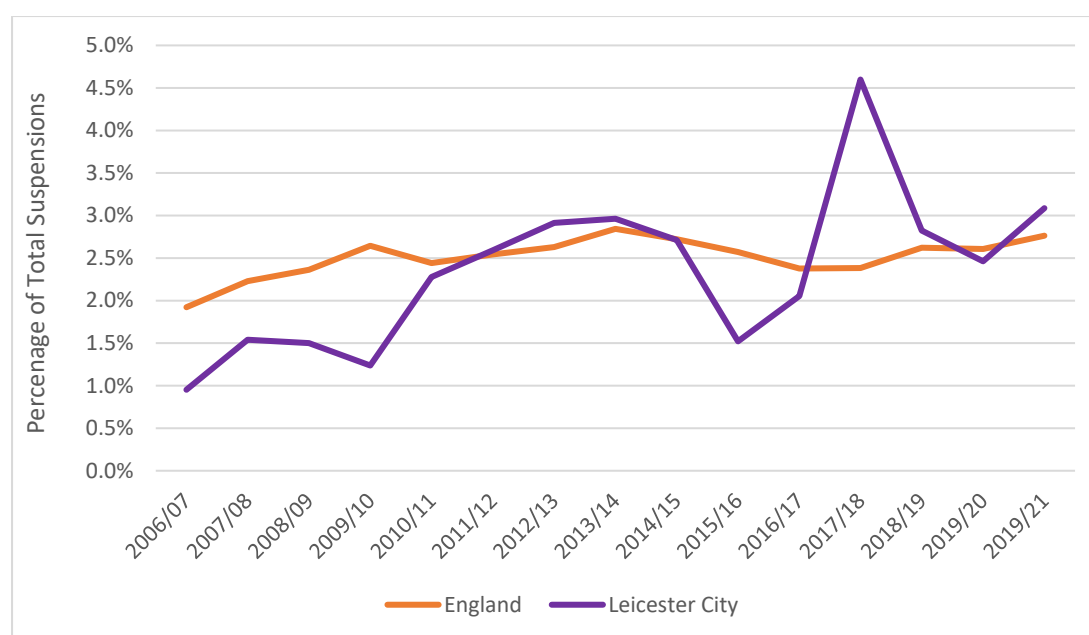
Adverse childhood experiences are well known to negatively impact mental and physical health across the life course. From a prevention perspective, reducing adversity is essential to improve mental well-being and health-harming behaviours and their combined contribution to non-communicable disease. Such impacts may be substantively mitigated by having support from an adult you trust in childhood.<sup>28</sup>

For those adults who had experienced ACEs in their childhood, providing 'trauma-informed' care should ensure that service users of health and social care services are routinely asked if they suffered ACEs in their childhood. This allows professionals to tailor their support to the person's prior experiences, and potentially to help service users better understand how their experiences had impacted them. It is also important that services asking about childhood adversity can provide or refer people to the appropriate support following investigation.<sup>29</sup>

### 8.1.4. Permanent Exclusions and Suspension from School

In Leicester, there were 6 permanent exclusions and 1,382 suspensions from state-funded schools in the 2020-21 academic year, including 51 drug and alcohol related suspensions. There were no permanent exclusions related to drug and alcohol.<sup>30</sup> Figure 2 shows the trend of percentage of suspensions due to drug and alcohol. The local percentages are variable due to the small numbers but infer an increasing trend compared to national. Schools are an important part of any young people's drug strategy, for building resilience, for early prevention, to identify substance use and refer into specialist treatment services. Being excluded and or suspended from school can have a negative effect on young people and increase their vulnerability to problematic substance use.

Figure 2: Percentage of suspensions from school for drug and alcohol in Leicester and England



## 8.2. Adults

### 8.2.1. Sexual Orientation

The Crime Survey for England & Wales concluded that gay and bisexual men were three times higher (33%) than heterosexual men (11.1%) to have taken any illicit drug in the last year. For lesbian and bisexual women use is more than four times as high (22.9%) than for heterosexual women (5.1%).<sup>31</sup>

### 8.2.2. Criminal Justice System

There is a relationship between substance use and crime. Heroin and crack cocaine addiction is linked to almost half of all acquisitive crime, including burglary, robbery and theft<sup>32</sup> and drugs contribute to almost half of all homicides.<sup>33</sup> Higher levels of alcohol-related recorded crimes and violent crimes are likely to be linked to increased drinking and the night-time economy. Alcohol is also a common feature in sexual assaults.

Liaison and Diversion (L&D) services identify people who have mental health, learning disability, substance use or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. The service can then support people through the early stages of criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required.

Table 18 and Table 19 identified in 2021/22, 26 youth cases had suspected harmful, hazardous or dependent drinking and 62 youth cases identified problematic or dependent substance use, however it is important to recognise that polydrug use is common. Of the substance use cases

identified, 71% cases had suspected substance use only and 26% had suspected substance use and alcohol misuse identified. In comparison, much smaller proportion of cases were likely to misuse alcohol only (26%). The majority (62%) who were suspected of alcohol misuse misused substances too. The majority of the referrals received were from police custody (82%) and youth court (9%).<sup>34</sup>

*Table 2: Counts of youth cases where Liaison and Diversion services were accepted by suspected alcohol misuse in Leicester City, 2019/20-2021/22*

<b>Drinking Level</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
Harmful or Hazardous	*	9	17
Dependence	*	15	9
No Problem	362	317	150
Unknown	*	10	64
<b>Total</b>	<b>365</b>	<b>351</b>	<b>240</b>

*Table 3: Counts of youth cases where Liaison and Diversion services were accepted by suspected substance use in Leicester City, 2019/20-2021/22*

<b>Substance Use</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
Problematic	*	51	27
Dependence	*	52	35
No Problem	362	240	109
Unknown	*	8	69
<b>Total</b>	<b>365</b>	<b>351</b>	<b>240</b>

Table 20 and Table 21 identified in 2021/22, 119 adult cases had suspected harmful, hazardous or dependent drinking and 118 adult cases identified problematic or dependent substance use. Approximately half (48%) of adult cases identified have suspected drinking and substance use behaviour. A similar proportion were suspected of alcohol use only (45%) and substance use only (43%) in the adult cases. The majority of the referrals received were from police custody (66%) and magistrate court (28%).

*Table 4: Counts of adult cases where Liaison and Diversion services were accepted by suspected alcohol use in Leicester City, 2019/20-2021/22*

<b>Drinking Level</b>	<b>2019/20</b>	<b>2020/21</b>	<b>2021/22</b>
Harmful	67	43	62
Hazardous	43	54	14
Dependence	65	80	43
No Problem	549	340	190
Unknown	14	29	317
<b>Total</b>	<b>738</b>	<b>546</b>	<b>626</b>

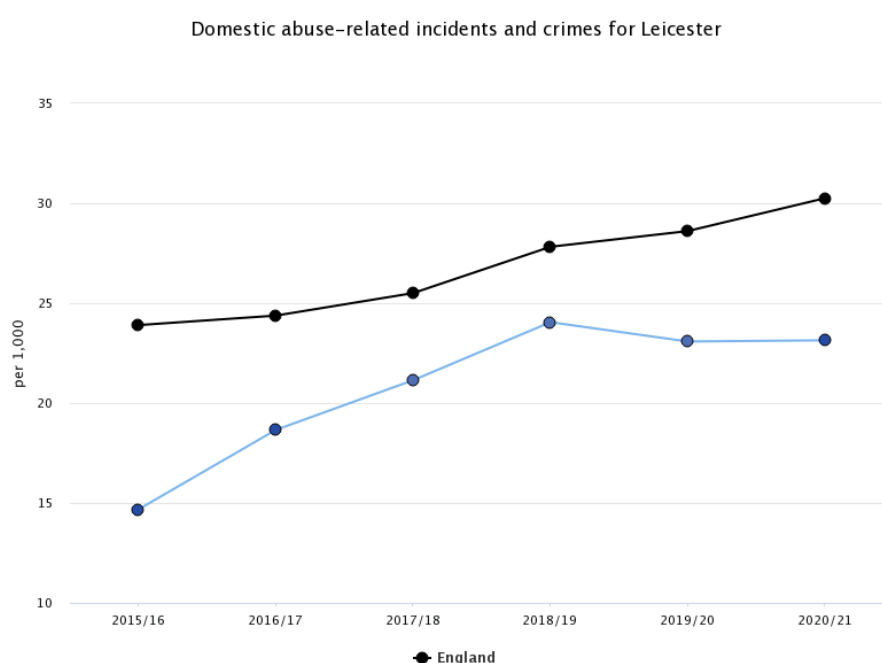
Table 5: Counts of adult cases where Liaison and Diversion services were accepted by suspected substance use in Leicester City, 2019/20-2021/22

Substance Use	2019/20	2020/21	2021/22
Problematic	179	127	70
Dependence	82	75	48
No Problem	462	322	195
Unknown	15	22	313
<b>Total</b>	<b>738</b>	<b>546</b>	<b>626</b>

### 8.2.3. Domestic Violence

Substance abuse may be a cause of domestic violence. There is also a growing body of research which describes the use of substances by women to cope with the psychological and physical harm resulting from their experiences of violence.<sup>35</sup> Figure 3 examines the trend in domestic abuse related incidents and crime in Leicester, Leicestershire and Rutland. The indicator cannot be examined by Leicester City only due to the geography the police force covers. Between 2015/16 and 2020/21 the rate of incidents remained below the national average and have stabilised over the last three years. However, it must be noted that the majority of domestic abuse incidents are not recorded and so the real unmet need is likely to be much higher.

Figure 3: Trend in Domestic abuse-related incidents and crimes in Leicester, Leicestershire and Rutland Police Area, 2015/16 – 2020/21



#### 8.2.4. Individuals with a Mental Health Need

The prevalence of co-existing mental health and substance use problems (termed “dual diagnosis”) may affect between 30-70% of those presenting to health and social care settings. There is growing awareness of the serious social, psychological and physical complications of the combined use of substances and mental health problems. Given the multiplicity of social, family and economic problems associated with dual diagnosis, an integrated, multi-agency approach is required.<sup>36</sup>

#### 8.2.5. Sex Workers

Sex work in Leicester that has a risk to health is divided into three areas: street based sex workers (SBSW), Sex workers in flats and Sex workers working in saunas and massage parlours. The number of women involved in each of these areas of sex work fluctuates and the level of vulnerability and sexual risk taking behaviour varies between each of these types of venue.<sup>37</sup>

SBSW have multiple and complex problems, most have substance use issues, which drives or exacerbates their need to earn money from selling sex. Their health needs include substance addiction, mental and physical health problems. Many SBSW have been in the care system as a child. In Leicester the majority of SBSW are of white British ethnicity, with a small group of Eastern European women. It is important to build a relationship of trust with SBSWs to provides insight and information that is useful to the police and others about the sex industry in Leicester.<sup>37</sup>

#### 8.2.6. Homeless

Individuals who are homeless are at greater risk of using substances and having reduced motivation to change their lifestyle. Additionally, their transient nature could reduce their access to health and social care services. In the city, a significantly high proportion of individuals attending the community treatment provider for alcohol (15.5%) or substance use treatment (32.9%) have a housing problem. At the time of writing, Leicester City Council are currently undertaking a Rapid Health Needs Assessment for Rough Sleepers which will be published in 2023.

## 9. Patterns of Alcohol Consumption

### 9.1. National Guidelines

As alcoholic drinks come in different strengths and sizes, alcohol units are used to provide a standardised measure of how much alcohol a person consumes. One unit is 10ml or 8g of pure alcohol.

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:

Table 1: Units of alcohol per week and levels of risk

Weekly units of alcohol	Up to 14 units	14-21 units	21-35 units	35-50 units	50+ units
Men	Low risk	Increasing risk			High risk
Women	Low risk	Increasing risk		High risk	

Source: UK Chief Medical Officers' Alcohol Guidelines Review, 2016

- 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 the following categories:

- Lower-risk drinkers: up to 14 units per week.
- Increasing-risk drinkers: regularly drinking 14-35 units per week in women, 14-50 units per week in men.
- Higher-risk drinkers: regularly drinking above 35 units in women, above 50 units per week in men.
- Binge drinking is defined as drinking 6+ units (women) or 8+ units (men) in a single session)

Alcohol dependence is a disorder of regulation of alcohol use arising from repeated or continuous use. It is characterised as a strong internal drive to use alcohol with the inability to control use despite harm or negative consequences that arise.

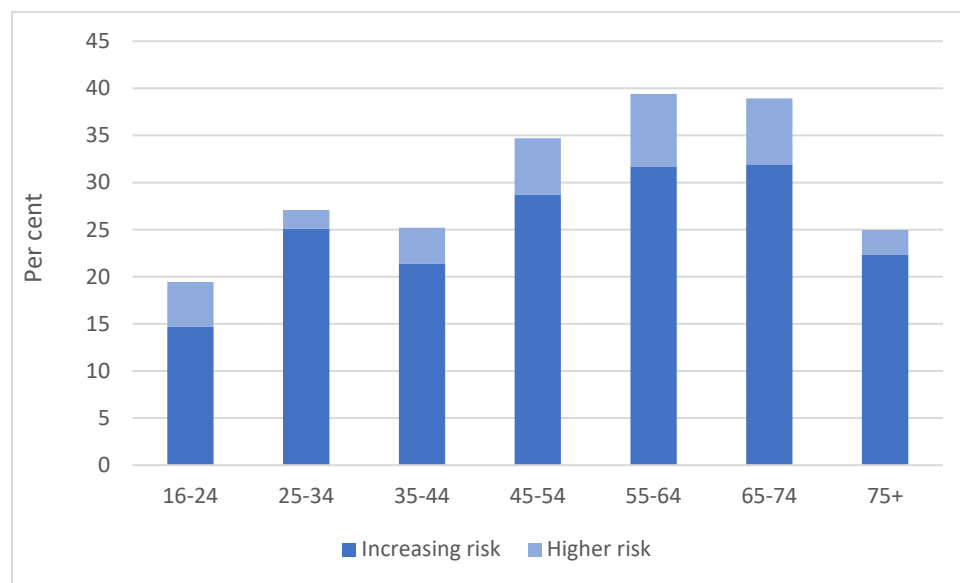
## 9.2. National Patterns of Alcohol Consumption

The Health Survey for England (HSE) is an annual survey designed to measure health and health-related behaviours in adults and children in England. Alcohol consumption is one area that is investigated in the 2019 survey.<sup>38</sup>

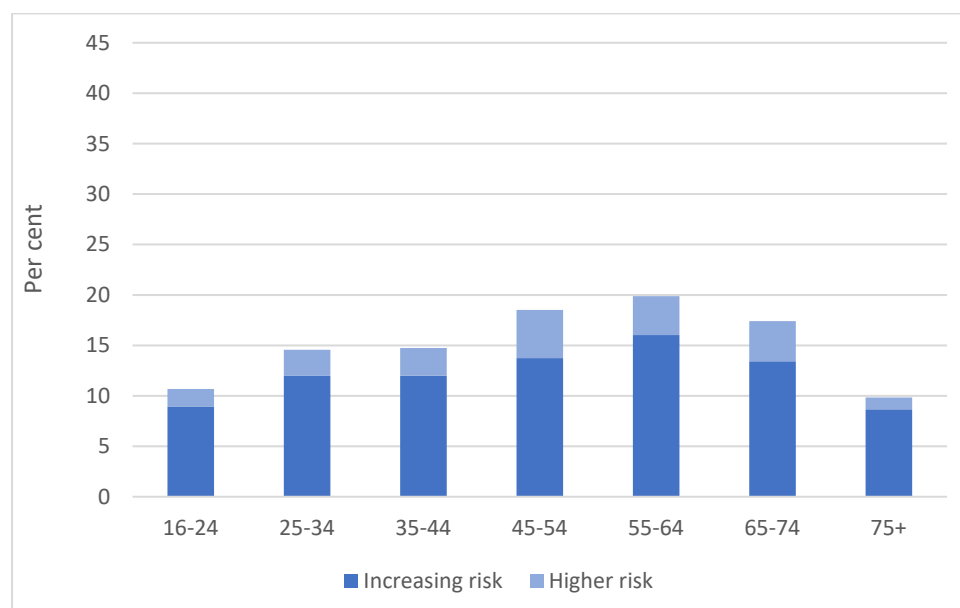
Figure 4 shows the proportion of men and women usually drinking over 14 units in a week varied across age groups and was most common among men and women aged 55 to 64 (39% and 20% respectively). Proportions drinking at these levels then declined among both sexes from the age of 65. In 25-34 years age group, females had a higher proportion of higher risk drinking (3%) compared to males (2%), however across all other age groups, men were more likely than women to drink at increasing and higher risk levels.<sup>38</sup>

Figure 4: Proportion of adults (aged 16 and over) drinking at increased or higher risk of harm, by age and sex<sup>38</sup>

(i) Men



(ii) Women

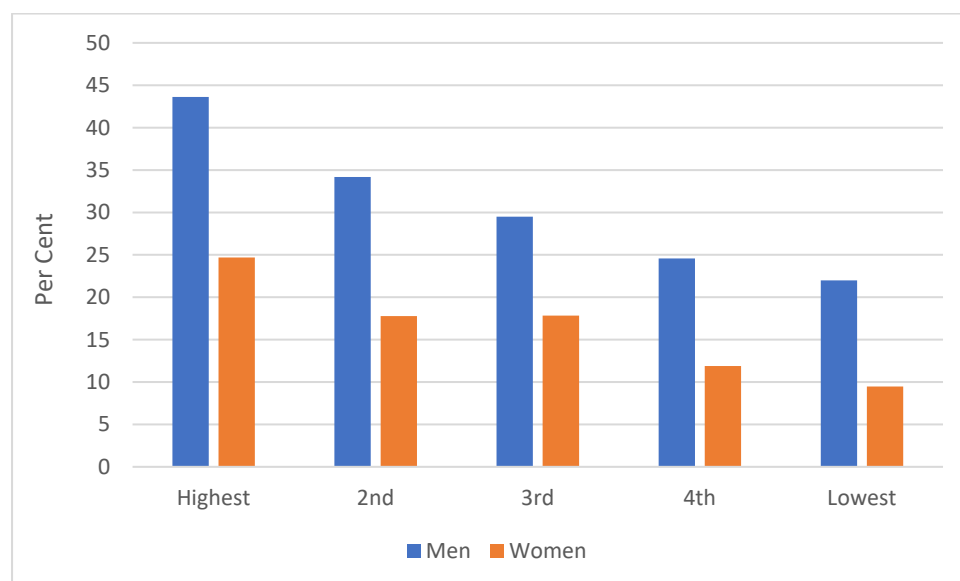




The HSE found the proportion of adults who were non-drinkers was highest in most deprived areas (33%) compared with 10% in the least deprived areas. Adults drinking at increased or higher risk levels was higher in least deprived areas (35%) than most deprived areas (15%). Almost half (44%) of men in the least deprived areas drank at increasing and higher risk levels, compared with less than a quarter (22%) of men in the most deprived areas. Women followed this pattern too, with 25% of women in the least deprived areas drinking more than 14 units compared with 10% of women in the most deprived areas.<sup>38</sup>

Interestingly, the variation in weekly alcohol consumption by deprivation was accounted for by differences in the proportions of men and women drinking at increasing levels of risk (that is, over 14 units and up to 50 units for men and over 14 units and up to 35 units for women) rather than the higher risk category (over 50 units for men and over 35 units for women). The proportion of men and women drinking at higher levels of risk was similar by IMD quintile.<sup>38</sup>

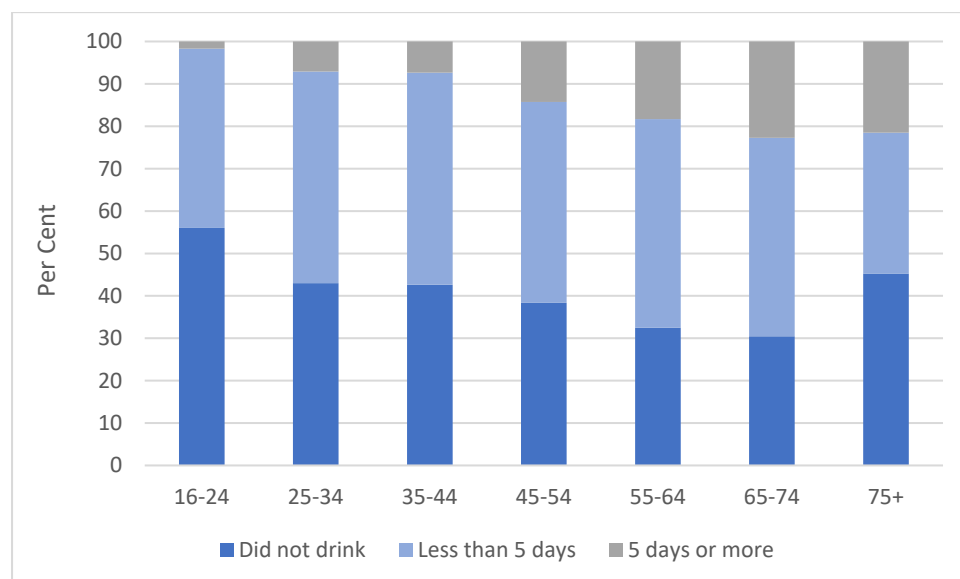
*Figure 5: Proportion of adults drinking at increased or higher risk of harm, by Household Income and Sex<sup>38</sup>*



Over half of all adults (54%) drank alcohol in the last week and 10% of adults drank on five or more days. The proportions who reported drinking in the last week increased with age from 41% of 16 to 24 year olds to 62% of those aged between 55 and 74 years old but was much lower in the oldest age group (47% of those aged 75 and over). Interestingly, the proportions of those who drank alcohol on five or more days in the last week increased with age and was highest in the retired age groups (18% of 65 to 74 years old and 17% of adults aged 75 and over). This pattern is witnessed in both men and women.<sup>38</sup>

Figure 6: Number of days on which drank alcohol in the last week, by age and sex<sup>38</sup>

(i) Males



(ii) Females

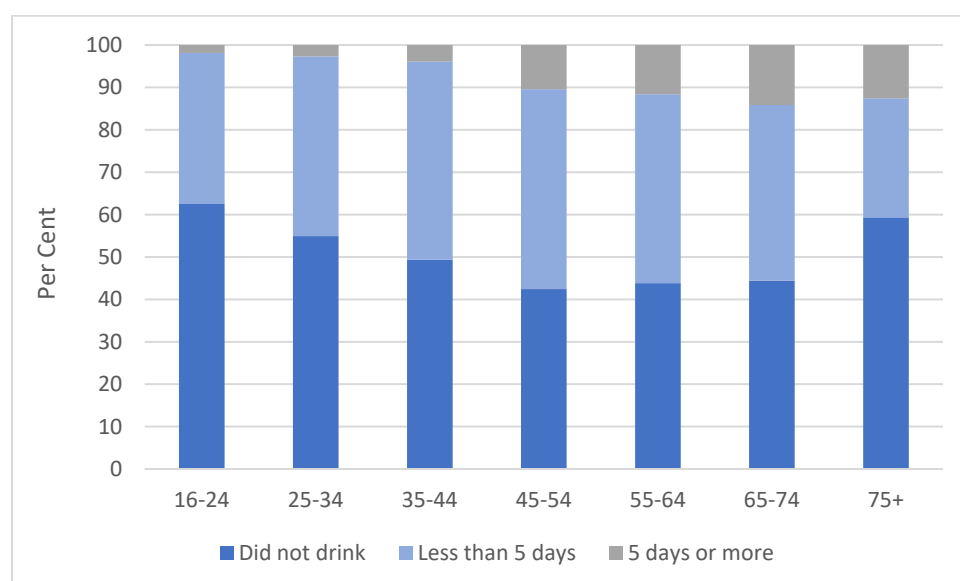
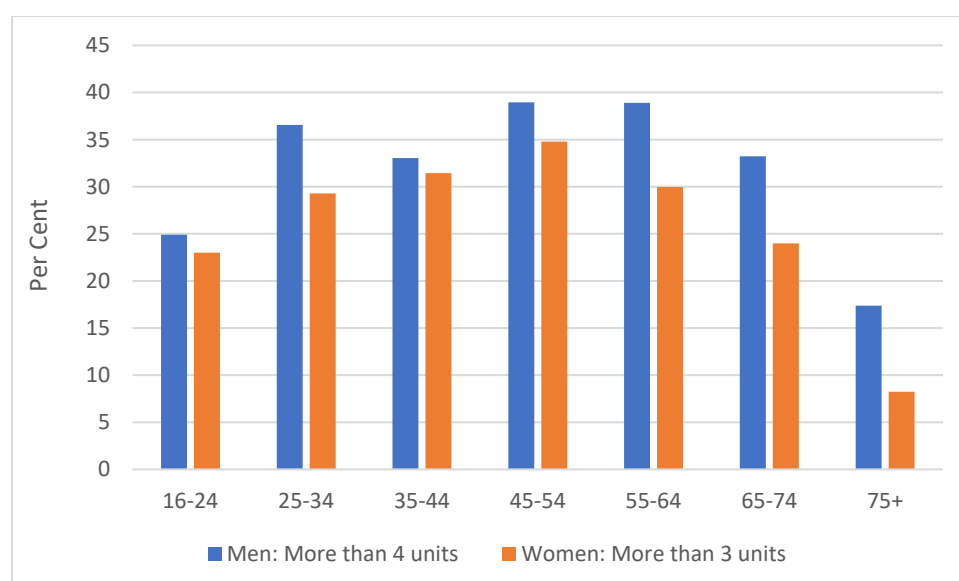


Figure 7 shows men were more likely than women to drink more than the recommended daily limit (33% compared with 27%). Across all age groups, a smaller proportion of women than men drank more than the recommended daily limit. The proportion of all adults who drank more than three units (women) or four units (men) on any day in the last week increased with age from 24% of 16 to 24 year olds to 37% of 45 to 54 year olds and then gradually decreased to 12% of participants aged 75 and over.<sup>38</sup>

Figure 7: Maximum amount drunk on any day in the last week, by age and sex<sup>38</sup>



It is important to note, the HSE in common with other surveys, collects information from a sample of the population. Although the sample is designed to represent the whole population as accurately as possible, it is important to be reminded that the statistics presented above are estimates, rather than precise figures and are subject to a margin of error.

The impact of COVID-19 has generated concern throughout the Public Health community with respect increased levels of alcohol consumption. PHE published a major report on alcohol consumption and harm during COVID-19 which summarised existing surveys and analysed alcohol purchasing data. Among existing surveys that measured participants' drinking before the pandemic, these found there was a 58.6% increase in the proportion of respondents drinking at increasing risk and higher risk levels. This data showed a step-change around the time the pandemic began, where the prevalence of increasing risk and higher risk drinking increased and then continued to be higher than previous years throughout the pandemic year. Furthermore, people who reported drinking more during the pandemic than before tended to be heavier drinkers.<sup>39</sup> The above research was collected from cross-sectional surveys which gives high quality evidence compared to surveys and polls of lower quality where various reporting methods used.

It has been widely discussed the impact of the COVID-19 pandemic widening existing health inequalities. A separate study (which used the same off trade alcohol purchasing data as the PHE analysis above) compared off-trade alcohol purchasing in 2020 with 2015-19, finding that alcohol purchasing increased the most in more deprived households and in the higher alcohol purchasing households.<sup>40</sup>

Recently released data from Office of National Statistics (ONS) shows in 2021, there were 9,641 deaths (14.8 per 100,000 people) from alcohol-specific causes registered in the UK, the highest number on record. The number recorded in 2021 was 7.4% higher than in 2020 (8,974 deaths; 14.0 per 100,000) and 27.4% higher than in 2019 (7,565 deaths; 11.8 per 100,000), the last pre-coronavirus (COVID-19) pandemic year. Alcohol-specific deaths have witnessed a statistically significant increase in rate since the onset of the coronavirus (COVID-19) pandemic in the United Kingdom, with alcoholic liver disease the leading cause of these deaths. This rise is likely to be the result of increased alcohol consumption during the pandemic.<sup>41</sup>

### 9.3. Local Patterns of Alcohol Consumption

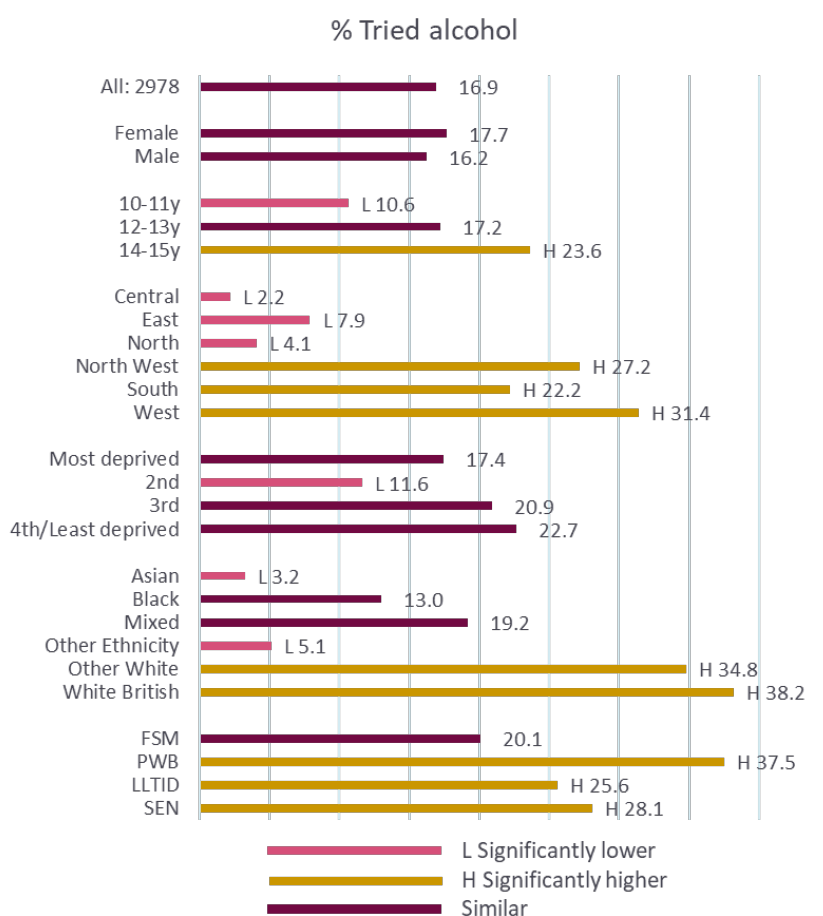
#### 9.3.1. Children and Young People

Over 3,000 10 to 15 year old children participated in the Leicester Children's Health and Wellbeing Survey in 2021/22. The survey sample was weighted against the known school aged population using the Leicester School Census (Spring 2022) to ensure survey responses were representative of the Leicester school population.

Children were asked 'How often do you drink alcohol? (more than just a sip)'. Around one in six children (17%) have tried alcohol, with one in one hundred children (1%) drinking alcohol at least once a week. Almost one quarter of 14-15 year olds have tried alcohol, this is significantly more than the proportion for 10-11 and 12-13 year olds. A significantly larger proportion of respondents in the North West, South and West of Leicester have tried alcohol. Children of White British or Other White ethnicity are significantly more likely to have tried alcohol, whilst those of Asian or Other Ethnicity heritage are significantly less likely to have tried alcohol. Children reporting a poor mental wellbeing, a long term illness or special educational need are significantly more likely to have tried alcohol.

There was no significant difference between the proportion of children that reported that they had tried alcohol (more than just a sip) in the 2021/22 survey (17%) and the proportion of children that reported drinking more than a sip of an alcoholic drink in the 2016/17 survey (15%).<sup>42</sup>

Figure 8: The proportion of respondents who had tried alcohol (more than just a sip) by demographic



**Deprivation Quintiles:** Most deprived (Living in 20% most deprived areas nationally and 4<sup>th</sup>/Least deprived (living in the 40% least deprived areas nationally)

**Additional groups:** FSM- Free School Meals

PWB – Poor Wellbeing

LLTID – Long term limiting illness or disability

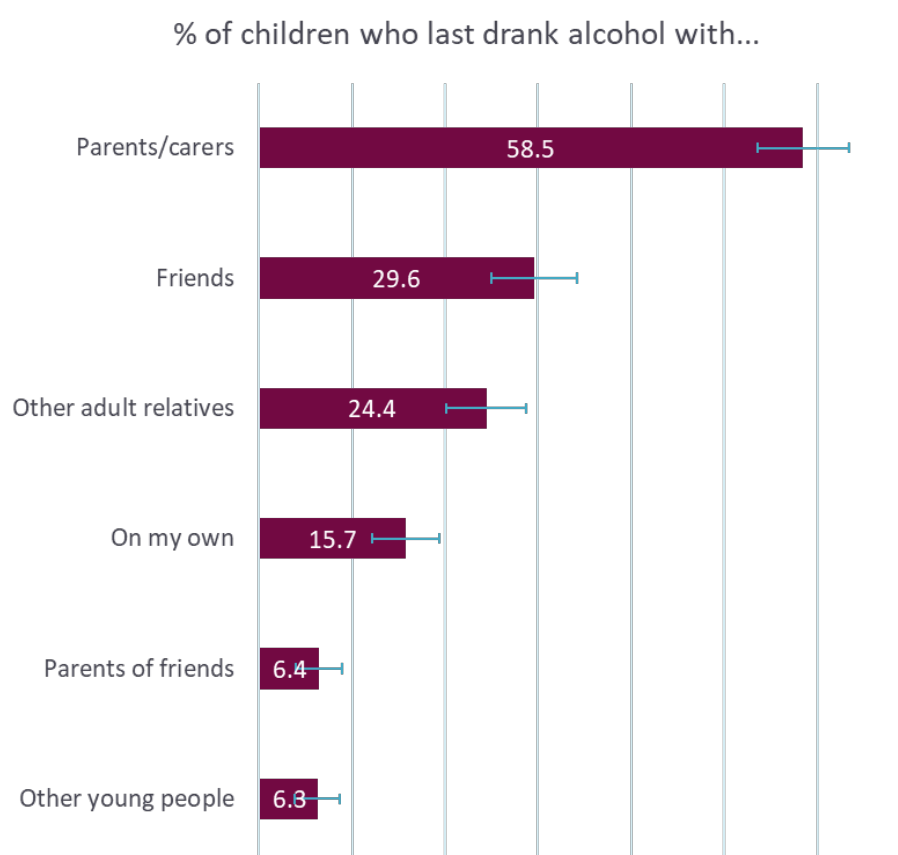
SEN Special Educational Need

Secondary aged children that had reported that they had tried alcohol were asked ‘Thinking about the last time you had an alcoholic drink, with whom did you drink it?’. The majority (59% of this group) last drank alcohol with their parents/carers. A significantly larger proportion of children had their last alcoholic drink with their parents/carers than with any other group. A significantly larger proportion last drank alcohol with their friends or other adult relatives than on their own, with parents of friends or with other young people. Around a sixth (16%) of secondary age children drank their last alcoholic drink on their own.

Interestingly, a cohort study from Australia examined the link between parental supply of alcohol to adolescents and the effects on their drinking. This showed parental supply of alcohol to adolescents was associated with increased risk of drinking, but not bingeing. These parentally-supplied children

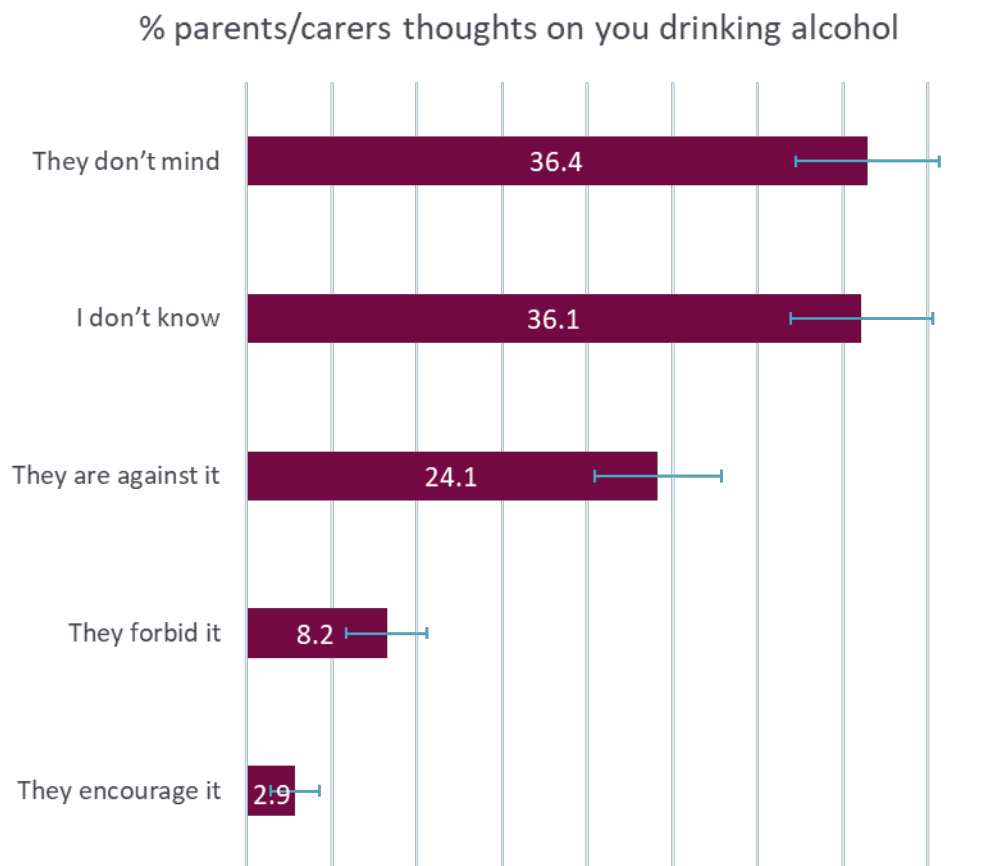
also consumed fewer drinks on a typical drinking occasion, whereas adolescents supplied alcohol from non-parental sources had greater odds of drinking and bingeing. Further research is needed to examine alcohol harm trajectories of these patterns.<sup>43</sup>

Figure 9: The proportion of secondary aged children that had last drank alcohol with their parents/carers, friends, other adult relatives, on their own, parents of friends or other young people



Children who had tried alcohol were asked 'What do your parents/carers think about you drinking alcohol?'. A small proportion of children (3%) reported that their parents/carers encourage them to drink alcohol. Most children reported that their parents/carers don't mind that they drink alcohol (36%) or that they don't know what their parents/carers thoughts are on them drinking alcohol (36%). About a quarter of children reported that their parents/carers are against them drinking alcohol (24%), and a further 8% reported that their parents/carers forbid them to drink alcohol. The proportion of children which reported that their parents/carers encourage them to drink alcohol was significantly smaller than the proportion of children reporting any of the other parent/carer thoughts.

Figure 10: Parents/carers thoughts on their children drinking alcohol



### 9.3.2. Adults

At Local Authority level, there is a lack of reliable information about alcohol consumption, primarily because of the cost of collecting this data. In order to address the need for local data in a cost effective manner, PHE commissioned Ipsos MORI to collect data for a sample of local authorities which were chosen to provide coverage of all regions and types of local authority. Leicester City was one of these local authorities included in the sample.

The majority of the data were collected via a postal survey between 29 February and 25 April 2016. After data cleaning, 9,683 completed postal responses were achieved, a response rate of 20% at a national level. In Leicester City, the response rate was lower, at 15% (424 responses). The survey found the lowest response rates tended to be areas with high levels of abstention, this was true for Leicester City. Figure 11 shows Leicester City has the highest rate of abstention of all local authorities surveyed at 37.6% (95% CI:33.1%-42.3%) and Figure 12 shows over a quarter (26.9%, 95% CI:21.8%-32.6%) of all drinkers were in AUDIT category 2 or more - increasing risk, higher risk or possible dependence.<sup>44</sup>

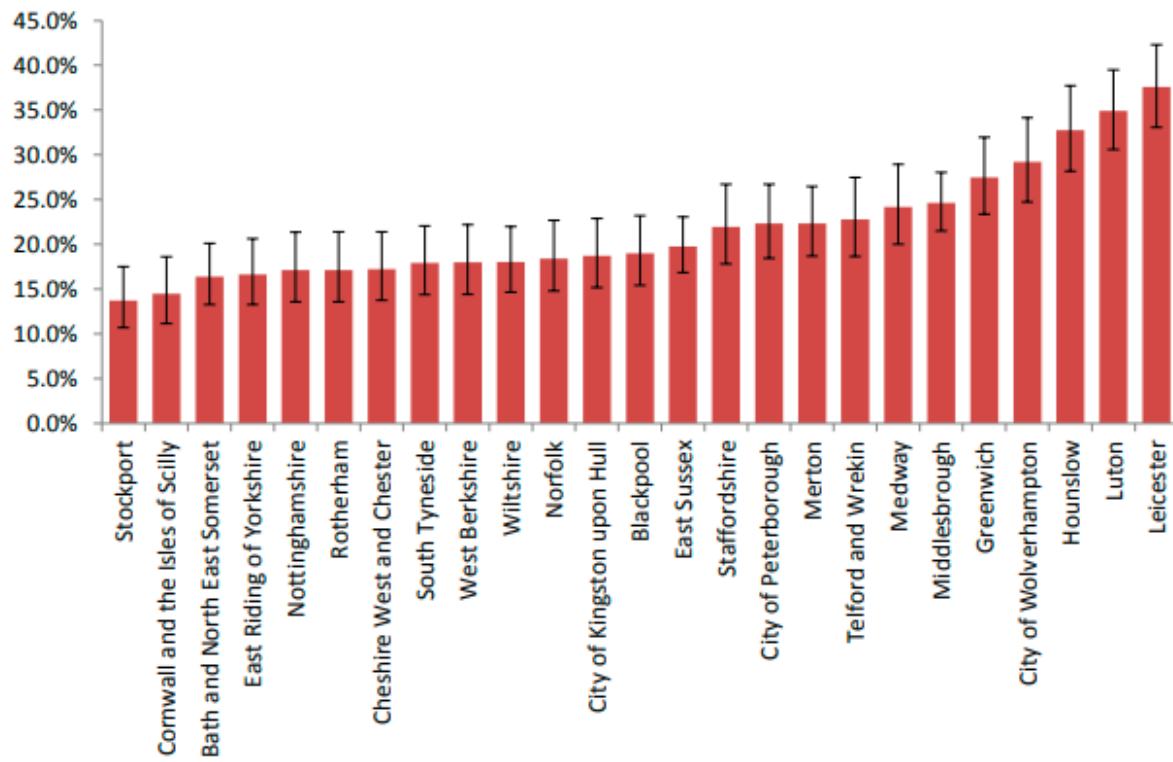
Figure 13 shows the rates of frequent drinking (amongst those who drink) varied from 8.9% in Peterborough to 21.6% in West Berkshire. In Leicester City 13.5% (95% CI:9.9%-18.2%) of drinkers, were drinking four or more days each week. Figure 14 examines the prevalence of binge drinkers defined as women drinking more than 6 units and men more than 8 units in a single drinking occasion on a weekly basis or more often. The survey found the prevalence ranged from 6.8% in Rotherham to 20.7%. In Leicester City 11.7% (95% CI:8.3%-16.2%) of drinkers were drinking more than 6/8 units of alcohol in a single occasion on a weekly or daily basis. The prevalence of frequent drinkers and regular binge drinkers in the city were ranked in the lowest third of all Local Authorities sampled. The figures highlight wide variation in alcohol behaviour between different local authorities, even local authorities which are geographically close such as Leicester City and Nottinghamshire have different profiles of drinking behaviour<sup>44</sup>.

It is important to be aware of the strengths and limitations of data collected through this manner. Validity checks conducted against established National Statistics sources have suggested that the collected data is of good quality, for example estimates of the population in the “possible dependence” group can be compared with the dependence estimates from Sheffield University.<sup>44</sup>

The limitations of the chosen methodology has the potential to affect the robustness of the results. The data have been collected through a sample survey, and although the achieved sample was 20% overall it was higher for households with older people and lower for households with young people leading to possible bias. Furthermore, any systematic biases in non-response related to alcohol consumption will affect the robustness of the analyses. It is also widely acknowledged that household surveys under-estimate population-level alcohol consumption with estimates suggesting UK surveys record between 55% and 60% of consumption compared with actual sales under-recorded in household surveys<sup>45</sup>. It is therefore reasonable to assume that the data collected for this survey will be an under-estimate.

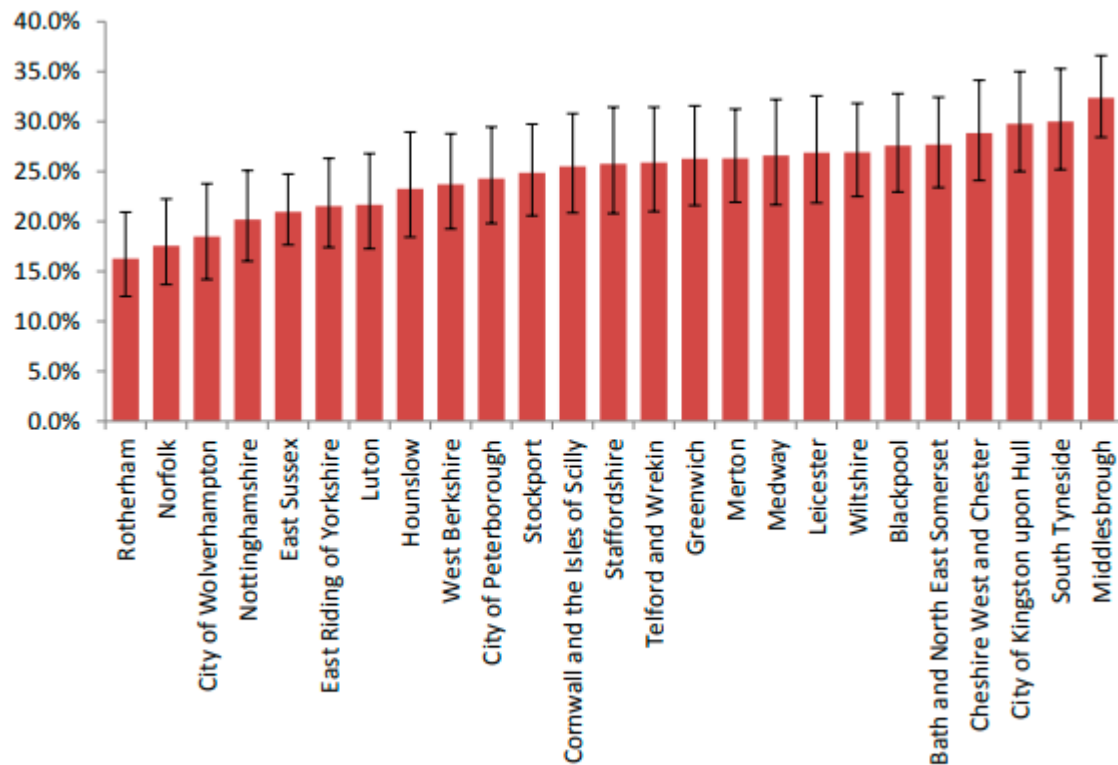


Figure 11: Rates of Abstention by Local Authority<sup>44</sup>



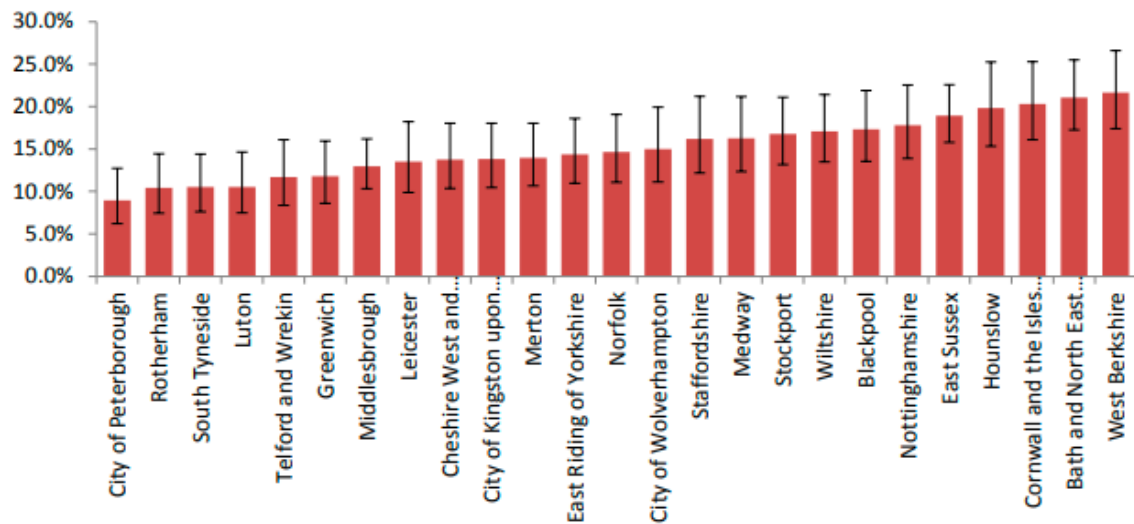
Error bars represent 95% confidence intervals

Figure 12: Percentage of drinkers in AUDIT group 2 or more by Local Authority<sup>44</sup>



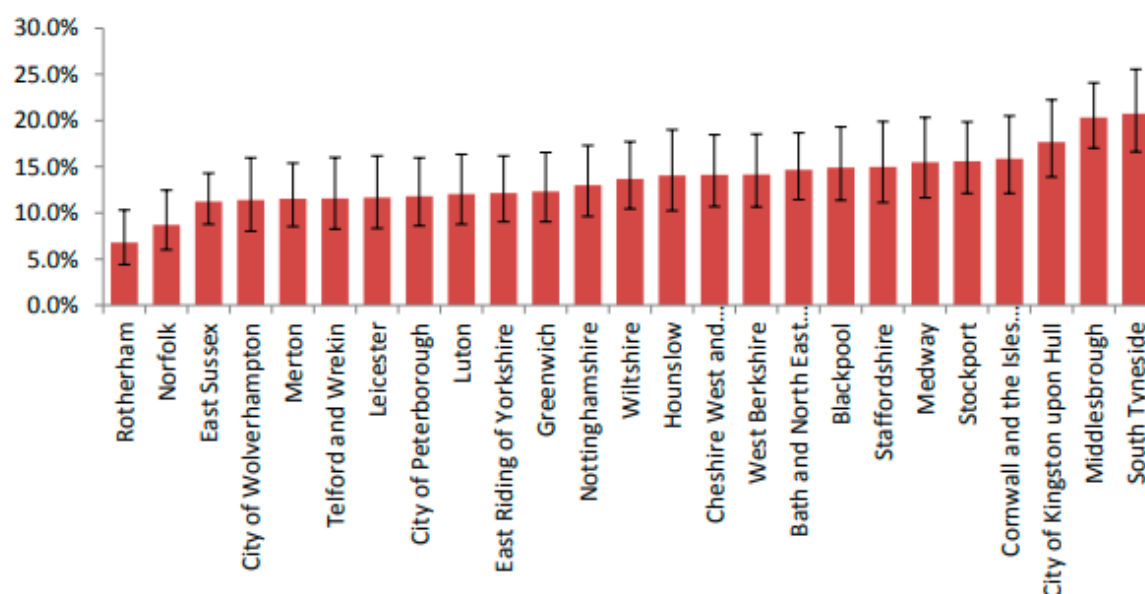
Error bars represent 95% confidence intervals

Figure 13: Percentage of drinkers who drink on 4 or more days a week by Local Authority<sup>44</sup>



Error bars represent 95% confidence intervals

Figure 14: Binge drinkers by Local Authority (as a percentage of all drinkers)<sup>44</sup>



Error bars represent 95% confidence intervals

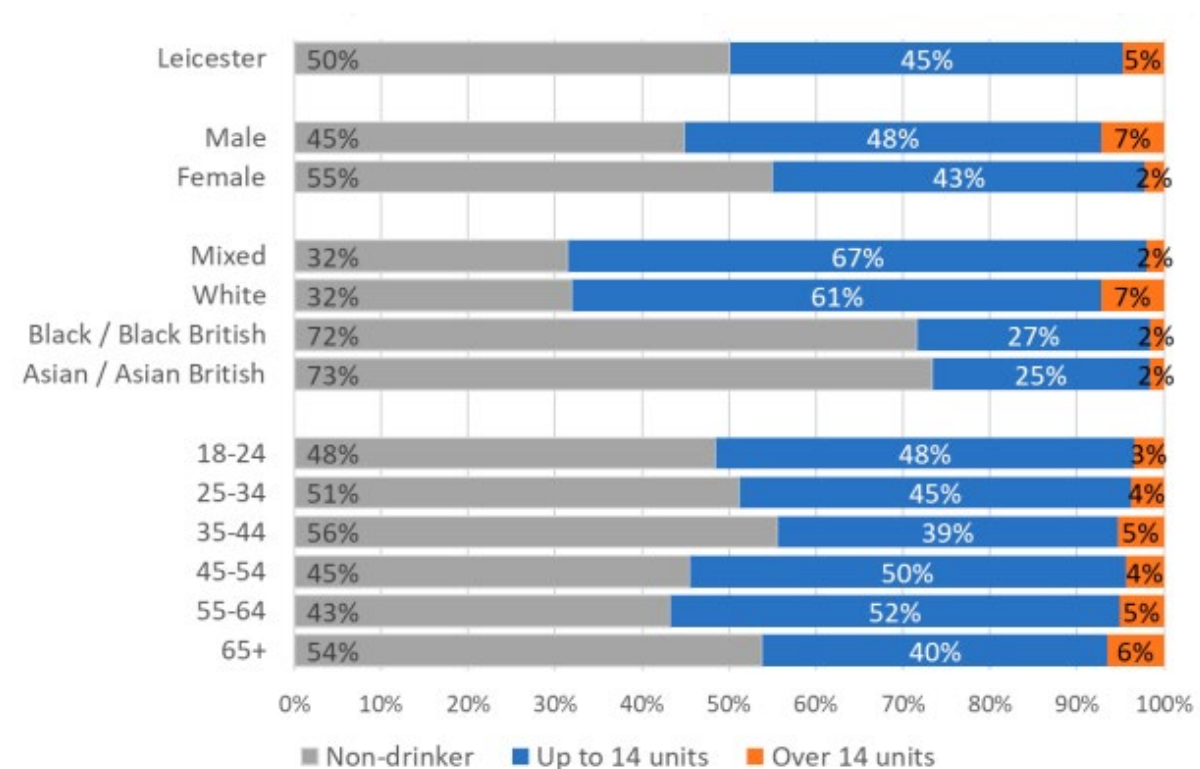
The Leicester Health and Wellbeing Survey is completed every three years and gives a snapshot of health and wellbeing issues in the city. The Leicester Health and Wellbeing Survey showed 50% of Leicester's adult population are non-drinkers, 45% drink within the recommended limits and 5% drink at increasing or higher levels (14 units or more). Men are found to have higher levels of drinking than women, with around 7% of men and 2% of women drinking above the recommended 14 weekly units. Generally, levels of drinking over the recommended weekly units of alcohol increased with age, with 6% of over 65 year olds exceeding the recommended alcohol consumption guidelines.<sup>46</sup>

When examined by ethnicity, the highest levels of non-drinkers are found in Asian ethnic groups (73%), followed by Black ethnic groups (72%), and lowest in White groups (32%) and Mixed groups (32%). White population groups have the highest levels of drinking above the recommended weekly levels (7%), with similar levels in Asian, Black and mixed ethnic groups (2%).<sup>46</sup>

Despite this finding, it is still important to understand and work collaboratively around the needs of different communities in Leicester, even where the prevalence of alcohol consumption is low at a population level. The Sikh Recovery Network reported when examining the impacts of alcohol consumption amongst Sikhs, of those who currently consume alcohol (61% of all respondents), 12% of women and 18% of men drink 10 or more units of alcohol per day<sup>47</sup>. This highlights a "hidden" population group that may warrant further support.

A higher proportion of non-drinkers were found in the North and Central areas with lower proportions in the South and West of Leicester. Of those who drink alcohol, residents of Western, Castle, Thurncourt and Stoneygate report highest levels of drinking more than 14 units per week, however these differences are not statistically significant.<sup>46</sup>

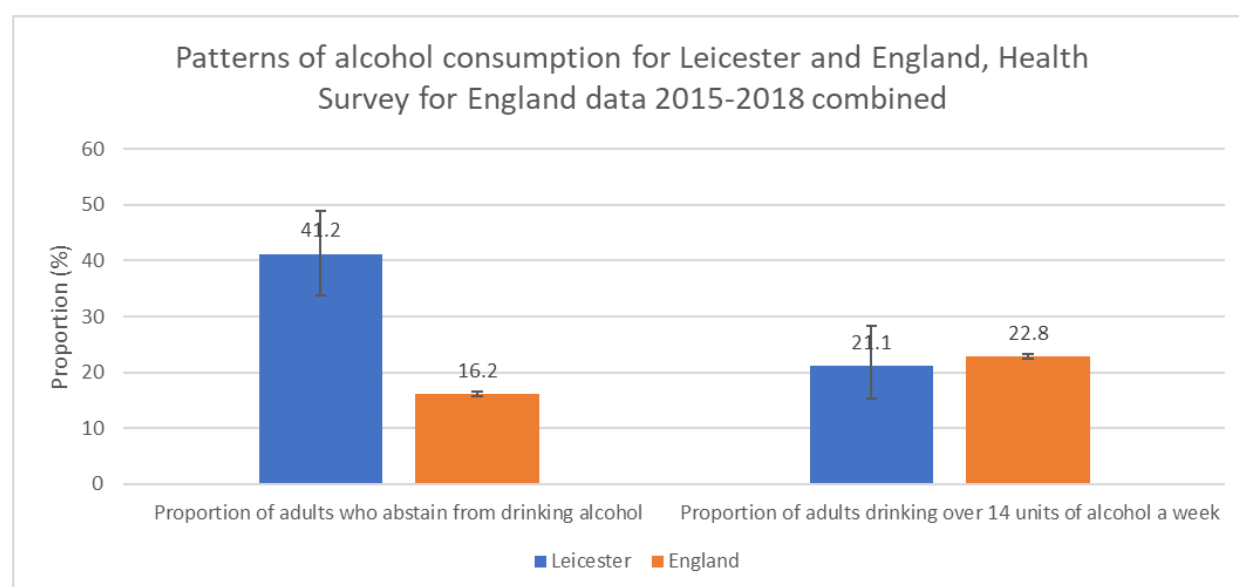
Figure 15: Alcohol Consumption data in Leicester City, 2018<sup>46</sup>



In January 2016 the Chief Medical Officer issued revised guidance on alcohol consumption, which advises that in order to keep to a low level of risk of alcohol-related harm, adults should not regularly drink more than 14 units of alcohol a week. In England, 22% of the population are drinking above low risk levels of alcohol so may benefit from some level of intervention. However, harm can be short-term and instantaneous, due to intoxication or long-term, from continued exposure to the toxic effect of alcohol or from developing dependence. This requires a multi-component response and pathways will differ from area to area. The data below gives an indication of potential local need for some form of alcohol intervention and is a weighted estimate from the [Health Survey for England \(2015-2018 combined\)](#).<sup>48</sup>

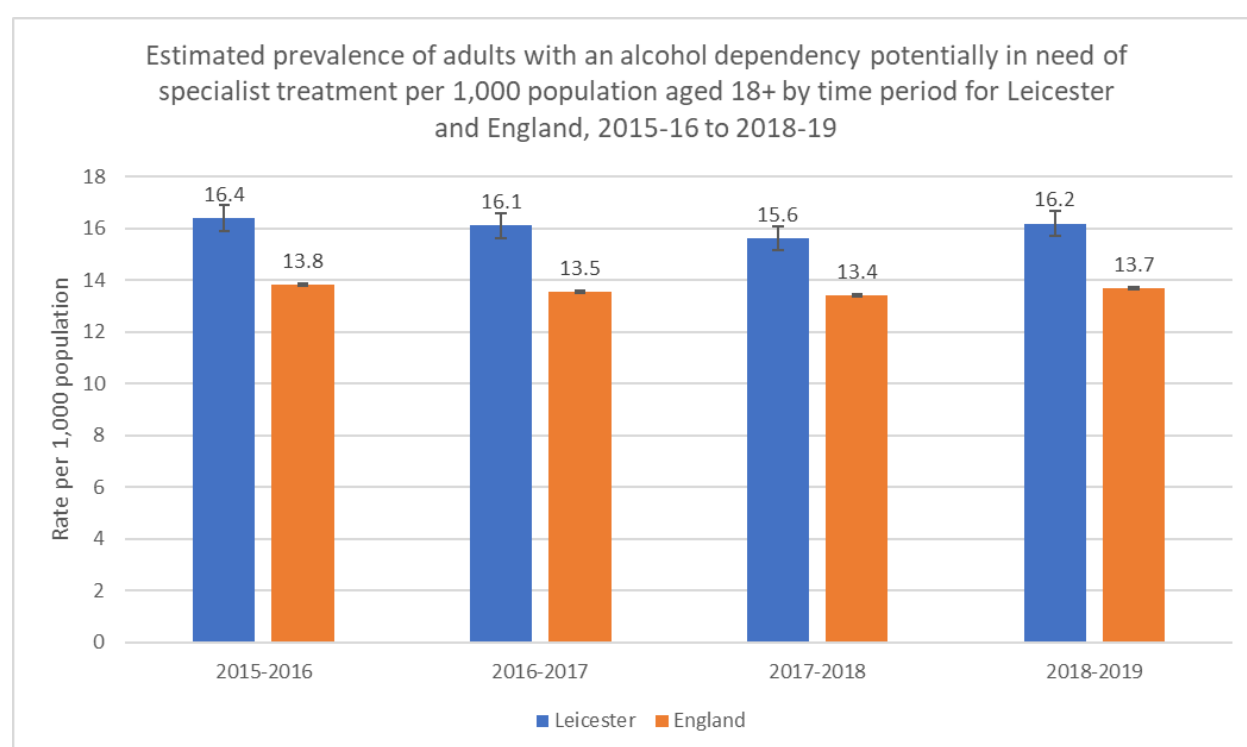
Figure 16 below shows that the proportion of adults who abstain from drinking alcohol in Leicester (41.2%) was significantly higher than the proportion of adults who abstain from drinking alcohol in England overall (16.2%). In Leicester in 2015-2018, the proportion of adults drinking over 14 units of alcohol a week (21.1%) was similar to the national average of 22.8%.

Figure 16: Proportion of adults who abstain from drinking alcohol and proportion of adults drinking over 14 units of alcohol a week for Leicester and England, weighted estimate 2015-2018<sup>31</sup>



As shown in Figure 17, the estimated prevalence of adults with an alcohol dependency in Leicester was significantly higher than the estimated prevalence for England across 2015-16 to 2018-19. The estimated prevalence of adults with an alcohol dependency in Leicester did not change significantly across the four time periods. The prevalence in England decreased significantly year on year between 2015-16 and 2017-18 before increasing significantly in 2018-19.

Figure 17: Estimated prevalence of adults with an alcohol dependency potentially in need of specialist treatment per 1,000 population aged 18+ by time period for Leicester and England, 2015-16 to 2018-19<sup>49</sup>



## 10. Alcohol Related Harm

The Leicester Health and Wellbeing Survey showed that 45% of the population drink within the recommended limits and 5% drink at increasing or higher levels. It is important to note that although less serious, most alcohol problems are not found among dependent drinkers. Greater population gain will be obtained by achieving a small reduction in alcohol misuse within a far larger group of "risky" drinkers with less serious problems than by trying to reduce problems among a smaller number of dependent drinkers.

Furthermore, it is important to be aware of the existence of the alcohol-harm paradox. This is the observation that people of low socioeconomic status (SES) tend to experience greater alcohol-related harm than those of high SES, even when the amount of alcohol consumption is the same or less than for individuals of high SES. This continues to challenge public health experts. A systematic review has highlighted two potential explanatory mechanisms for this:<sup>50</sup>

1. The differences in the volume and patterns of alcohol consumption between SES groups,
2. An interactive or modifying effect of SES and alcohol consumption

Probst and colleagues found that the greatest difference in harms between low and high SES was for heavy episodic drinking (or risky single occasion drinking), rather than for the quantity of alcohol consumed per month or week. Additionally, they found suggestive evidence for a multiplicative effect between SES and alcohol consumption, which would imply that higher alcohol consumption poses disproportionately greater health risks for individuals with low SES than for those with high SES.<sup>50</sup> However, it should be noted that in the literature reviewed by Probst and colleagues, drinking patterns explained a maximum of 30% of the variability in alcohol harm between socioeconomic groups. This value could partially be explained by an under-reporting of alcohol consumption by participants in the reviewed studies. Nevertheless, it is clear that substantial variability in alcohol-related harms between SES groups cannot be explained by drinking patterns alone.

Another important aspect of the alcohol-harm paradox is how risk factors of a person's social and physical environment can cause an effect. An example of this is alcohol outlet density. This along with alcohol related-harm has been shown to correlate positively with deprivation.<sup>5152</sup> In Leicester, where there is high level of deprivation, alcohol outlet density is likely to be a particular pertinent issue and further understanding of our population's environment is required.

The following sections examine hospital admissions related to alcohol. It is important to recognise there are several potential limitations using this source. There are likely to be geographical variations in admission practices and in other factors influencing admission. Inaccuracies in diagnosis

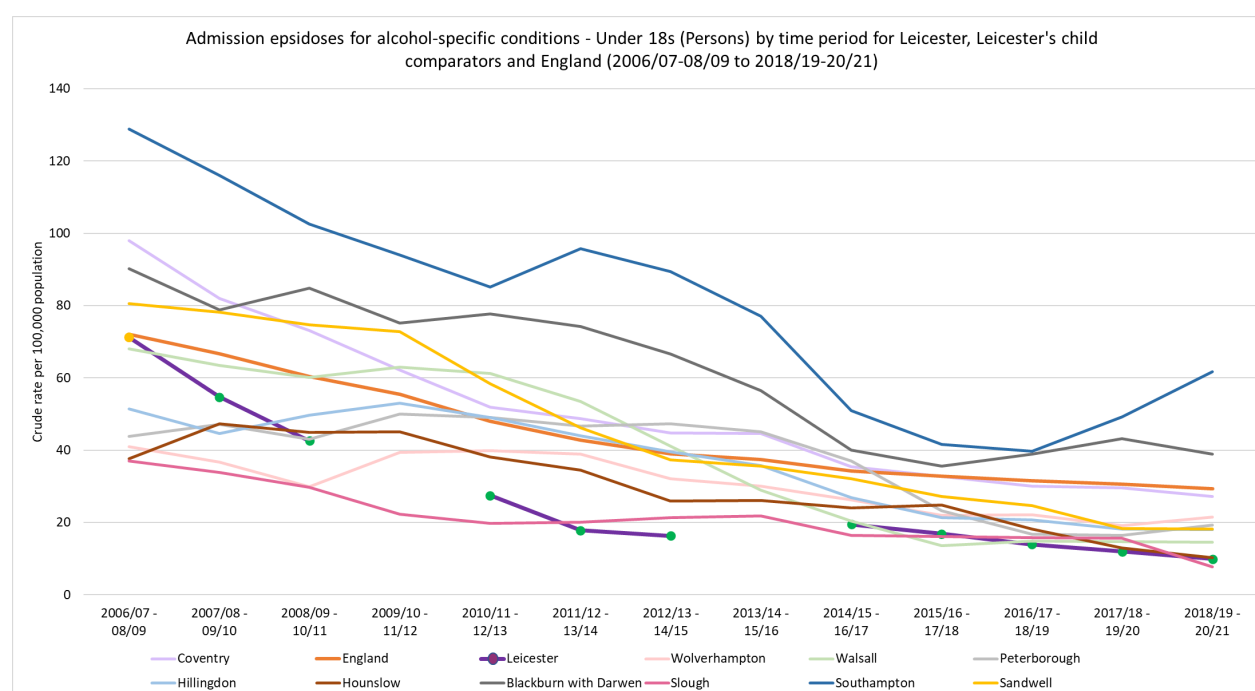
and coding and variation in diagnostic and coding practices over time and by place are further potential sources of error. Imprecision in attributable fractions could have also contributed to a reduction in counts of admissions seen. Furthermore, due to the nature of how injuries (for example) may result from alcohol, such as fights, falls etc. patients may be less likely to seek help for treatment and so the counts may be an underestimate.

## 10.1. Alcohol Specific Hospital Admissions

### 9.1.1 Children and Young People

Since 2007/08 – 09/10, where data is available, the rate of admission episodes for alcohol-specific conditions in under 18s in Leicester has been significantly lower (better) than the rate in England overall. In 2018/19-2020/21, there were 25 admission episodes for alcohol-specific conditions in under 18s in Leicester. Leicester had the 2<sup>nd</sup> lowest rate of admission episodes for alcohol-specific conditions when compared its 10 comparators. In 2018/19 – 20/21, the rate of admission episodes for alcohol-specific conditions in under 18s in Leicester (9.9 per 100,000 population) was significantly lower than that of Coventry (27.1), Blackburn with Darwen (38.8) and Southampton (61.7).

*Figure 18: Admission episodes for alcohol-specific conditions for under 18s (Persons) by time period for Leicester, Leicester's comparators and England (2006/07-08/09 to 2018/19-20/21)<sup>53</sup>*

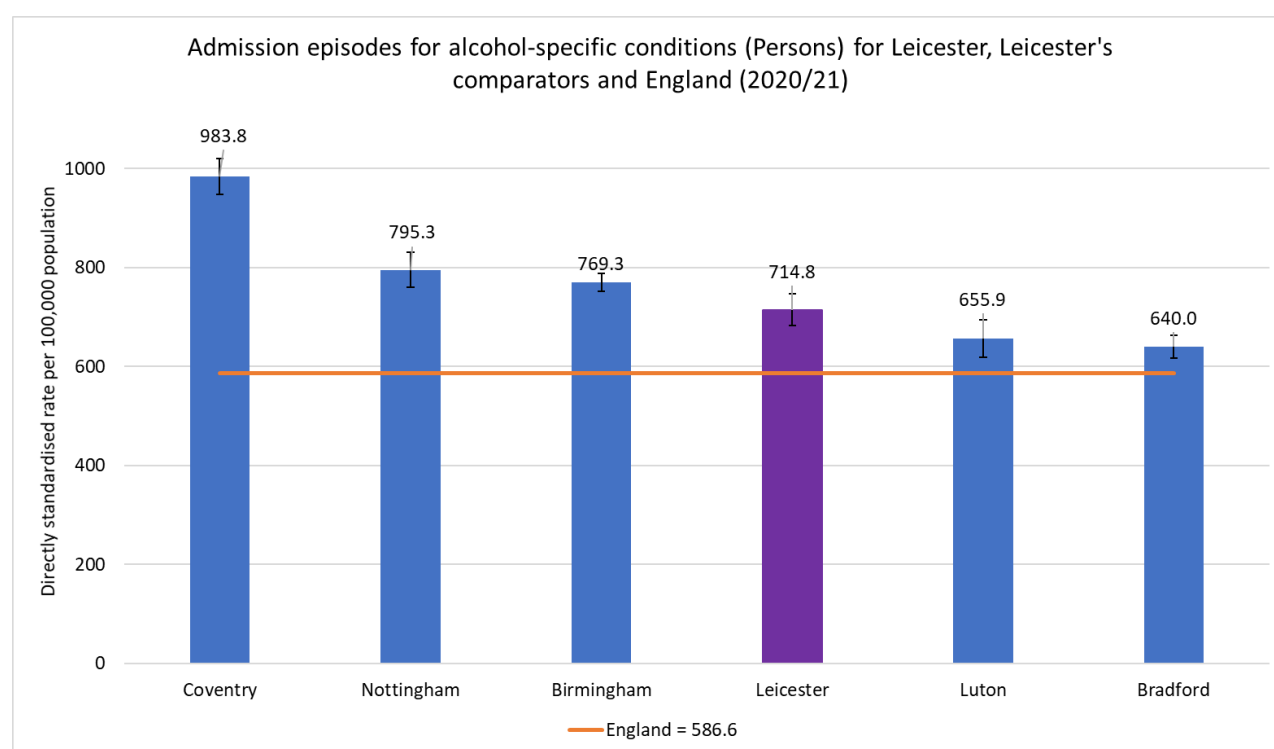


### 9.1.2 Adults

Alcohol-specific admissions are those where the primary diagnosis or any of the secondary diagnoses are wholly attributable to alcohol. These include alcoholic liver disease, mental and behavioural

disorders and alcohol poisoning where the condition is caused primarily by alcohol. In Leicester in 2020/21 there were 2,050 admission episodes for alcohol-specific conditions in people of all ages. Figure 19 shows that the rate of hospital admissions in Leicester in 2020/21 due to alcohol-specific conditions (714.8 per 100,000 population) was significantly higher (worse) than that of England (586.6 per 100,000 population). The rate of admission episodes for alcohol-specific conditions (Persons) for Leicester (714.8 per 100,000 population) was significantly higher than that of Bradford (640.0) and significantly lower than the rate for Birmingham (769.3), Nottingham (795.3) and Coventry (983.8).

Figure 19: Admission episodes for alcohol-specific conditions (Persons) for Leicester, Leicester's comparators and England (2020/21)<sup>54</sup>

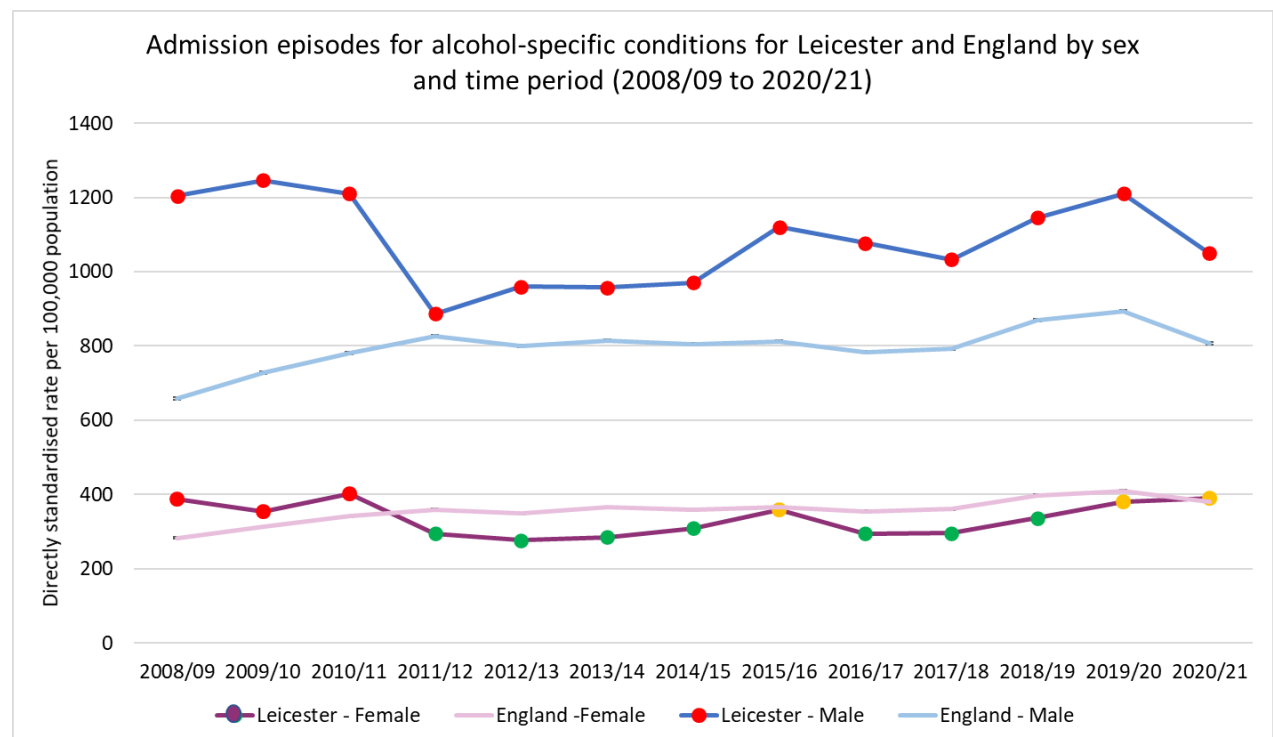


In 2020/21 in Leicester, there were 1,475 admission episodes for alcohol-specific conditions in males of all ages and 575 admission episodes for alcohol-specific conditions in females of all ages. Figure 20 shows that between 2008/09 and 2020/21 the rate of admission episodes for alcohol-specific conditions was significantly higher (worse) for men in Leicester compared to men in England overall. Between 2008/09 and 2020/21 the rate of admission episodes for alcohol-specific conditions in females in Leicester was most often significantly lower (better) than the rate in females in England overall, over the previous two time periods (2019/20 and 2020/21) the rate in females in Leicester was not significantly different to the rate in females in England overall. In Leicester and England the rate of hospital admissions due to alcohol-specific conditions is significantly higher in men than in



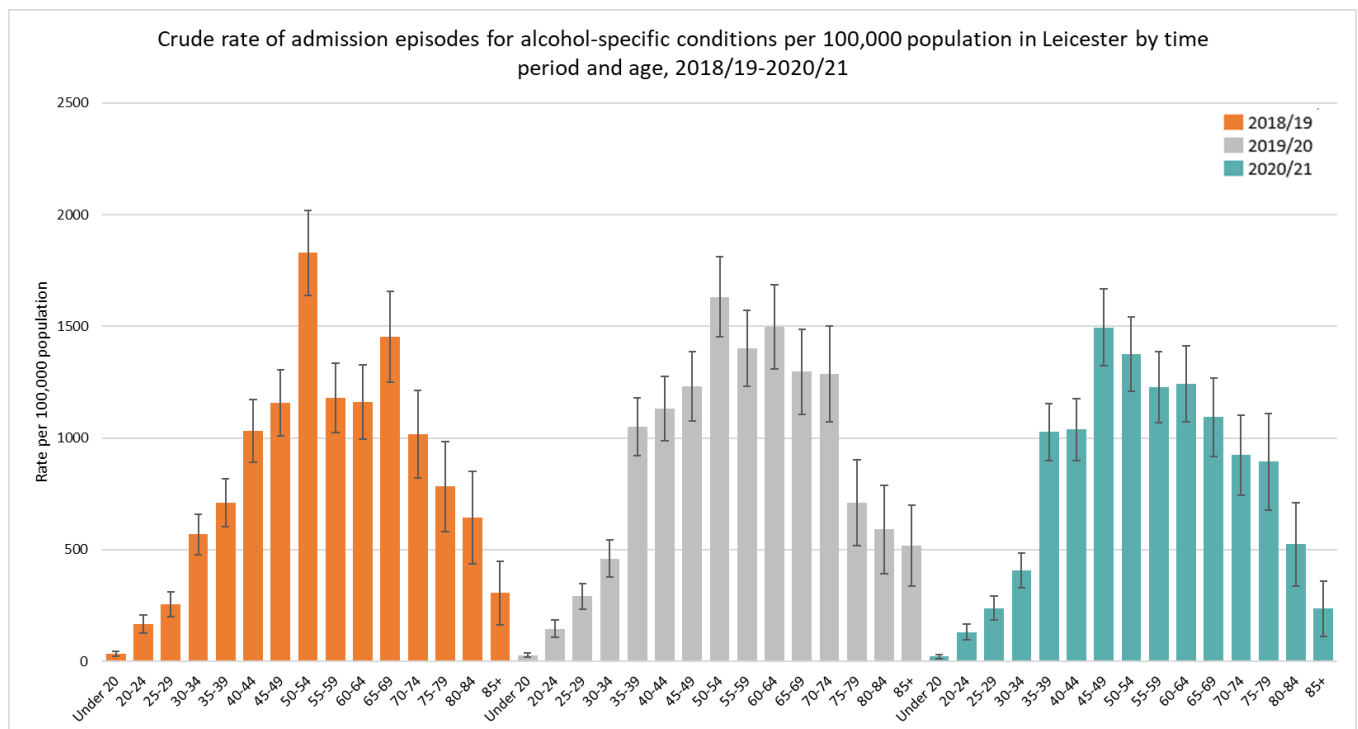
women. Over the last five time periods the rate of admissions for alcohol-specific conditions in females in Leicester has shown a significant increasing and worsening trend, there has been no significant change in the rate in males within the same time period.

Figure 20: Admission episodes for alcohol-specific conditions for Leicester and England by sex and time period (2008/09 to 2020/21)<sup>5556</sup>



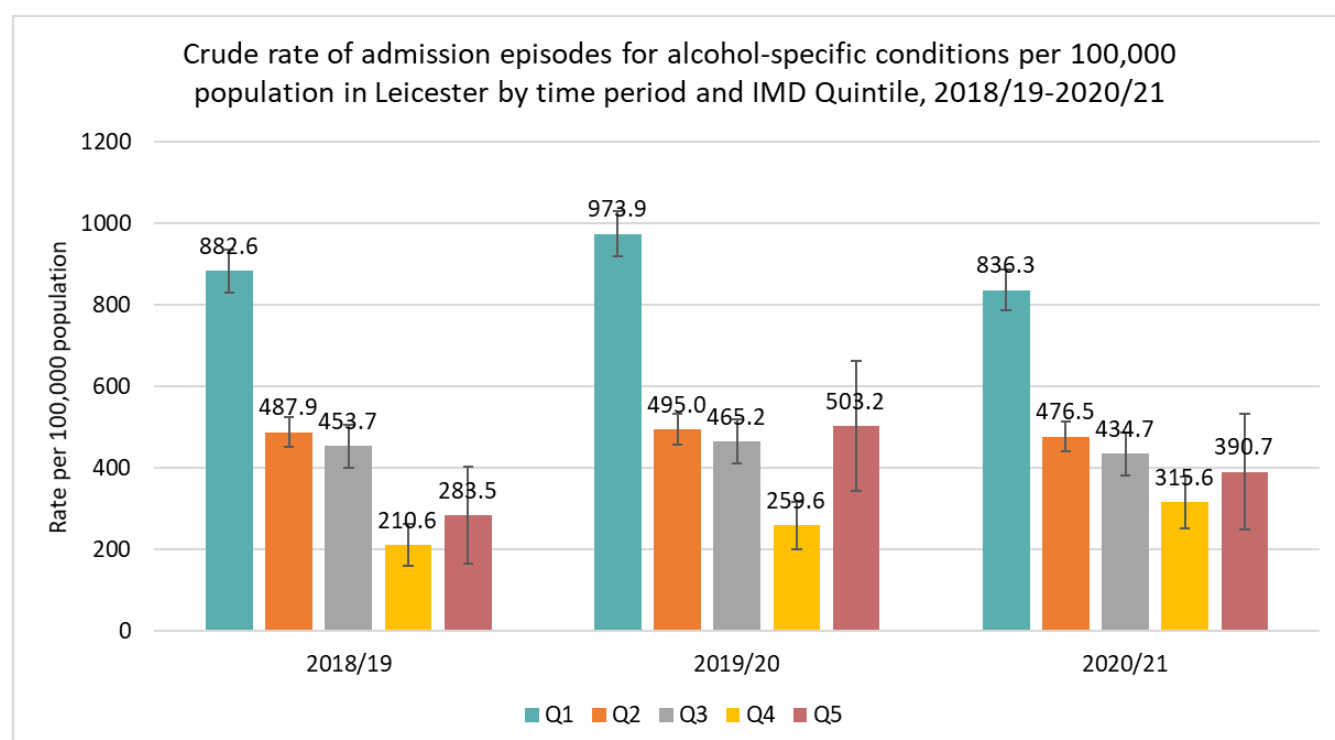
As shown in Figure 21, in 2018/19 and 2019/20 the rate of admission episodes for alcohol-specific conditions increased with age from the under 20 to the 50-54 year age band and in 2020/21 the same trend was witnessed up to the 45-49 year age band. In 2020/21 this increase in rate by age band was significant with each increase in age band between under 20 up to and including the 35-39 year age group. There was no significant difference between the rate of admission episodes for alcohol-specific conditions in Leicester in 2020/21 in the 35-39 and 40-44 year age bands. The rate in the 45-49 year age band was significantly higher than the rate in all younger age bands. Between the 45-49 year age band and the 85+ year age band in Leicester in 2020/21 the rate of admission episodes for alcohol-specific conditions showed a decreasing trend, although the decreases in rate by each of the increases in age band were not significant. In 2020/21 in Leicester, the rates of admission episodes for alcohol-specific conditions for age bands between 35-39 and 70-74 were significantly higher (worse) than the rates for age bands between under 20 and 30-34 and those for the 80+ age bands.

Figure 21: Crude rate of admission episodes for alcohol-specific conditions per 100,000 population in Leicester by time period and age, 2018/19 to 2020/21



As shown in Figure 22 below, in 2018/19, 2019/20 and 2020/21 the rate of admission episodes for alcohol-specific conditions in Leicester was significantly higher (worse) in quintile 1 (most deprived areas) than in the other quintiles. Across all three time periods the rate of admission episodes for alcohol-specific conditions in Leicester decreased significantly with decreasing levels of deprivation between quintiles 1 and 2 and between quintiles 3 and 4, there were no significant differences between the rates between quintiles 2 and 3. Across all three time periods the rate for alcohol-specific conditions in Leicester increased between quintile 4 and quintile 5, although these differences were not significant. The rate of admission episodes for alcohol-specific conditions in Leicester in quintile 1 (most deprived areas) decreased significantly from 973.9 per 100,000 population in 2019/20 to 836.3 per 100,000 population in 2020/21.

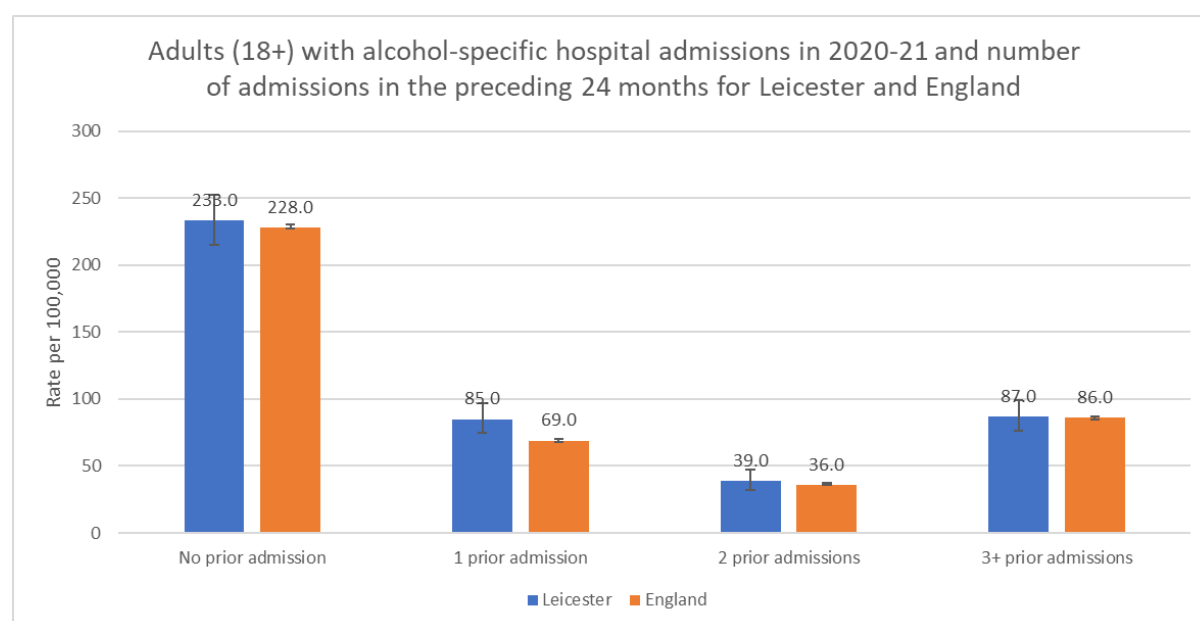
Figure 22: Crude rate of admission episodes for alcohol-specific conditions per 100,000 population in Leicester by time period and IMD Quintile, 2018/19, 2019/20 and 2020/21



In adults (18+) in Leicester in 2020-21 there were 630, 230, 105 and 235 alcohol-specific hospital admissions with no prior admission, 1 prior admission, 2 prior admissions and 3+ prior admissions in the preceding 24 months respectively. As shown in Figure 23, the rates of alcohol-specific hospital admissions in Leicester in 2020-21 with no prior admissions, 2 prior admissions or 3+ prior admissions in the preceding 24 months were not significantly different to the rates in England. The rate of alcohol-specific hospital admissions in 2020-21 with 1 prior admission in the preceding 24 months in Leicester (85.0 per 100,000 population) was significantly higher than the rate in England (69.0 per 100,000 population). In both Leicester and England, the rate of alcohol-specific hospital admissions in 2020-21 with no prior admissions in the preceding 24 months was significantly higher than the rate with 1, 2 or 3+ prior admissions in the preceding 24 months. The rate of alcohol-specific hospital admissions in 2020-21 with 1 prior admission or 3+ prior admissions in the preceding 24 months was significantly higher than the rate with 2 prior admissions in Leicester and in England.

*Note: The local counts have been rounded to the nearest 5.*

Figure 23: Adults (aged 18+) with alcohol specific hospital admissions in 2020-21 and the number of admissions in the preceding 24 months for Leicester and England<sup>57</sup>



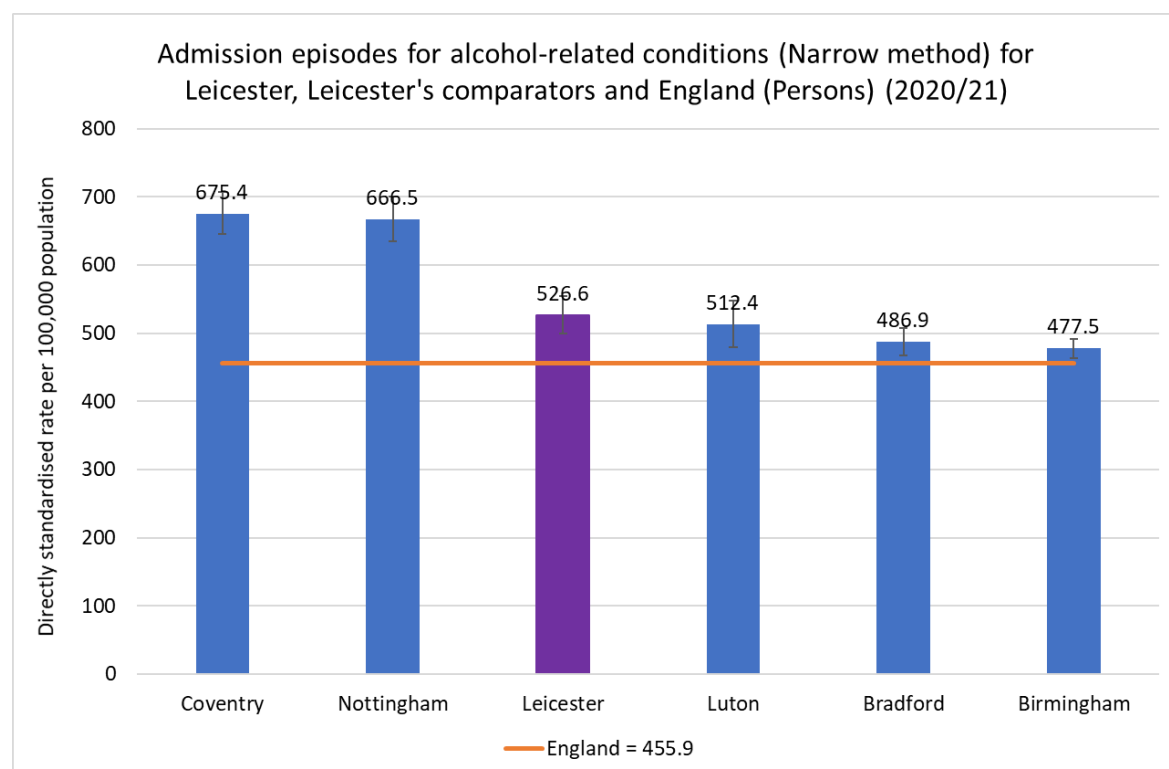
## 10.2. Alcohol Related Hospital Admissions

Alcohol-related hospital admissions are admissions to hospital where the primary diagnosis is an alcohol-attributable code or a secondary diagnosis is an alcohol-attributable external cause code. Alcohol-related hospital admissions are used as a way of understanding the impact of alcohol on the health of a population and can include admissions for alcohol-related hypertensive diseases and heart failure. There are two measures used to assess this burden: the narrow and the broad measure. The narrow definition is a measure of hospital admissions where the primary diagnosis (main reason for admission) is an alcohol-related condition whereas the broad definition is a measure of hospital admissions where either the primary diagnosis (main reason for admission) or one of the secondary (contributory) diagnoses is an alcohol-related condition.<sup>58</sup>

### 10.2.1. Narrow Method

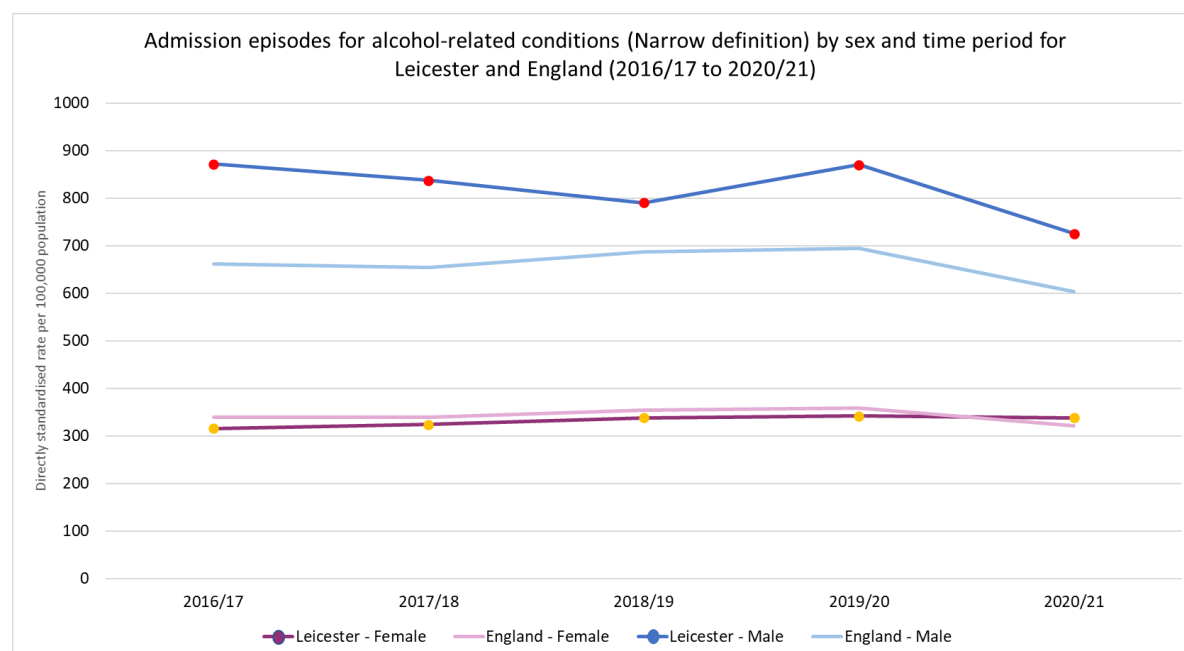
In Leicester in 2020/21 there were 1,501 admission episodes for alcohol-related conditions when using the narrow method. As shown in Figure 24, the rate of admission episodes for alcohol-related conditions in Leicester in 2020/21 when using the narrow method (526.6 per 100,000 population) is significantly higher (worse) than the rate for England overall (455.9 per 100,000 population). The rate for Leicester is also significantly higher than that of Birmingham (477.5 per 100,000 population) but significantly lower than the rate for Nottingham (666.5 per 100,000 population) and Coventry (675.4 per 100,000 population).

Figure 24: Admission episodes for alcohol-related conditions (Narrow method) for Leicester, Leicester's comparators and England (Persons) (2020/21)<sup>59</sup>



In Leicester in 2020/21 there were 1,006 admission episodes for alcohol-related conditions (narrow method) in males and 495 in females. In Leicester and England the rate of hospital admissions for alcohol-related conditions (narrow method) is significantly higher (worse) in males than in females (see Figure 25). The rate of admission episodes for alcohol-related conditions (narrow definition) in males in Leicester has been significantly higher than that of males in England since recording of the indicator began in 2016/17, whilst the rate for females in Leicester has not been significantly different to the rate for females in England over the same time period. Over the last five time periods the rate of admission episodes for alcohol-related conditions (narrow definition) in males in Leicester has shown a decreasing and improving trend, the rate in females in Leicester has shown no significant change across the last five time periods.

Figure 25: Admission episodes for alcohol-related conditions (Narrow definition) by sex and time period for Leicester and England (2016/17 to 2020/21)<sup>6061</sup>



Admission episodes for alcohol-related conditions (narrow method) by gender and age-band have been examined in Figure 26, Figure 27 and Figure 28. The figures highlight across both genders the highest rate of alcohol-related admissions (narrow method) were from 40-64 years, followed by 65 and above and the under 40 age band. Figure 26 shows the trend of rate of admission episodes for alcohol related conditions (narrow method) in under 40 age band has varied compared to the national rate. The latest data shows males and females in Leicester perform not significantly different to the national average in 2020/21. Figure 27 shows the rate of admission episodes for alcohol related conditions (narrow method) in 40-64 aged band. It shows the rate in males in Leicester has been significantly higher than the rate in males in England overall since recording of the indicator began in 2016/17. The rate in females in Leicester has not performed significantly different to the rate in females in England overall between 2016/17 and 2019/20, with the exception of 2020/21 where the rate in females in Leicester was significantly higher (worse) than the national rate in females. Over the last five time periods there has been no significant change in the rate of admission episodes for alcohol-related conditions for 40-64 age bands in Leicester in males or females. Figure 28 shows the alcohol-related admissions for 65 years and above. It shows the rate in males in Leicester has declined significantly (improved) over the last five years, where it performed significantly higher (worse) than the national average in 2016/17 to performing similar to the national average since 2018/19. The trend in females in Leicester has remained stable over the last five years and continued to perform similar to the national rate.

Figure 26: Admission episodes for alcohol-related conditions (narrow method) for under 40 years age band by sex and time period for Leicester and England (2016/17 to 2020/21)

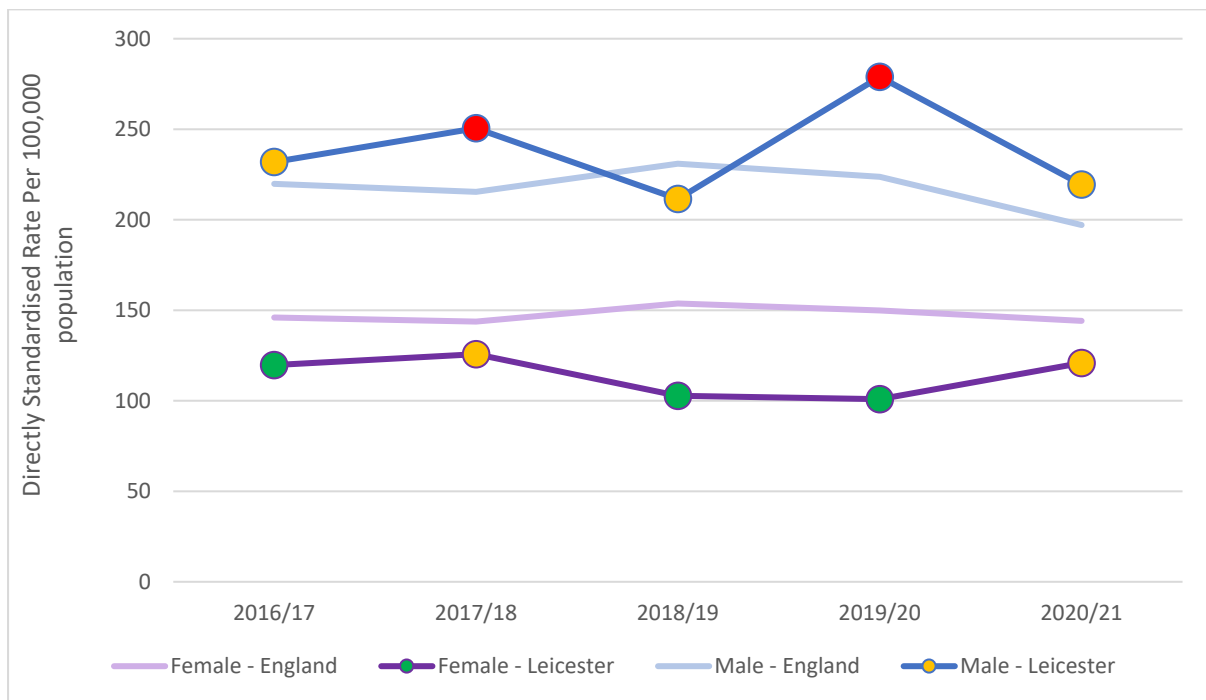


Figure 27: Admission episodes for alcohol-related conditions (narrow method) for 40-64 age band by sex and time period for Leicester and England (2016/17 to 2020/21)

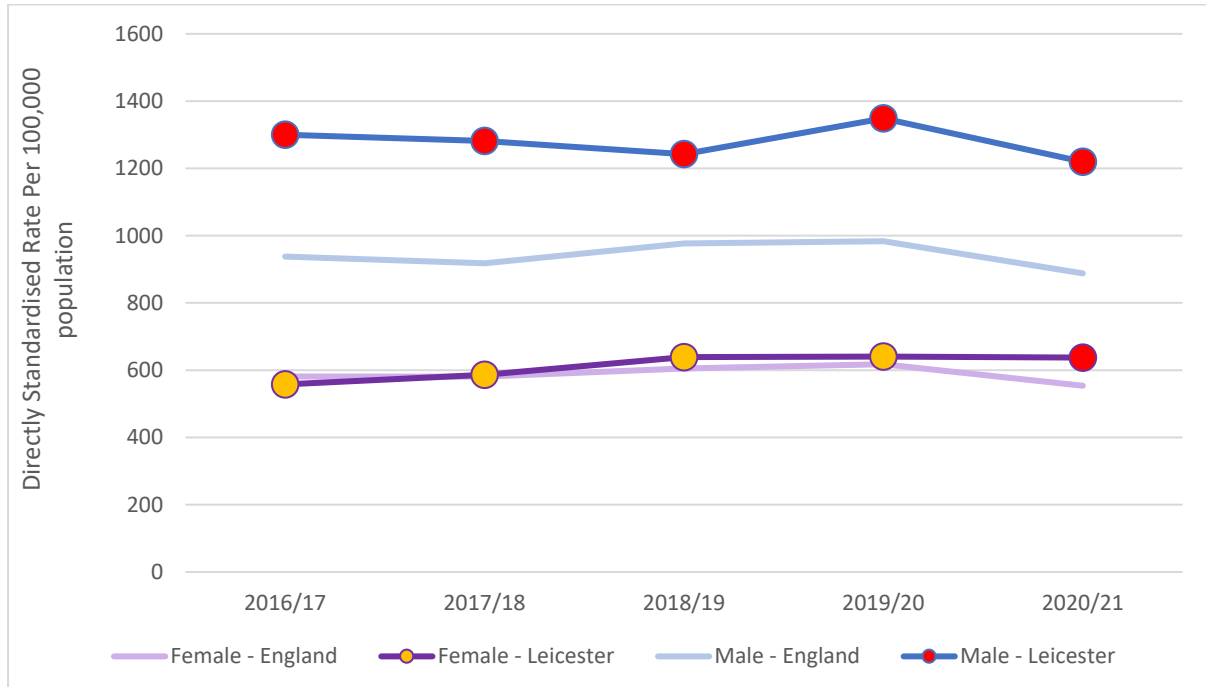
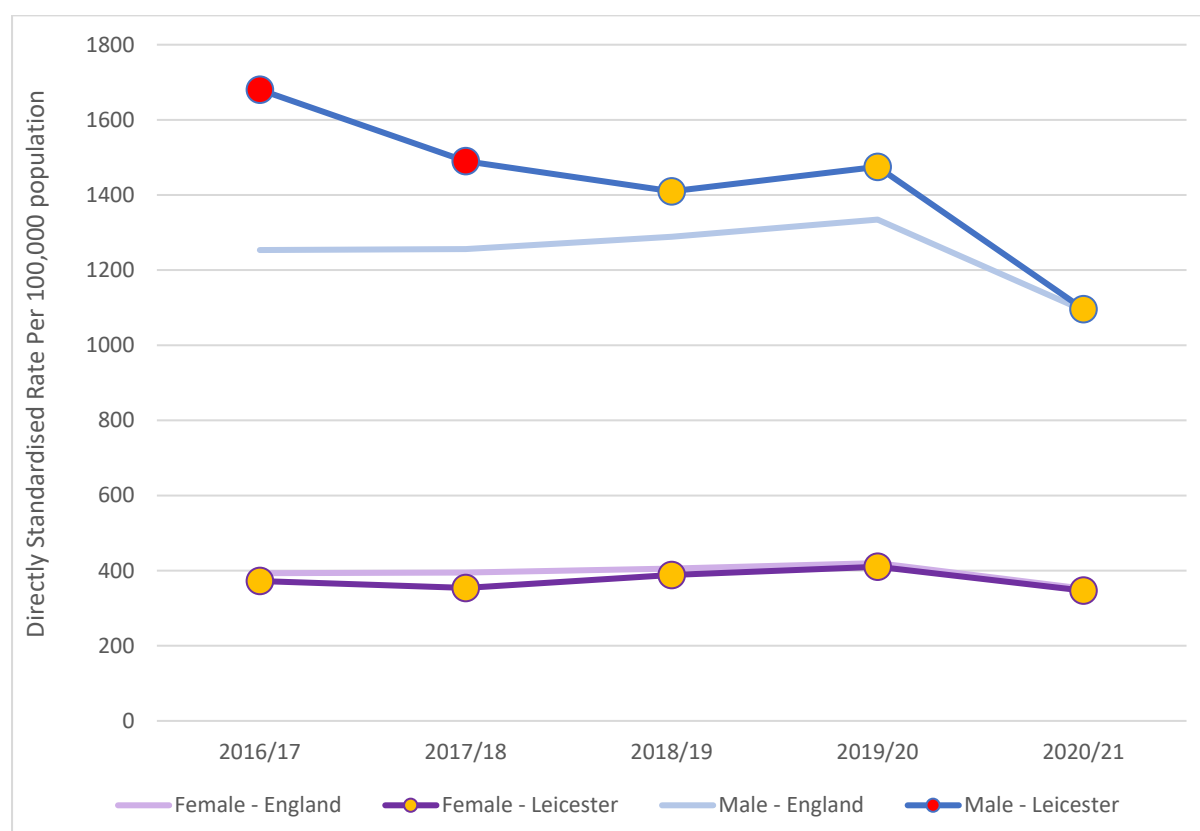


Figure 28: Admission episodes for alcohol-related conditions (narrow method) for 65 year and above age band by sex and time period for Leicester and England (2016/17 to 2020/21)

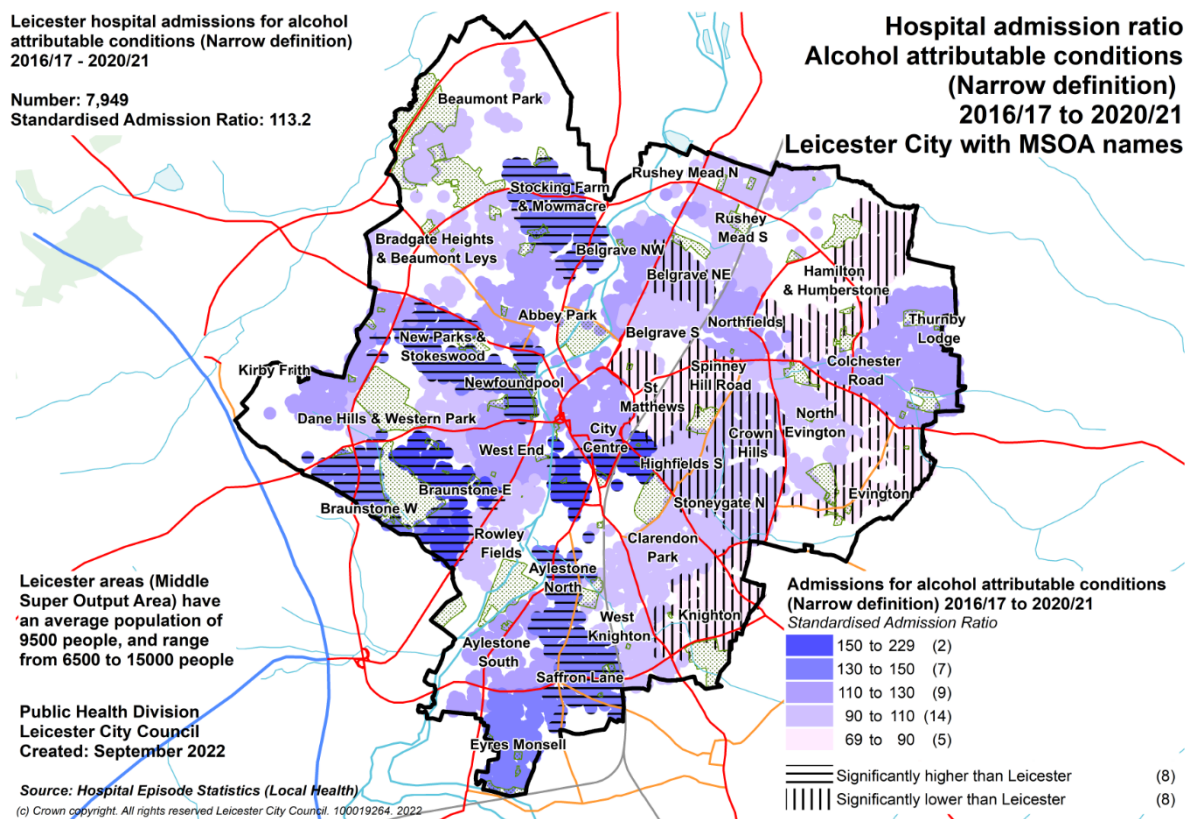


Between 2016/17 and 2020/21 in Leicester there were 7,949 hospital admissions for alcohol attributable conditions (narrow definition). Figure 29 below shows that eight Middle Layer Super Output Areas (MSOAs) in Leicester have a significantly higher ratio of hospital admissions for alcohol attributable conditions (narrow definition) than Leicester in 2016/17-2020/21 and eight MSOAs have ratios which are significantly lower than the value for Leicester. Of the six locality areas across Leicester, in 2016/17 to 2020/21 the West and North West areas have the largest proportions of MSOAs where the ratio of hospital admissions for alcohol attributable conditions (narrow definition) is significantly higher than that of Leicester (3 out of 7 and 2 out of 5 of their MSOAs respectively), whilst the Central and East locality areas have the largest proportion of MSOAs where the ratio is significantly lower than that of Leicester overall (3 out of 7 and 2 out of 5 of their MSOAs respectively). The highest ratio of hospital admissions for alcohol attributable conditions (narrow definition) in 2016/17-2020/21 in Leicester was in the centre of the city in the Leicester City South MSOA with a ratio of 228.1 which was significantly higher than the value for Leicester overall (113.2). Following this, the highest ratios in Leicester were in Braunstone Park East (159.6) and Braunstone Park West (148.2) in the West of the city, Saffron Lane (148.1) in the South of the city and Stocking Farm & Mowmacre (147.8) in the North West of the city. Of the eight MSOAs with ratios of hospital admissions for alcohol attributable conditions (narrow definition) which were



significantly lower than the value for Leicester in 2016/17 to 2020/21, Evington (69.7) and Hamilton & Humberstone (74.0) in the East of the city and Knighton (78.5) in the South of the city had the lowest ratios.

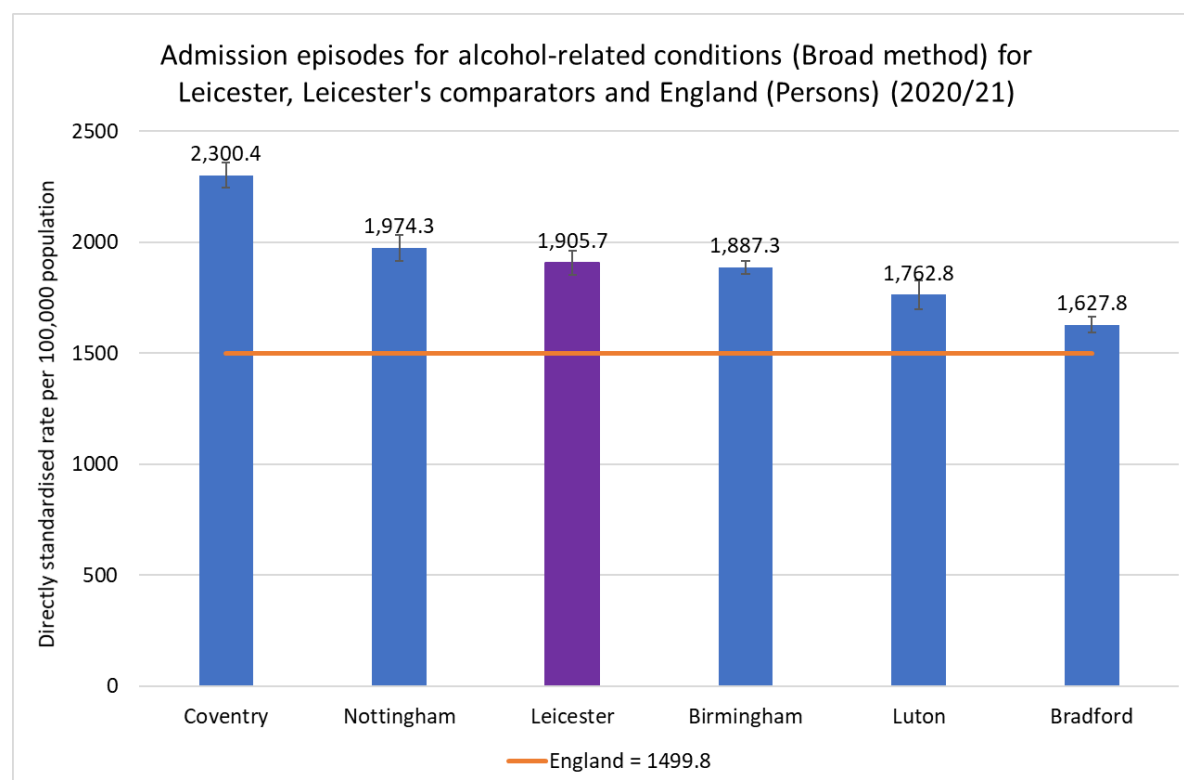
Figure 29: Standardised Admission Ratio for alcohol attributable conditions (narrow definition) by MSOA in Leicester, 2016/17 to 2020/21<sup>62</sup>



### 10.2.2. Broad Method

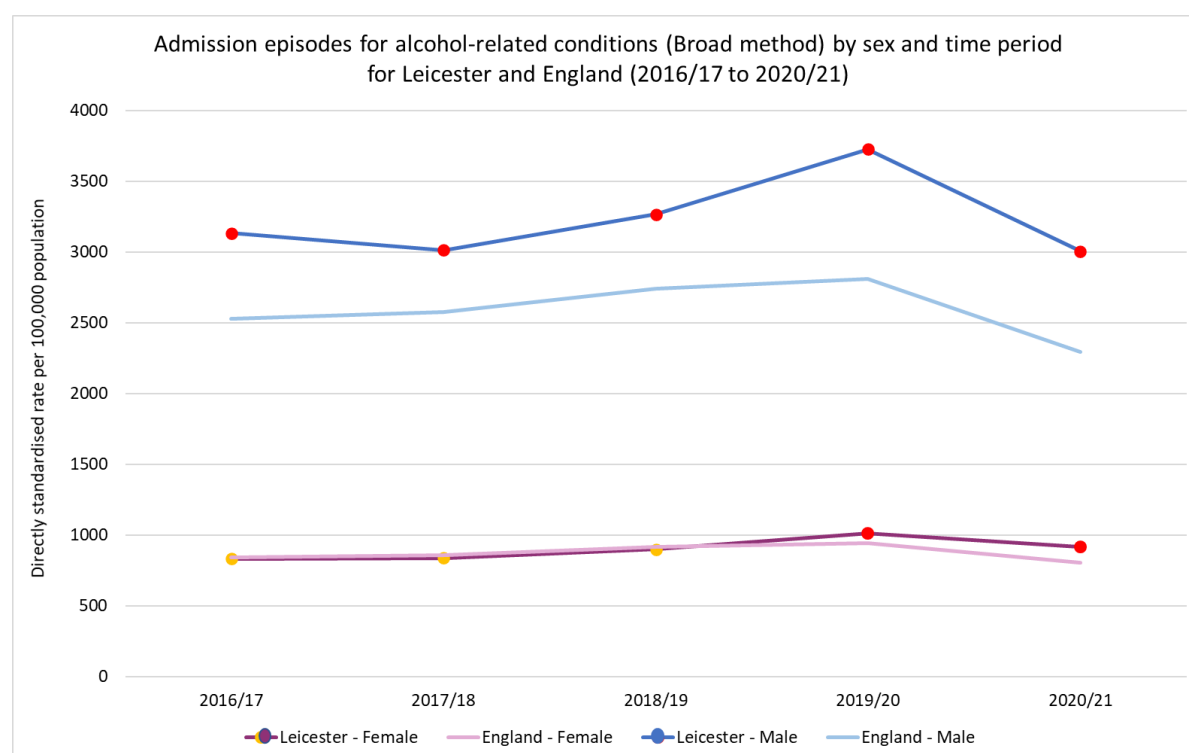
In Leicester in 2020/21 there were 5,079 admission episodes for alcohol-related conditions when using the broad method. In 2020/21, the rate of hospital admission episodes for alcohol-related conditions (broad method) (1,905.7 per 100,000 population) is significantly higher (worse) than the rate for England (1499.8 per 100,000 population), Luton (1762.8) and Bradford (1,627.8) (Figure 30). The rate in Leicester is significantly lower than that of Coventry (2,300.4 per 100,000 population).

Figure 30: Admission episodes for alcohol-related conditions (Broad method) for Leicester, Leicester's comparators and England (Persons) (2020/21)<sup>63</sup>



In Leicester males in 2020/21 there were 3,778 admission episodes for alcohol-related conditions (broad method), compared to 1,301 in females in Leicester. The rate of hospital admissions for alcohol-related conditions (broad method) is significantly higher (worse) for males than females in Leicester and in England in 2020/21. As shown in Figure 31, the rate of admission episodes for alcohol-related conditions (broad method) in males in Leicester has been significantly worse than the rate for males in England since recording of the indicator began in 2016/17. Between 2016/17 and 2018/19, the rate of hospital admissions for alcohol-related conditions (broad method) in females in Leicester was not significantly different to the rate in females in England overall, since 2019/20 the rate in females in Leicester has been significantly worse than the value for females in England. Over the last five time periods, the rate of hospital admissions in females in Leicester has shown an increasing and worsening trend.

Figure 31: Admission episodes for alcohol-related conditions (Broad method) by sex and time period for Leicester and England (2016/17 to 2020/21)<sup>64 65</sup>

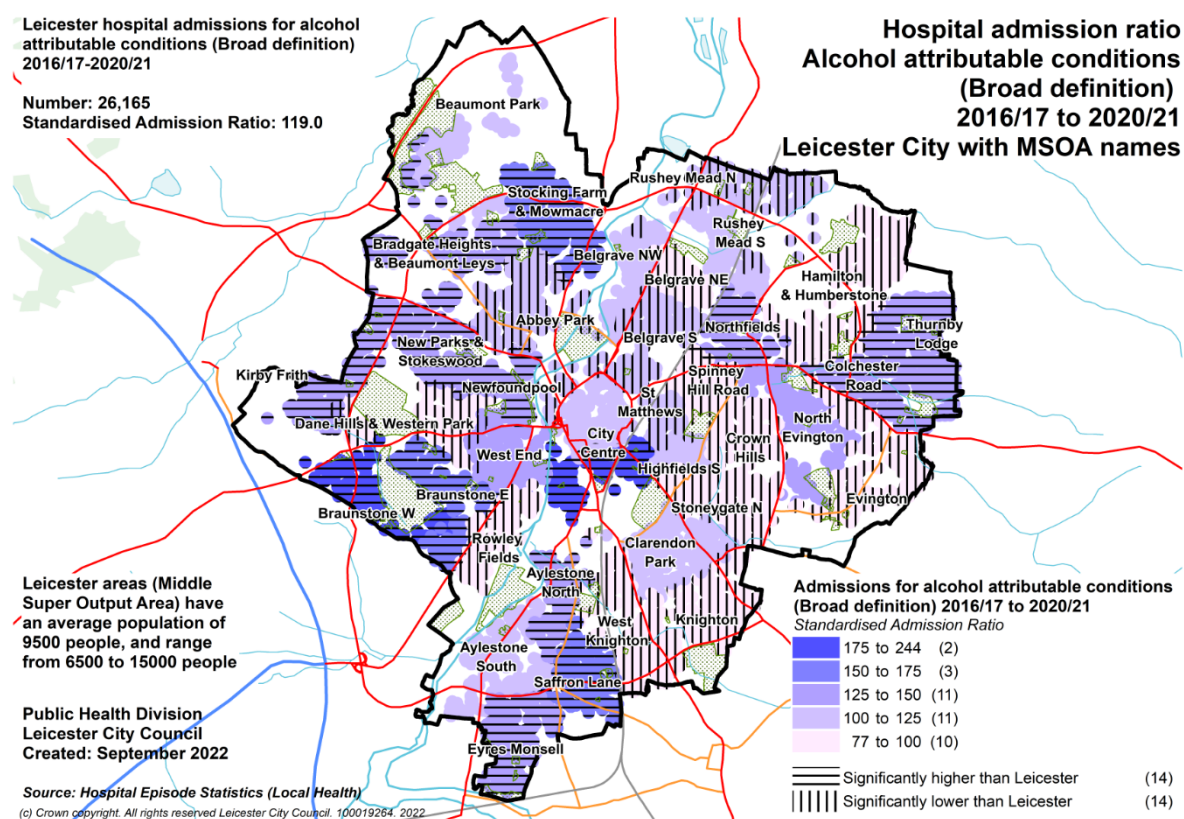


*Note: A Standardised Admission Ratio is a measure of how likely a person is to have an admission to hospital compared to the standard population, in this case England. An SAR higher than 100 indicates that the area has a higher than average admission rate, lower than 100 indicates a lower than average admission rate.*

In Leicester between 2016/17 and 2020/21, there were 26,165 admission episodes for alcohol attributable conditions (broad definition). Figure 32 below shows that 14 Middle Layer Super Output Areas (MSOAs) in Leicester have a significantly higher ratio of hospital admissions for alcohol attributable conditions (broad definition) than Leicester in 2016/17-2020/21 and 14 MSOAs have ratios which are significantly lower than the value for Leicester. Of the six locality areas across Leicester, in 2016/17 to 2020/21 the North West of the city has the largest proportion of MSOAs where the ratio of admissions for alcohol attributable conditions (broad definitions) is significantly higher than that of Leicester (3 out of its 5 MSOAs), whilst the North of the city has the largest proportion of MSOAs where the ratio is significantly lower than that of Leicester overall (4 out of its 7 MSOAs). The highest ratio of hospital admissions for alcohol attributable conditions (broad definition) in 2016/17-2020/21 in Leicester was in the centre of the city in the Leicester City South MSOA with a Standardised Admission Ratio of 243.4 which was significantly higher than the ratio for Leicester overall (119.0). Following this, the highest ratios in Leicester were in Braunstone Park West

(188.0) and Braunstone Park East (170.1) MSOAs in the West of the city, Stocking Farm & Mowmacre (154.8) in the North West of the city and Saffron Lane (150.1) in the South of the city. Of the 14 MSOAs with ratios of hospital admissions for alcohol attributable conditions (broad definition) which were significantly lower than the value for Leicester in 2016/17-2020/21, Evington (77.4) in the East of the city, Knighton (84.7) in the South of the city and Spinney Hill Road (88.9) in the North of the city had the lowest ratios.

Figure 32: Standardised Admission Ratio for alcohol attributable conditions (broad definition) by MSOA in Leicester, 2016/17 to 2020/21<sup>66</sup>

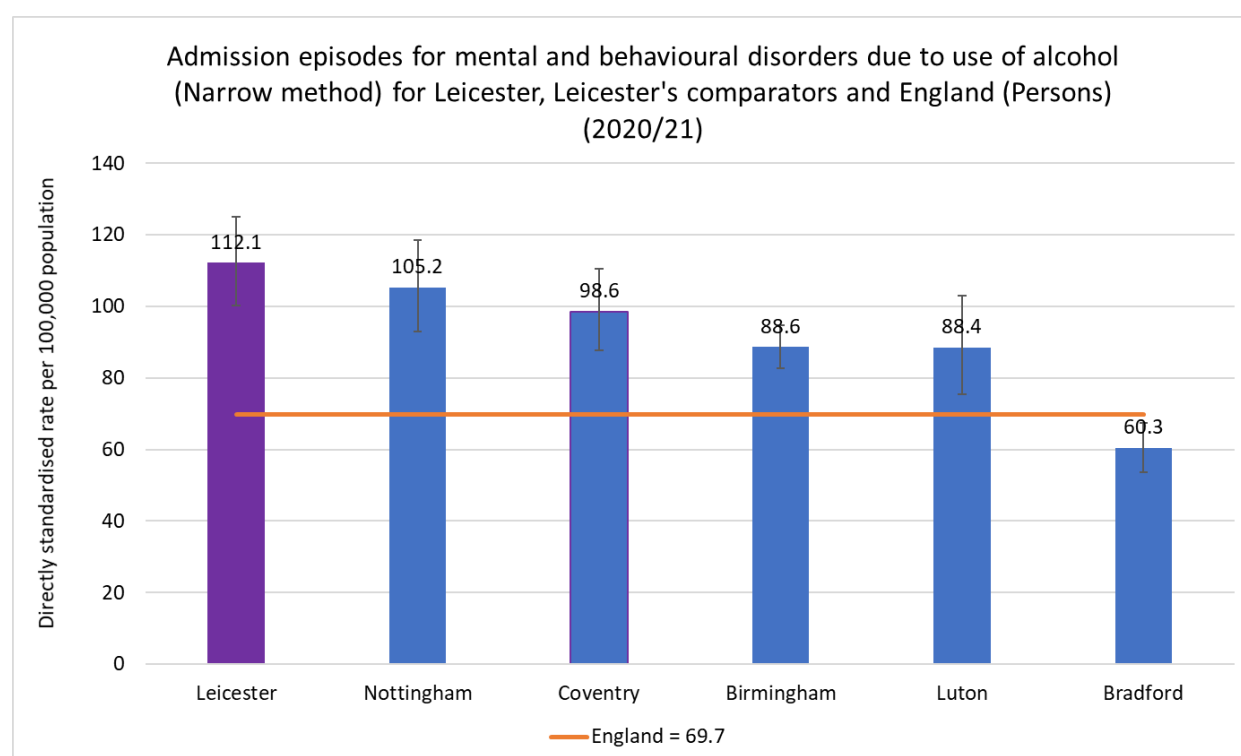


### 10.2.3. Mental and behavioural disorders due to use of alcohol (narrow method)

Admission episodes for mental and behavioural disorders due to use of alcohol (narrow method) examines where the primary diagnosis is an alcohol-attributable mental and behavioural disorders due to use of alcohol code (F10). The four character sub-divisions are used to give further detail to the diagnosis and are subdivided by the following: acute intoxication, harmful use, dependence syndrome, withdrawal state, withdrawal state with delirium, psychotic disorder, amnesic syndrome and residual and late-onset psychotic disorder. The diagnoses represent conditions that develop after repeated substance use or that are secondary to heavy consumption.

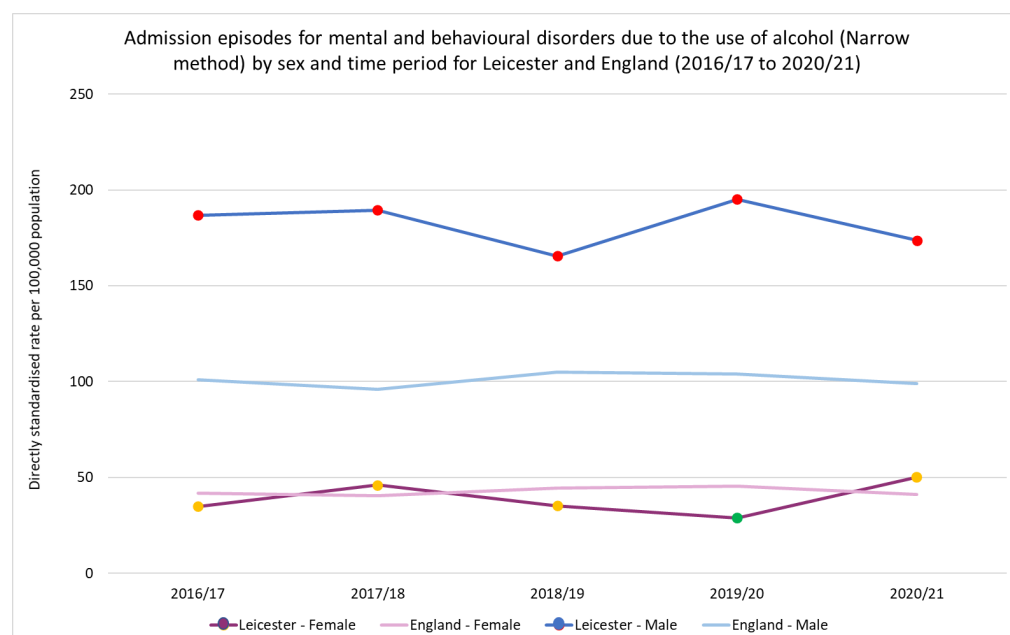
There were 333 admission episodes for mental and behavioural disorders due to use of alcohol (narrow method) in Leicester in 2020/21. Figure 33 shows that compared to its comparators and England, Leicester had the highest (worst) rate of admission episodes for mental and behavioural disorders due to use of alcohol (narrow method) in 2020/21. The rate for Leicester (112.1 per 100,000 population) was significantly worse than that of England (69.7), Birmingham (88.6), Luton (88.4) and Bradford (60.3).

Figure 33: Admission episodes for mental and behavioural disorders due to use of alcohol (Narrow method) for Leicester, Leicester's comparators and England (Persons) (2020/21)<sup>67</sup>



In 2020/21 in Leicester there were 256 admission episodes for mental and behavioural disorders due to use of alcohol (narrow method) in males and 77 in females. As shown in Figure 34, in Leicester and England the rate of admission episodes for mental and behavioural disorders due to the use of alcohol (narrow method) is significantly higher (worse) in males than in females. The rate in males in Leicester has been significantly higher than the rate in males in England overall since recording of the indicator began in 2016/17. The rate in females in Leicester has not been significantly different to the rate in females in England overall since 2016/17, with the exception of 2019/20 where the rate in females in Leicester was significantly lower (better) than the rate in females in England overall. Over the last five time periods there has been no significant change in the rate of hospital admission episodes for mental and behavioural disorders due to the use of alcohol (narrow method) in Leicester in males or females.

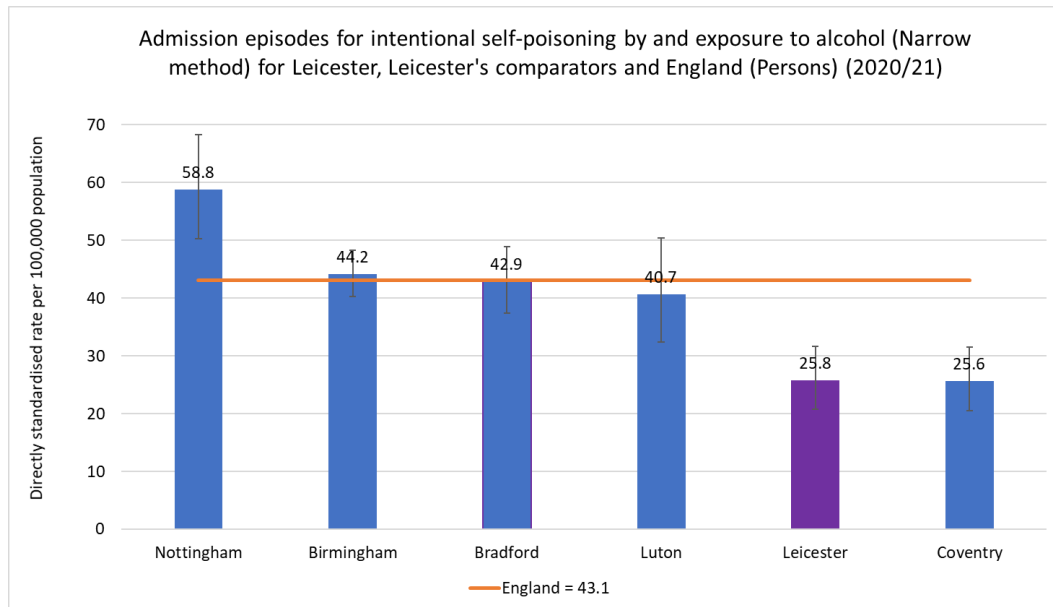
Figure 34: Admission episodes for mental and behavioural disorders due to the use of alcohol (narrow method) by sex and time period for Leicester and England (2016/17 to 2020/21)<sup>6869</sup>



#### 10.2.4. Intentional self-poisoning by and exposure to alcohol (narrow method)

In 2020/21 in Leicester there were 100 admission episodes for intentional self-poisoning by and exposure to alcohol (narrow method). Figure 35 shows that the rate of hospital admission episodes for intentional self-poisoning by and exposure to alcohol (narrow method) for Leicester in 2020/21 (25.8 per 100,000 population) is significantly lower (better) than the value for England (43.1 per 100,000 population), Luton (40.7), Bradford (42.9), Birmingham (44.2) and Nottingham (58.8). In 2020/21, Leicester has the second lowest rate of admission episodes for intentional self-poisoning by and exposure to alcohol (narrow method) when compared to its comparators.

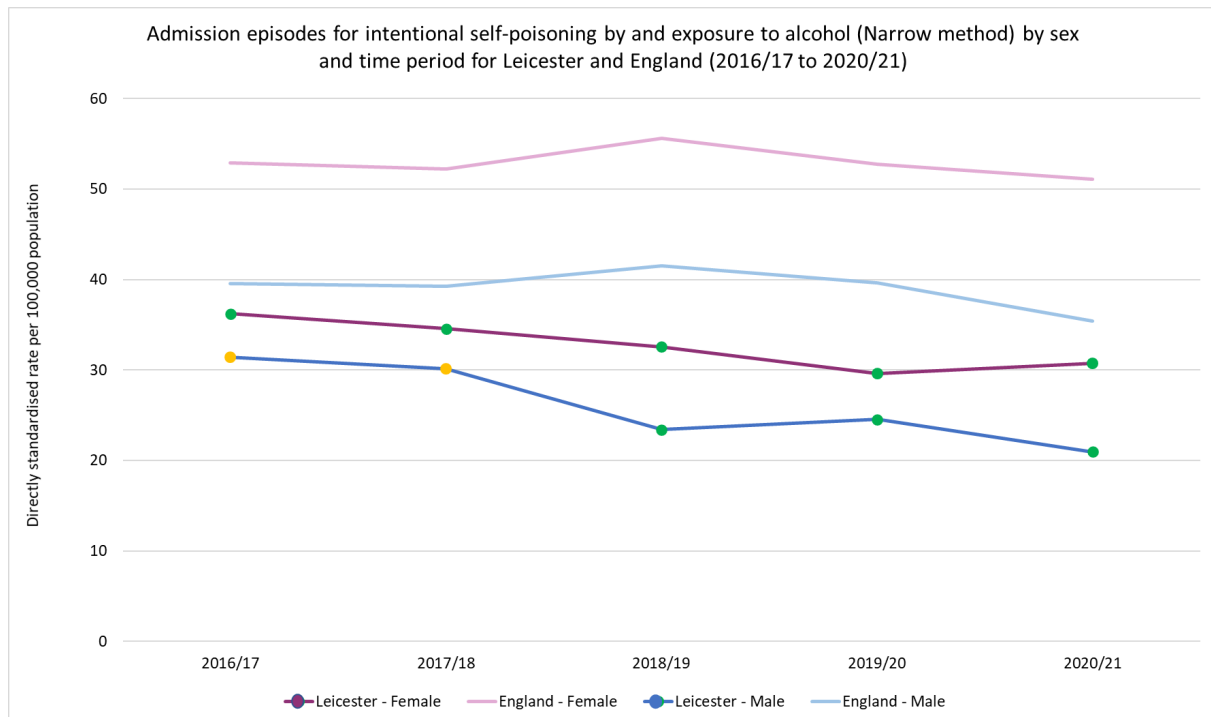
Figure 35: Admission episodes for intentional self-poisoning by and exposure to alcohol (narrow method) for Leicester, Leicester's comparators and England (Persons) (2020/21)<sup>70</sup>



In 2020/21 in Leicester there were 40 admission episodes for intentional self-poisoning by and exposure to alcohol (narrow method) in males and 60 in females. There has been no significant difference between the rate of admission episodes for intentional self-poisoning by and exposure to alcohol (narrow method) in males compared to females in Leicester since recording of this indicator began in 2016/17. As shown in Figure 36, since 2016/17 the rate of hospital admission episodes for intentional self-poisoning by and exposure to alcohol (narrow method) in females in Leicester has been significantly lower (better) than the rate in females in England overall. For males in Leicester the rate has been significantly lower than that of males in England since 2018/19, before which the rate for males in Leicester was not significantly different to the rate for males in England overall.

Over the last five time periods there has been no significant change in the rate of hospital admission episodes for intentional self-poisoning by and exposure to alcohol in males or females in Leicester.

Figure 36: Admission episodes for intentional self-poisoning by and exposure to alcohol (narrow method) by sex and time period for Leicester and England (2016/17 to 2020/21)<sup>7172</sup>

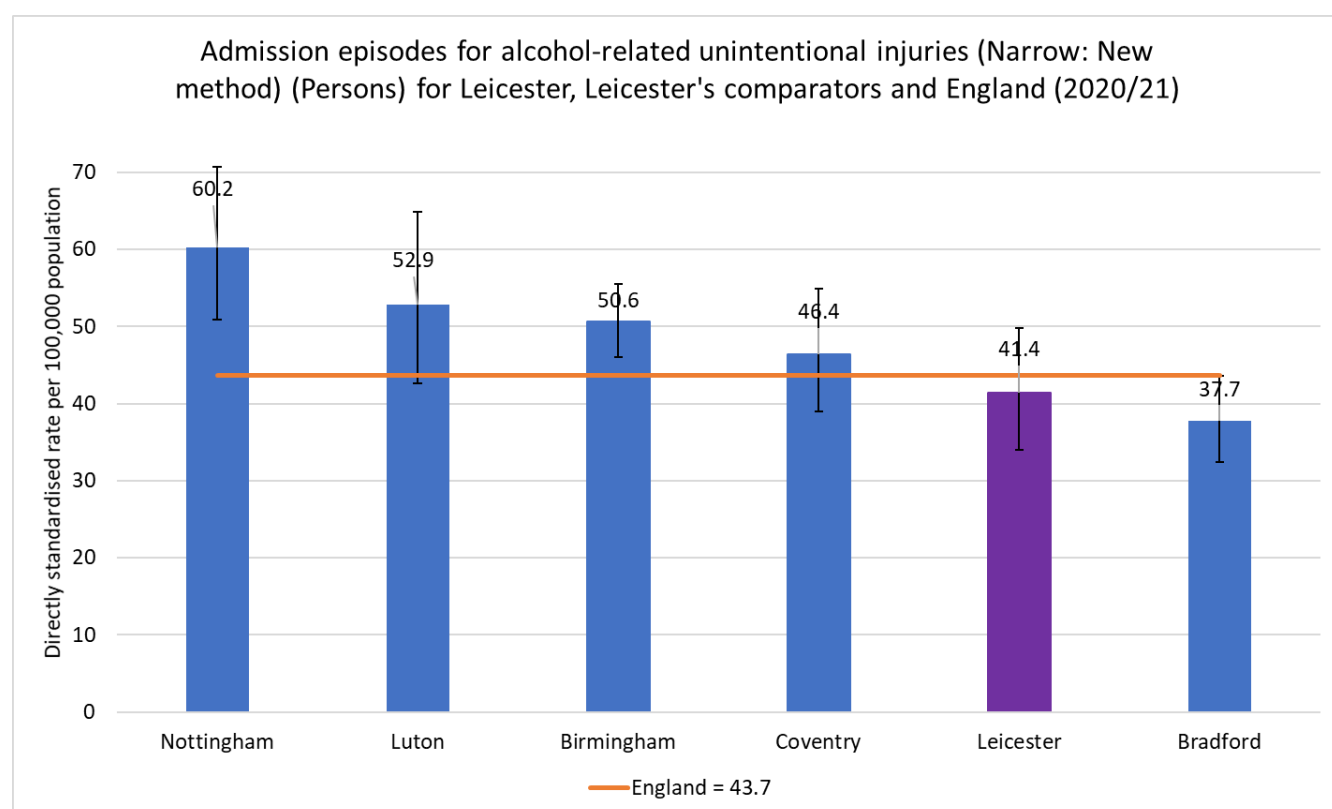


#### 10.2.5. Unintentional injuries (narrow method)

In Leicester in 2020/21 there were 117 admission episodes for alcohol-related unintentional injuries (narrow method). As shown in Figure 37, the rate of admission episodes for alcohol-related unintentional injuries in Leicester in 2020/21 (41.4 per 100,000 population) was not significantly different to the rate in England (43.7 per 100,000 population). The rate in Leicester was significantly lower than the rate in Nottingham (60.2 per 100,000 population) but not significantly different to any of its other local authority comparators. Leicester had the 2<sup>nd</sup> lowest rate of admission episodes for alcohol-related unintentional injuries of its comparators.

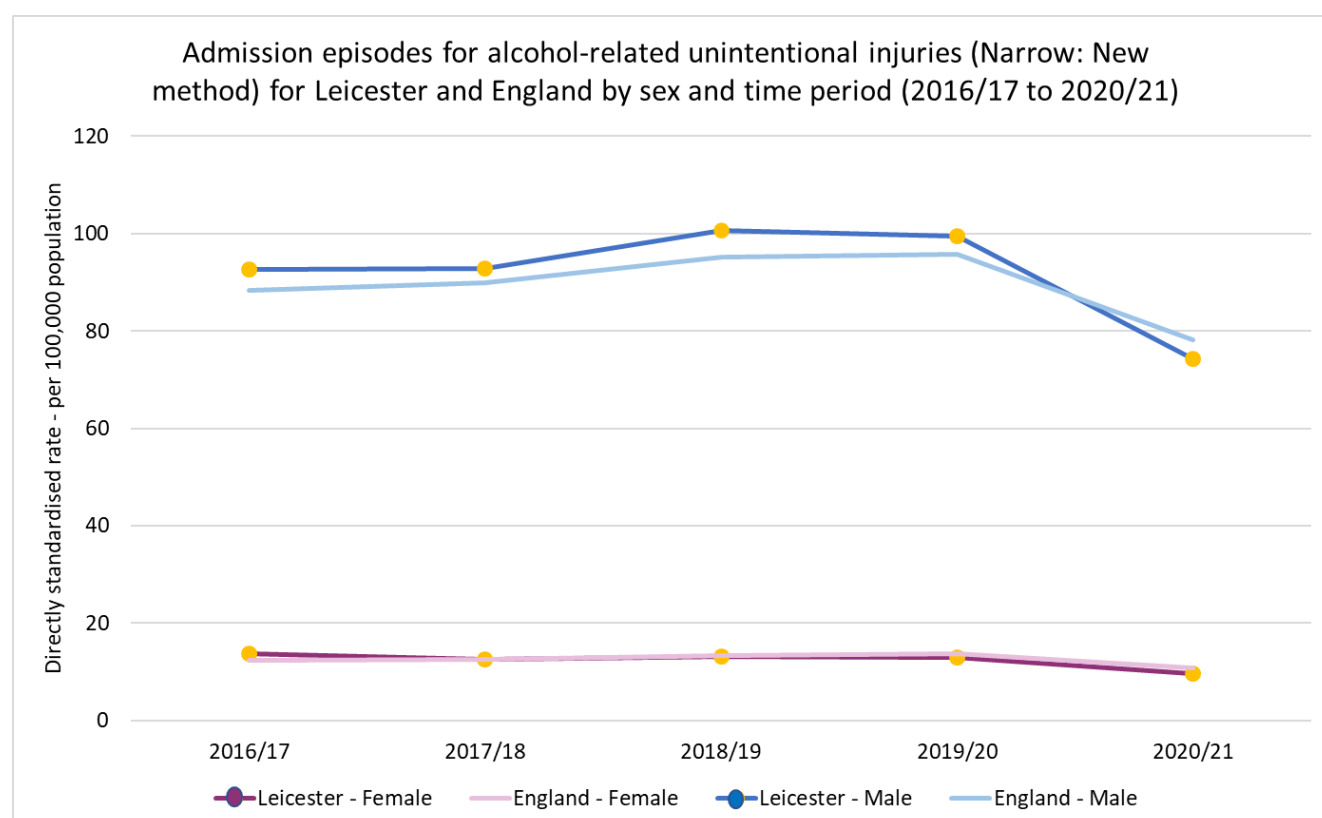


Figure 37: Admission episodes for alcohol-related unintentional injuries (Narrow: New method) for Leicester, Leicester's comparators and England in 2020/21<sup>73</sup>



There were 102 admission episodes for alcohol-related unintentional injuries in males and 15 in females in Leicester in 2020/21. Between 2016/17 and 2020/21 the rate of admission episodes for alcohol-related unintentional injuries in males and females in Leicester was not significantly different to the rate in males and females in England overall. The rate of admission episodes for alcohol-related unintentional injuries was significantly higher (worse) in males than in females in Leicester and in England between 2016/17 and 2020/21. Since 2018/19 in both males and females in Leicester the rate of admission episodes for alcohol-related unintentional injuries has shown a declining trend. However, over the last five time periods there was no significant change in the rate of admission episodes for alcohol-related unintentional injuries in males or females in Leicester.

Figure 38: Admission episodes for alcohol-related unintentional injuries in Leicester and England by sex and time period between 2016/17 and 2020/21<sup>74 75</sup>

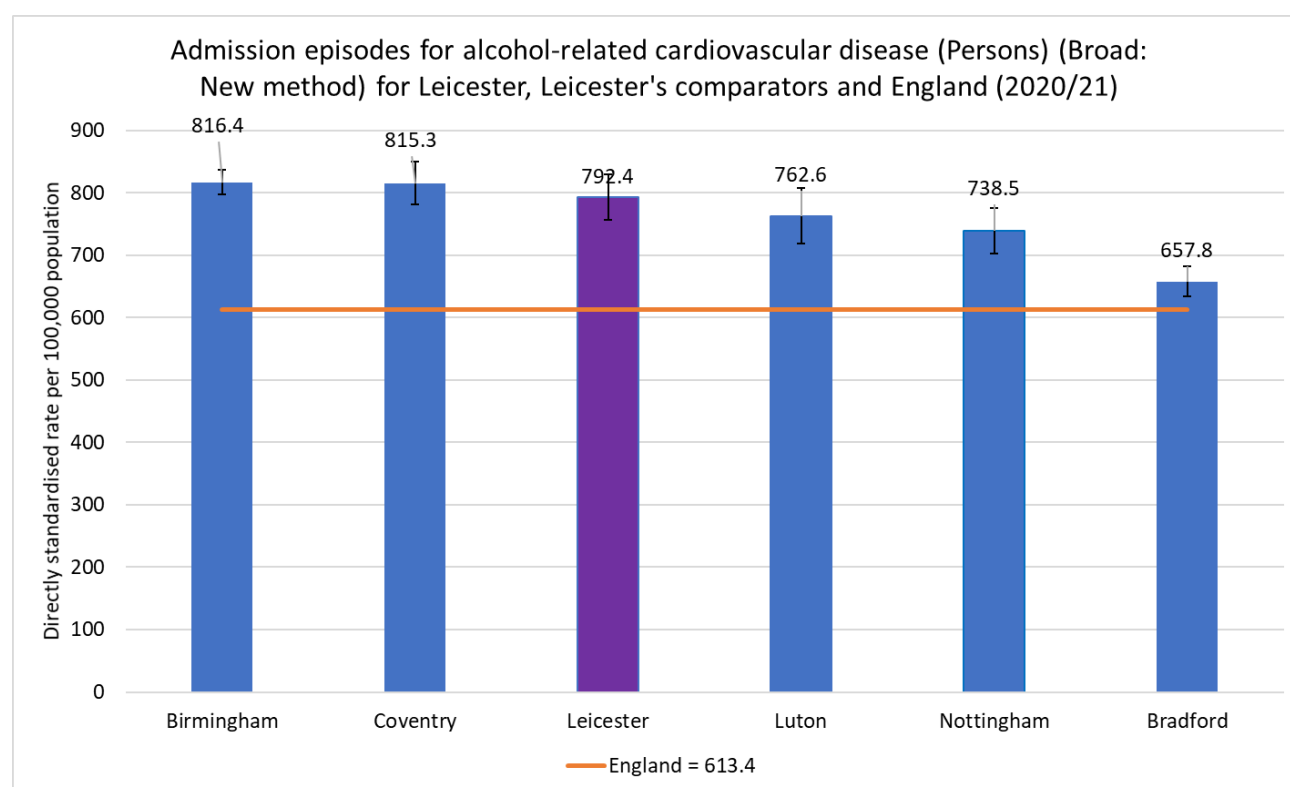


#### 10.2.6. Cardiovascular disease

Hospital admissions for alcohol-related cardiovascular disease are calculated where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable cardiovascular disease code. This includes Hypertensive diseases (I10-I15); Cardiac arrhythmias (I47-I48); Heart failure (I50-I51); Haemorrhagic stroke (I690-I692); Ischaemic stroke (I63-I66); Oesophageal varices (I85). For each episode identified, an alcohol-attributable fraction is applied based on the diagnostic codes, age group, and sex of the patient.

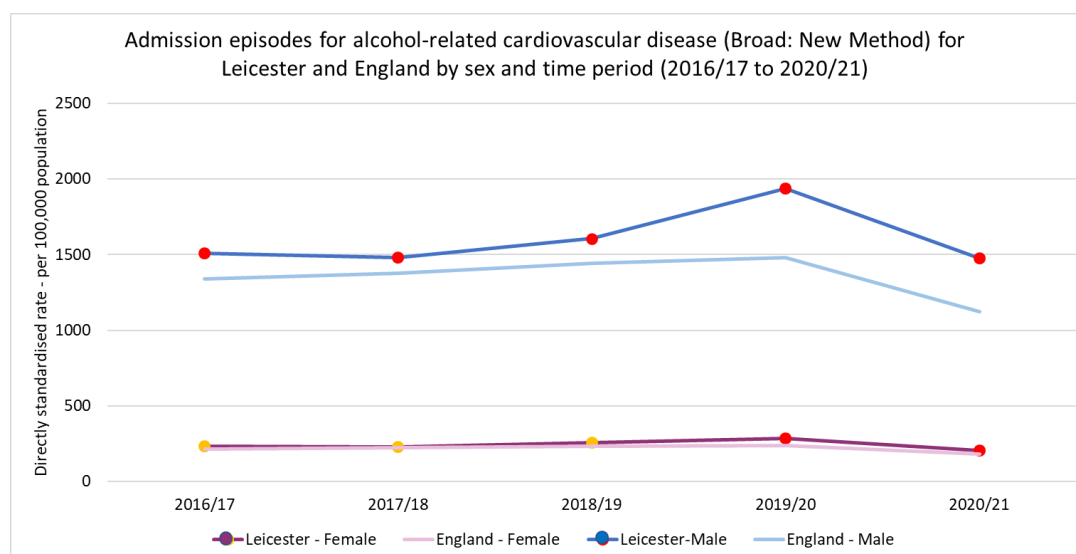
In 2020/21 in Leicester there were 1,931 admission episodes for alcohol-related cardiovascular disease (broad method). As shown in Figure 39, the rate of hospital admissions in Leicester in 2020/21 for alcohol-related cardiovascular disease (792.4 per 100,000 population) was significantly higher (worse) than the rate in England overall (613.4 per 100,000 population). The rate of admission episodes for alcohol-related cardiovascular disease in Leicester in 2020/21 was significantly higher than that of Bradford (657.8 per 100,000 population) but not significantly different to any of its other local authority comparators.

Figure 39: Admission episodes for alcohol-related cardiovascular disease for Leicester, Leicester's comparators and England (2020/21)<sup>76</sup>



In Leicester in 2020/21 there were 1,661 admission episodes for alcohol-related cardiovascular disease (broad method) in males and 269 in females. As shown in Figure 40, the rate of hospital admissions for alcohol-related cardiovascular disease in males in Leicester was significantly higher than the rate in males in England for each time period between 2016/17 and 2020/21. Between 2016/17 and 2018/19 the rate of admission episodes for alcohol-related cardiovascular disease in females in Leicester was not significantly different to the rate in females in England. In 2019/20 and 2020/21, the rate in females in Leicester was significantly higher than the rate in females in England. Between 2016/17 and 2020/21, the rate of hospital admissions for alcohol-related cardiovascular disease in males was significantly higher than the rate in females in Leicester and in England. The rate of admission episodes for alcohol-related cardiovascular disease in males in Leicester showed an increasing trend between 2017/18 and 2019/20 before decreasing between 2019/20 and 2020/21, a similar trend was witnessed nationally. The rate of admission episodes for alcohol-related cardiovascular disease in females in Leicester showed a similar trend, although the changes were less pronounced in the female rate.

Figure 40: Admission episodes for alcohol-related cardiovascular disease in Leicester and England by sex and time period between 2016/17 and 2020/21<sup>77,78</sup>



### 10.2.7. Alcoholic liver disease

Liver disease is one of the top causes of death in England and people are dying from it at younger ages. Much of liver disease is influenced by alcohol consumption and obesity prevalence, both of which are amenable to public health interventions. Increasing and higher risk drinkers are between 3-10 times more likely to develop liver cirrhosis compared to non-drinkers.

Figure 41: Hospital admission rate (per 100,000 population) for alcoholic liver disease (Persons) for Leicester, Leicester's comparators and England (2020/21)<sup>79</sup>

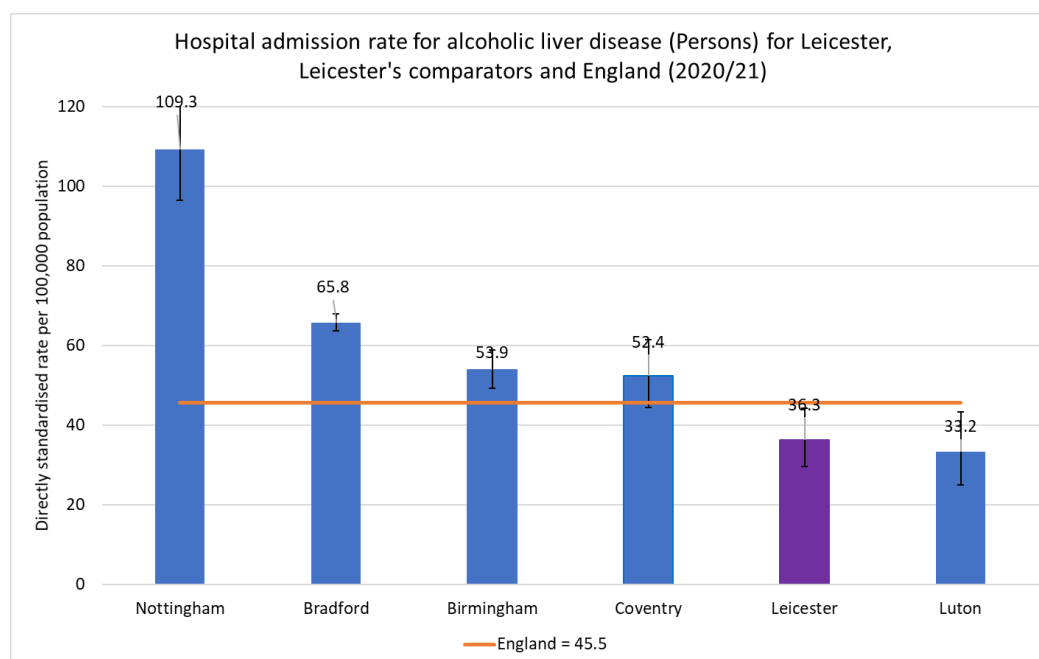


Figure 41 examines the hospital admission rate for alcoholic liver disease defined as the number of hospital admissions due to alcoholic liver disease with a primary diagnosis of ICD10 code K70 (any

4th digit). In 2020/21 in Leicester there were 100 hospital admissions for alcoholic liver disease. The figure shows that in 2020/21 the rate in Leicester (36.3 per 100,000 population) was significantly lower (better) than that of England (45.5 per 100,000 population). The rate of hospital admissions for alcoholic liver disease in Leicester in 2020/21 was significantly lower (better) than that of Nottingham (109.3 per 100,000 population), Bradford (65.8), Birmingham (53.9) and Coventry (52.4).

In Leicester in 2020/21 there were 70 hospital admissions for alcoholic liver disease in males and 30 in females. Figure 42 shows that in 2020/21 the rate of admission episodes for alcoholic liver disease in Leicester was significantly higher (worse) in males (50.7 per 100,000 population) than in females (22.3 per 100,000 population), this pattern was also witnessed in England overall (males: 61.7 per 100,000 population, females: 30.1 per 100,000 population). There were no significant differences between the rate of hospital admissions for alcoholic liver disease in males or females between Leicester and England. Over the last five time periods the rate of admissions for alcoholic liver disease in England has shown a significant increasing and worsening trend for both males and females. In Leicester, there has been no significant change in the trend of rates in males and females within the same time period. This is particularly interesting as despite the significantly high level of alcohol-related hospital admissions in the local population and this high sustained level of activity particularly for males, this trend is not reflected in alcoholic liver disease admissions.

Figure 42: Hospital admission episodes for alcoholic liver disease for Leicester and England by sex and time period (2010/11 to 2020/21)

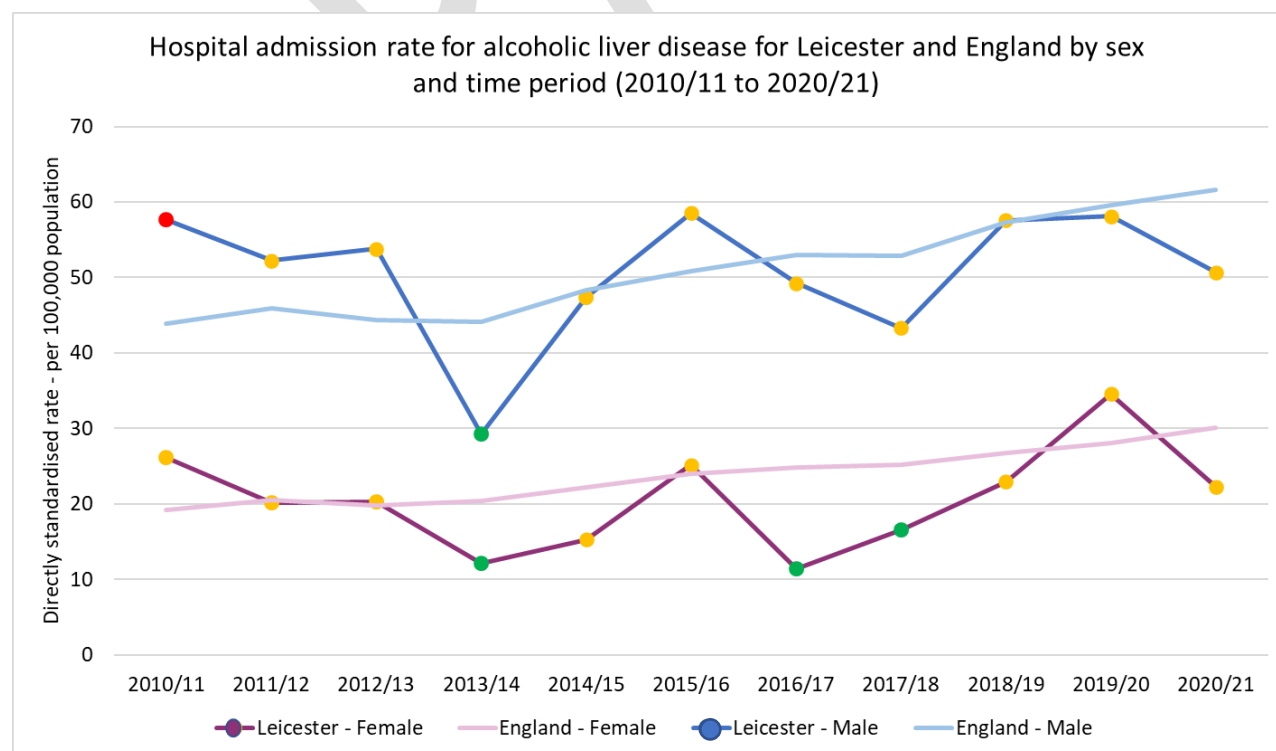
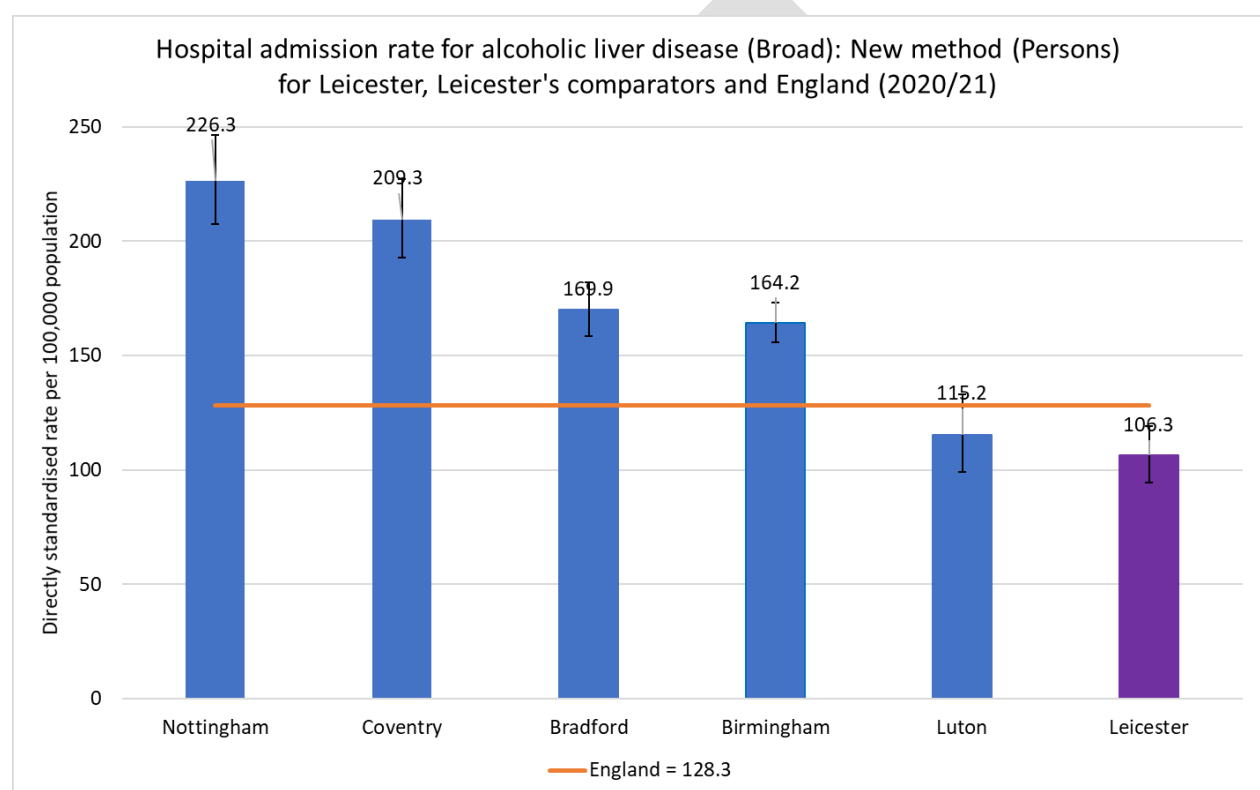


Figure 43 examines admissions to hospital where the primary diagnosis or any of the secondary diagnoses are an alcohol-attributable alcoholic liver disease code (K70). In Leicester in 2020/21 there were 293 admission episodes for alcoholic liver disease (broad method). The rate of hospital admissions for alcoholic liver disease (Broad) in Leicester in 2020/21 (106.3 per 100,000 population) was significantly lower (better) than the rate for England (128.3 per 100,000 population). Leicester had the lowest rate of hospital admissions for alcoholic liver disease (Broad) in 2020/21 when compared to its comparators, the rate in Leicester was significantly lower than that of Nottingham (226.3 per 100,000 population), Coventry (209.3), Bradford (169.9) and Birmingham (164.2).

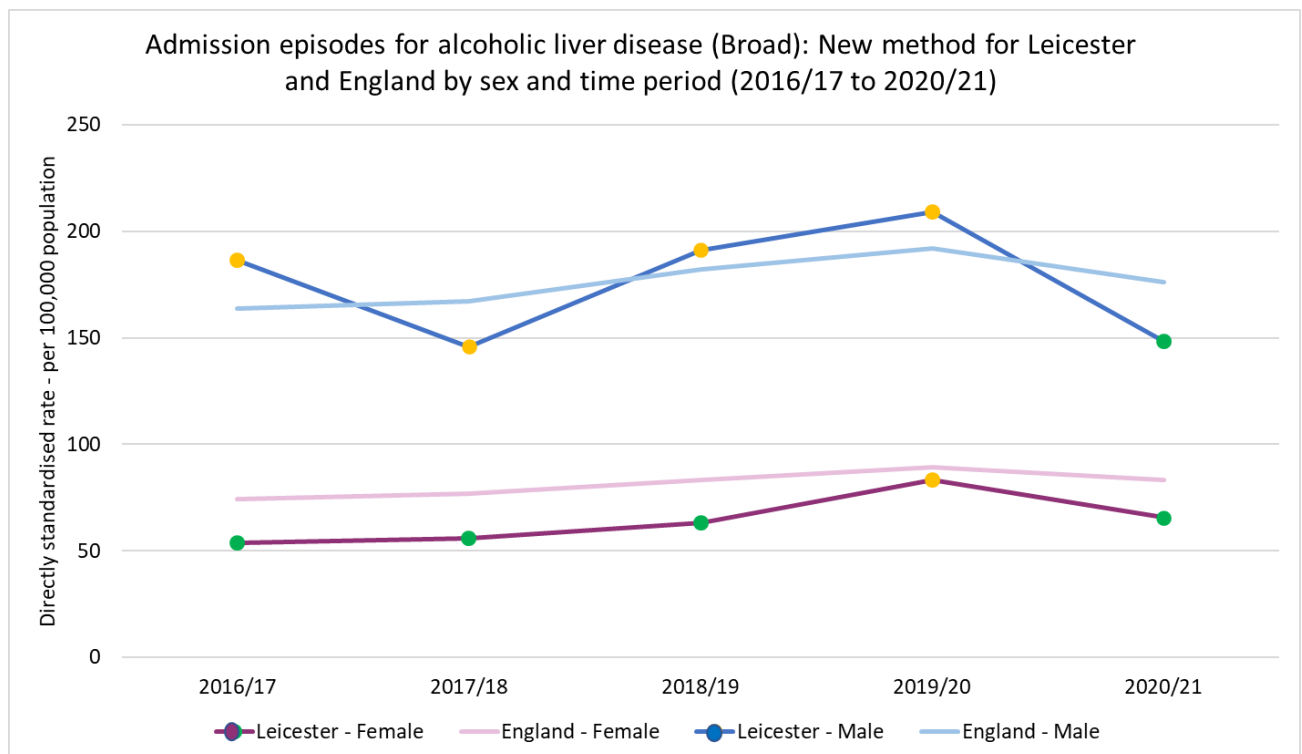
Figure 43: Admission episodes for alcoholic liver disease (Broad) in Leicester, Leicester's comparators and England in 2020/21<sup>80</sup>



In Leicester in 2020/21 there were 202 admission episodes for alcoholic liver disease (broad method) in males and 91 in females. Figure 44 shows that the rate of admission episodes for alcoholic liver disease (Broad) in males in Leicester was not significantly different to the rate in males in England between 2016/17 and 2019/20. In 2020/21 the rate in males in Leicester was significantly lower (better) than the rate in males in England. The rate of admission episodes for alcoholic liver disease (Broad) in males in Leicester decreased between 2016/17 and 2017/18 before showing an increasing trend to a peak in 2019/20, following this peak the rate in males in Leicester decreased significantly in 2020/21. The rate of admission episodes for alcoholic liver disease (Broad) in females in Leicester has been significantly lower (better) than the rate in females in England since recording of the

indicator began in 2016/17, with the exception of 2019/20 where the rate in females in Leicester was not significantly different to the rate in females in England. The rate of admission episodes for alcoholic liver disease (Broad) in females in Leicester showed an increasing trend from the lowest rate recorded in 2016/17 to a peak in 2019/20, following this increase the rate in females in Leicester declined in 2020/21.

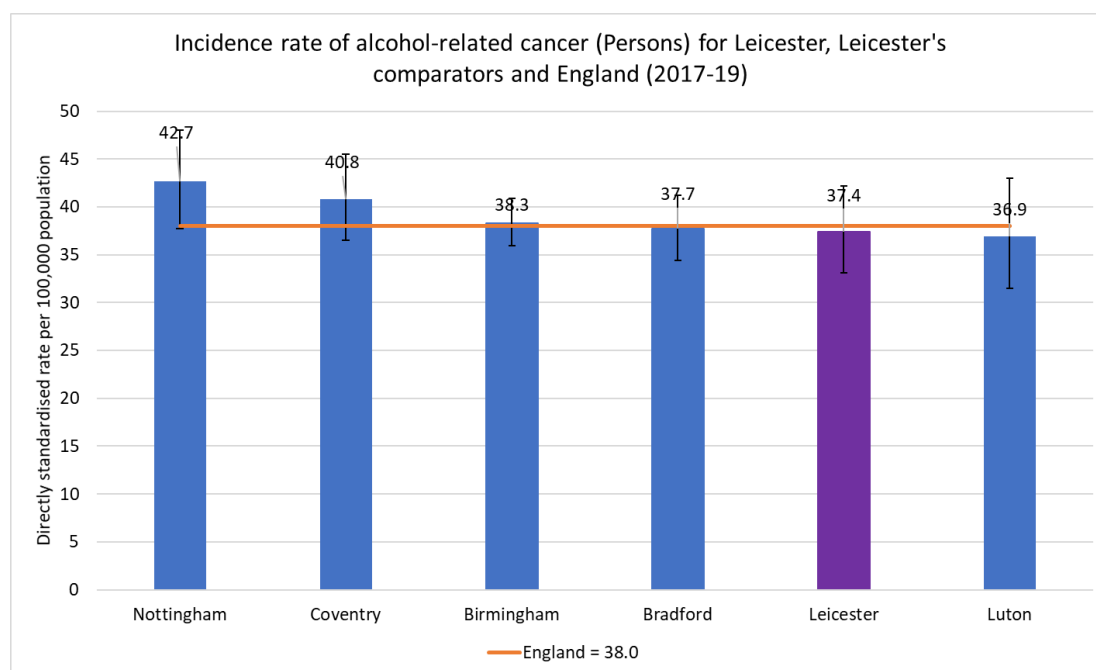
Figure 44: Admission episodes for alcoholic liver disease (Broad) for Leicester and England by sex and time period between 2016/17 and 2020/21<sup>8182</sup>



### 10.3. Alcohol Related Harm

In Leicester in 2017-19 there were 275 new alcohol related cancer incidence records. In 2017-19 in Leicester the incidence rate of alcohol-related cancer (37.4 per 100,000 population) was not significantly different to the rate in England overall (38.0 per 100,000 population), this has been the case since recording of the indicator began in 2004-06. The incidence rate of alcohol-related cancer in Leicester in 2017-19 was not significantly different to the rate in any of its local authority comparators.

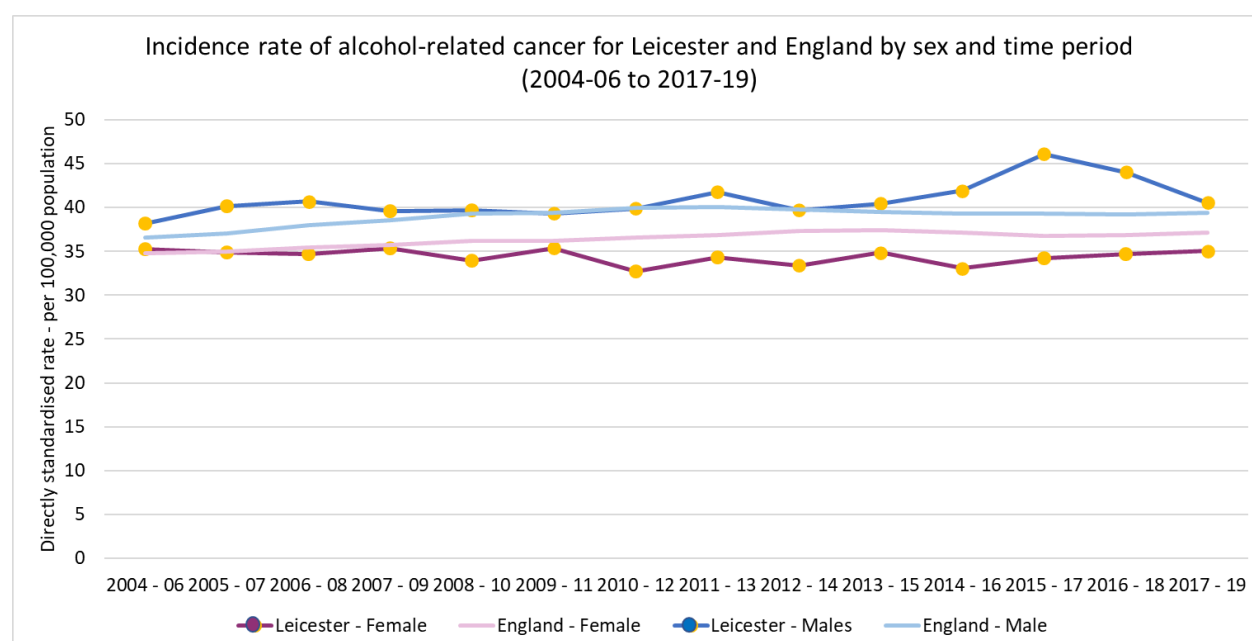
Figure 45: Incidence rate of alcohol-related cancer in Leicester, Leicester's comparators and England in 2017-19<sup>83</sup>



In Leicester in 2017-19 there were 140 new alcohol related cancer incidence records in males and 140 in females. Figure 46 shows that between 2004-06 and 2017-19 the incidence rate of alcohol-related cancer in males and females in Leicester was not significantly different to the rate in males and females in England. Between 2004-06 and 2012-14 the incidence rate of alcohol-related cancer in males in Leicester fluctuated. Between 2012-14 and 2015-17 the rate in males in Leicester showed an increasing trend from 39.7 per 100,000 population to a peak of 46.1 per 100,000 population. Following this, between 2015-17 and 2017-19, the rate in males in Leicester decreased, falling to a rate similar to that seen in 2013-15 (40.6 per 100,000 population). The incidence rate of alcohol-related cancer in females in Leicester fluctuated between 2004-06 and 2014-16 before showing an increasing trend up to 2017-19.



Figure 46: Incidence rate of alcohol-related cancer in Leicester and England by sex and time period between 2004-06 and 2017/19<sup>8485</sup>



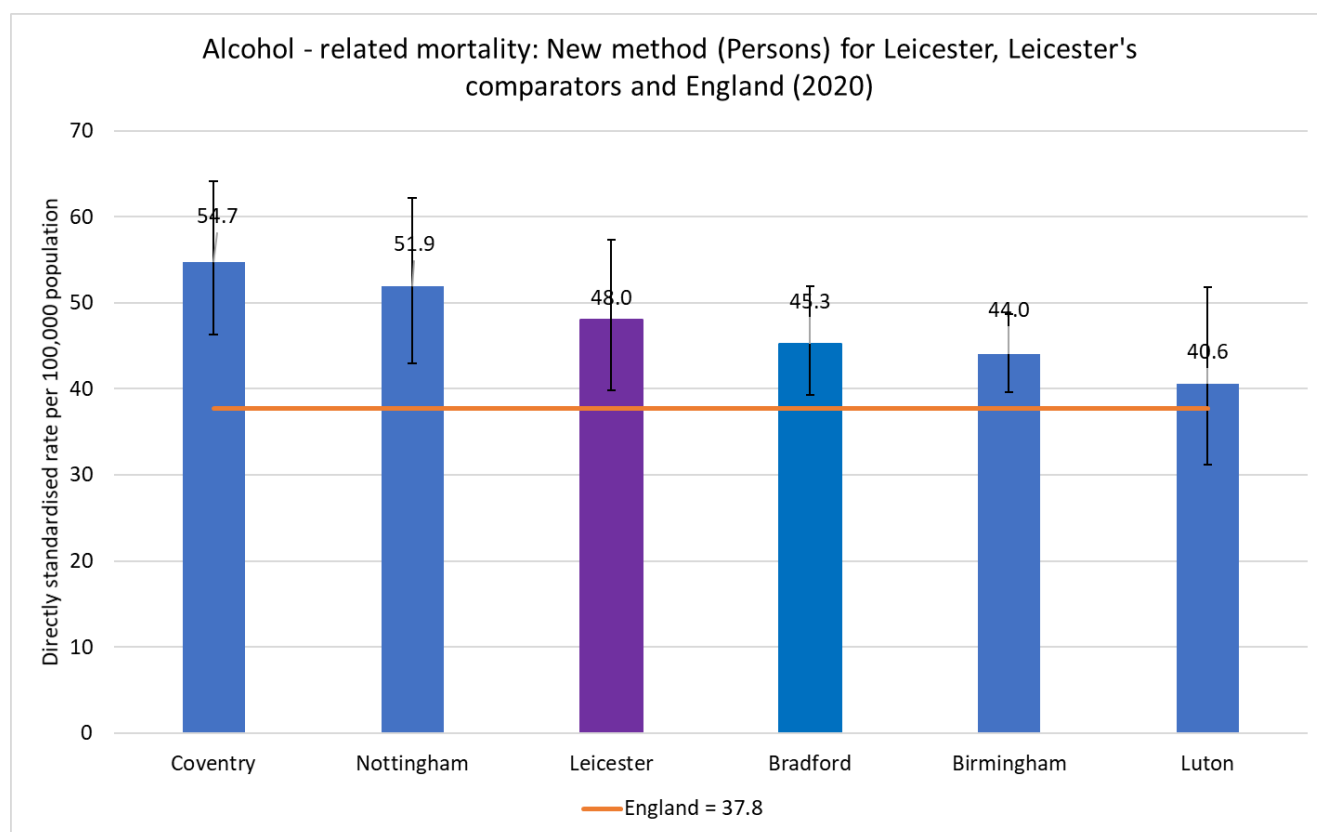
## 10.4. Mortality from Alcohol

### 10.4.1. Alcohol-related mortality

Deaths from alcohol-related conditions are based on underlying cause of death. Each alcohol related death is assigned an alcohol attributable fraction based on underlying cause of death (and all cause of deaths fields for the conditions: ethanol poisoning, methanol poisoning, toxic effect of alcohol).

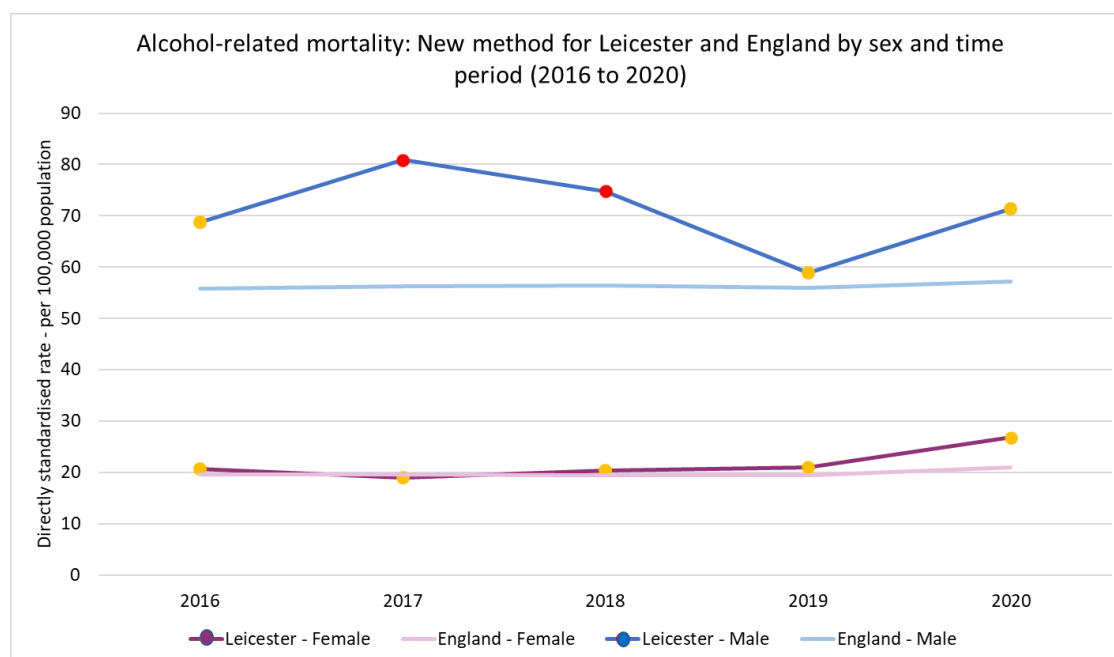
In Leicester in 2020 there were 125 deaths from alcohol-related conditions. As shown in Figure 47, the alcohol-related mortality in Leicester in 2020 (48.0 per 100,000 population) was significantly higher (worse) than that of England (37.8 per 100,000 population). Leicester had the third highest rate of it's comparators, although the rate in Leicester was not significantly different to any of it's comparators.

Figure 47: Alcohol-related mortality: New method (Persons) for Leicester, Leicester's comparators and England (2020)<sup>86</sup>



In Leicester in 2020 there were 90 deaths from alcohol-related conditions in males and 35 in females. As shown in Figure 48, rates of alcohol-related mortality are significantly higher in males than in females in Leicester and in England. Since recording of the indicator began in 2016, rates for women have been less than half those for men in both Leicester and England. The alcohol-related mortality rate in females in Leicester has not been significantly different to the rate for females in England overall since recording of the indicator began. For males, the alcohol-related mortality rate in Leicester has not been significantly different to the rate for England for the previous two years, before which the rate in Leicester was significantly worse than England for two years. Over the last five time periods there has been no significant change in the rate of alcohol-related mortality in males or females in Leicester.

Figure 48: Alcohol-related mortality: New method for Leicester and England by sex and time period (2016 to 2020)<sup>8788</sup>



#### 10.4.2. Alcohol-specific mortality

The definition used to compile statistics on alcohol-specific deaths across the UK is shown in Appendix 1. This definition includes only those causes known to be exclusively caused by alcohol consumption. It does not include deaths from partially attributable conditions such as cancers of the mouth, oesophagus and liver. Apart from deaths due to poisoning with alcohol (accidental, intentional or undetermined), this definition excludes any other external causes of death, such as road traffic and other accidents. The definition allows for consistent comparisons over time for those deaths most clearly associated with alcohol consumption.

In Leicester in 2017-19 there were 117 deaths from alcohol-specific conditions. As shown in Figure 49 the rate of alcohol-specific mortality in Leicester in 2017-19 (14.6 per 100,000 population) was significantly higher (worse) than the rate in England overall (10.0 per 100,000 population). The rate of alcohol-specific mortality in Leicester (14.6 per 100,000 population) was significantly higher (worse) than that of Luton (7.3 per 100,000 population).

Figure 49: Alcohol-specific mortality (Persons) for Leicester, Leicester's comparators and England in 2017-19<sup>89</sup>

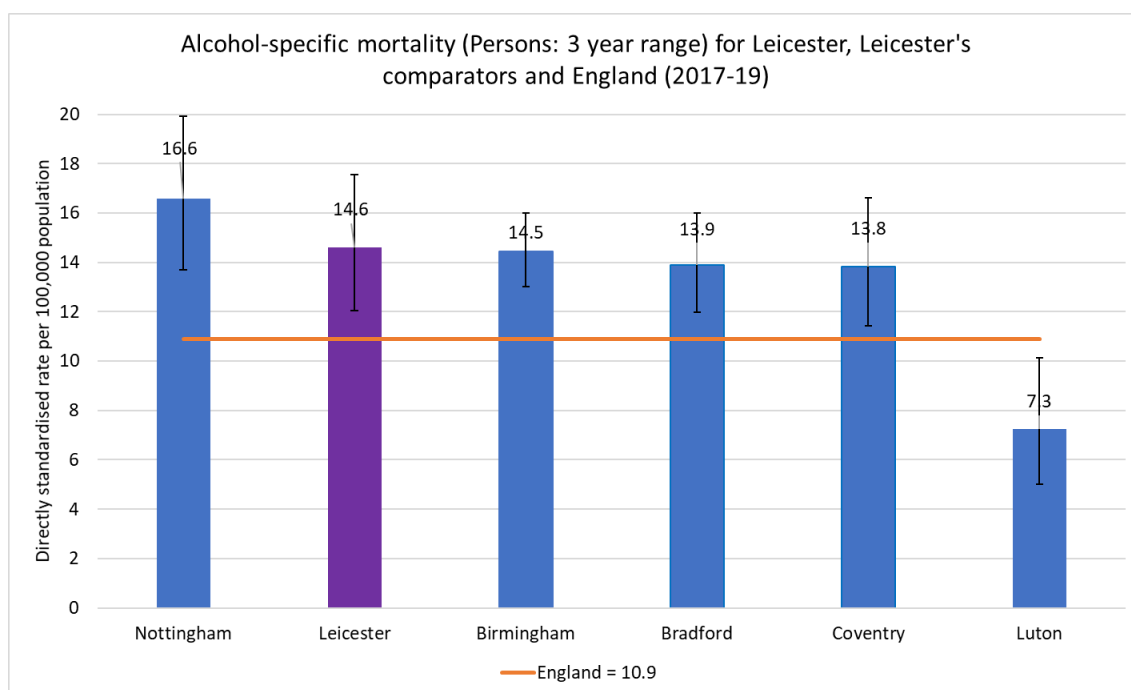
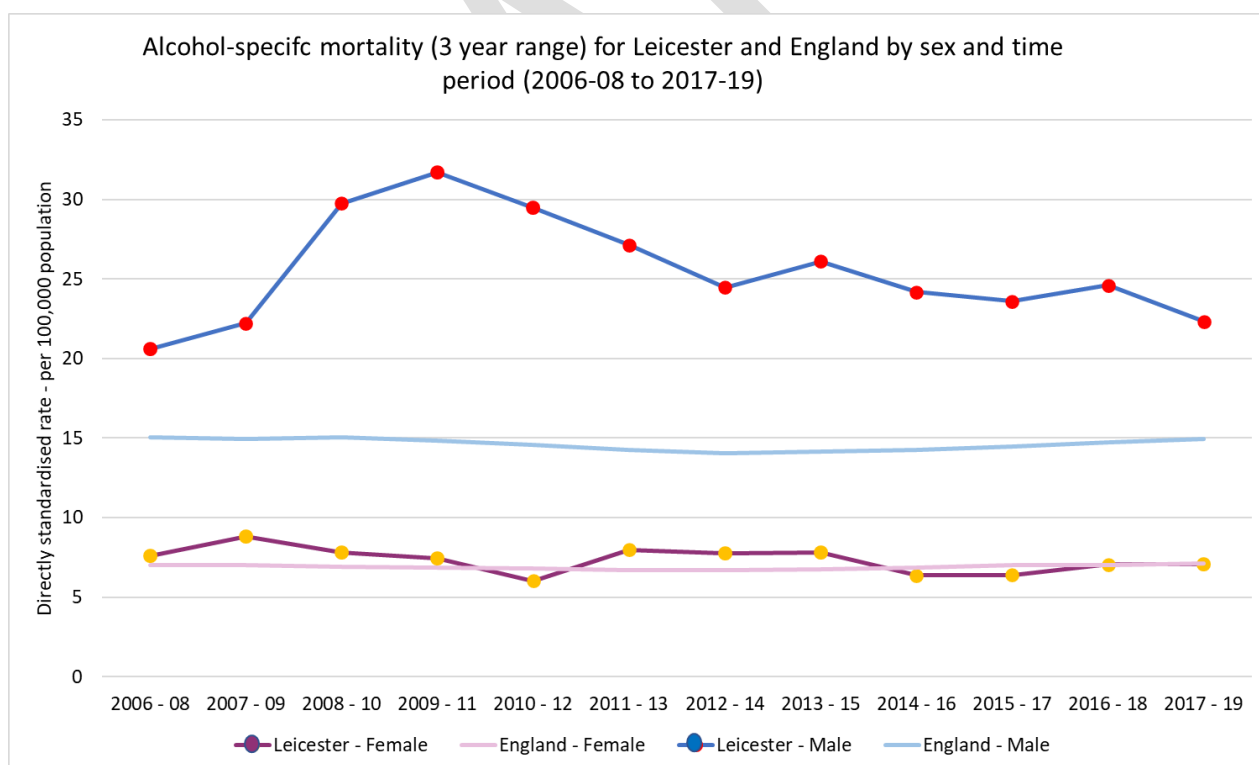


Figure 50: Alcohol-specific mortality for Leicester and England by sex and time period (2006-08 to 2017-19)<sup>90,91</sup>

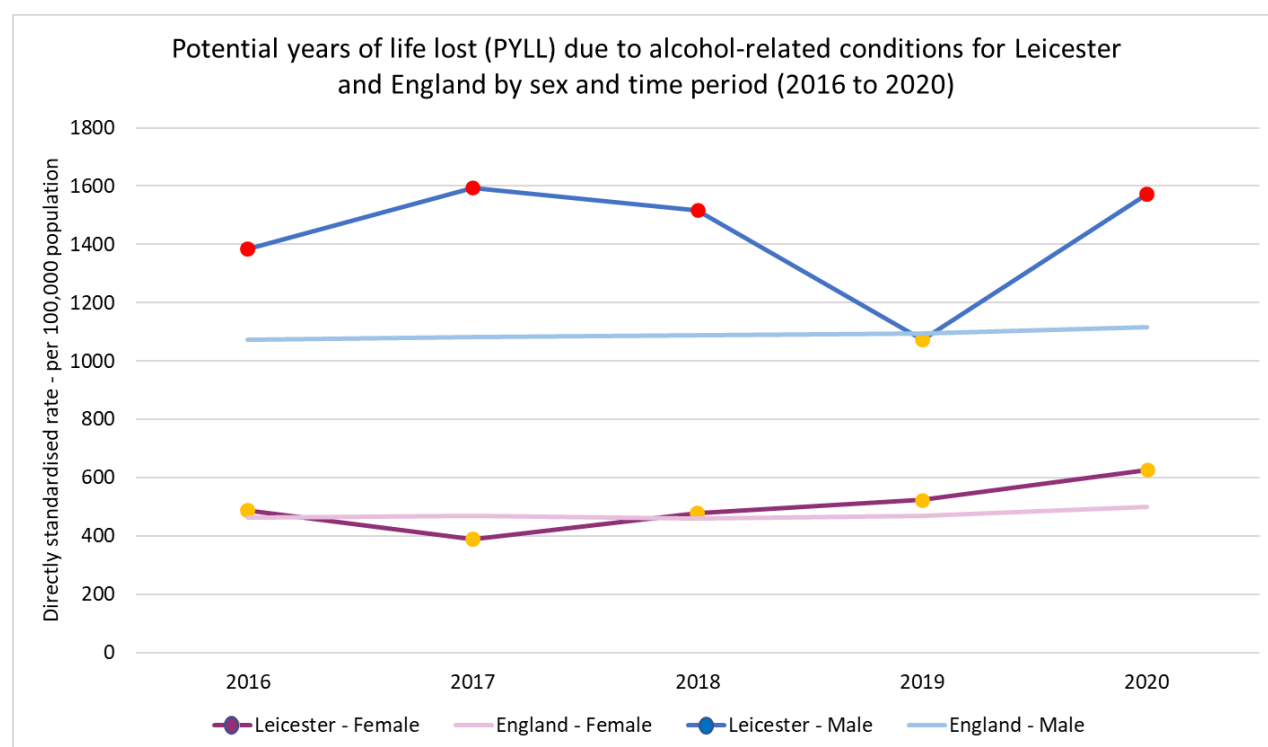


In Leicester in 2017-19 there were 88 deaths from alcohol-specific conditions in males and 29 in females. Between 2006-08 and 2017-19 the rate of alcohol-specific mortality was significantly higher in males than in females in both Leicester and England. The rate of alcohol-specific mortality in males in Leicester has been significantly higher (worse) than the rate in males in England since

recording of this indicator began in 2006-08. The rate in females in Leicester has not been significantly different to the rate in females in England within the same time period. Between 2006-08 and 2009-11 the rate of alcohol-specific mortality in males in Leicester showed an increasing trend before showing a decreasing trend between 2009-11 and 2017-19, throughout the entire period the rate in males in England remained fairly stable in comparison.

In Leicester in 2020 there were 2,173 potential years of life lost due to alcohol-related conditions in males and 868 potential years of life lost due to alcohol-related conditions in females. The rate of potential years of life lost (PYLL) due to alcohol-related conditions has been significantly higher (worse) in males than in females in Leicester and in England overall since recording of the indicator began in 2016. As shown in Figure 51, there has been no significant difference between the PYLL due to alcohol-related conditions in females in Leicester compared to females in England since recording of the indicator began. The rate of PYLL due to alcohol-related conditions in males in Leicester has been significantly higher (worse) than the rate for males in England since 2016, with the exception of 2019 when there was no significant difference between the rate for males in Leicester compared to males in England. Over the last five time periods there has been no significant change in the rate of PYLL due to alcohol-related conditions in males or females in Leicester.

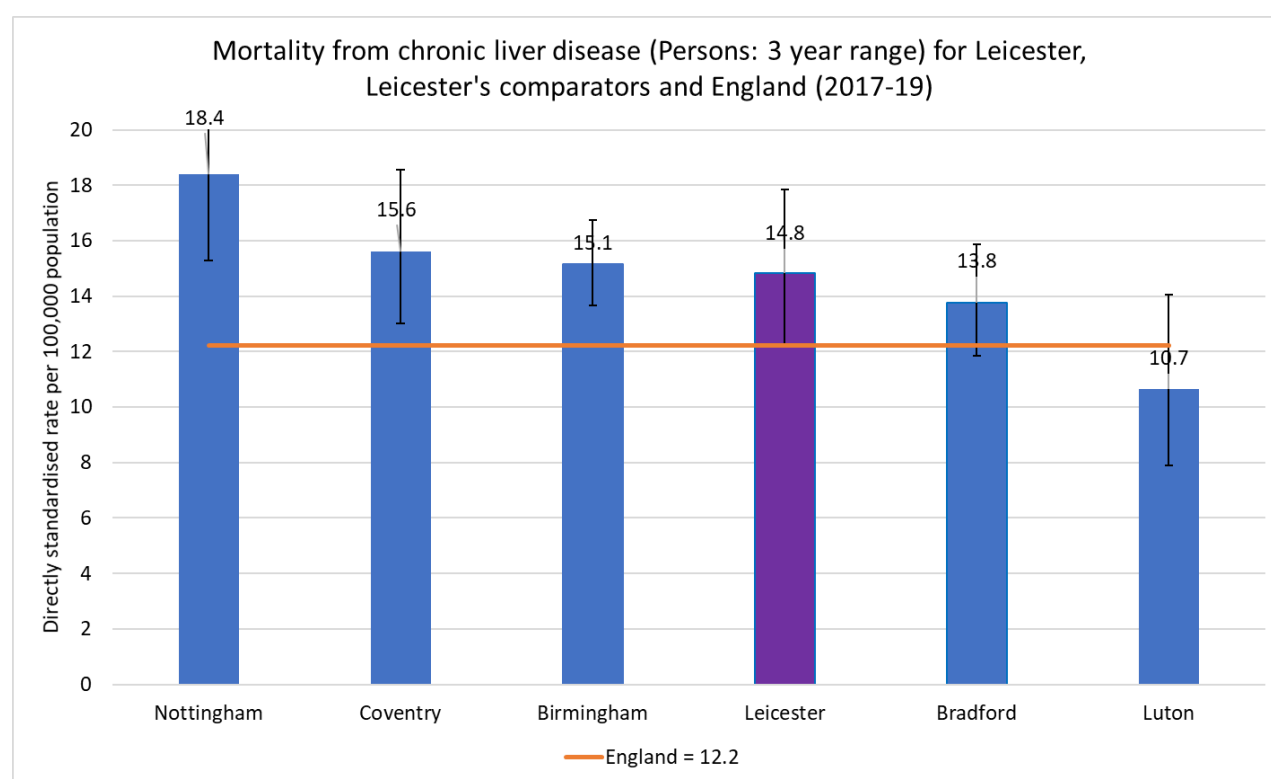
Figure 51: Potential years of life lost (PYLL) due to alcohol-related conditions for Leicester and England by sex and time period (2016 to 2020)<sup>92,93</sup>



In 2017-19 in Leicester there were 114 deaths from chronic liver disease. The mortality rate from chronic liver disease in Leicester in 2017-19 (14.8 per 100,000 population) was not significantly

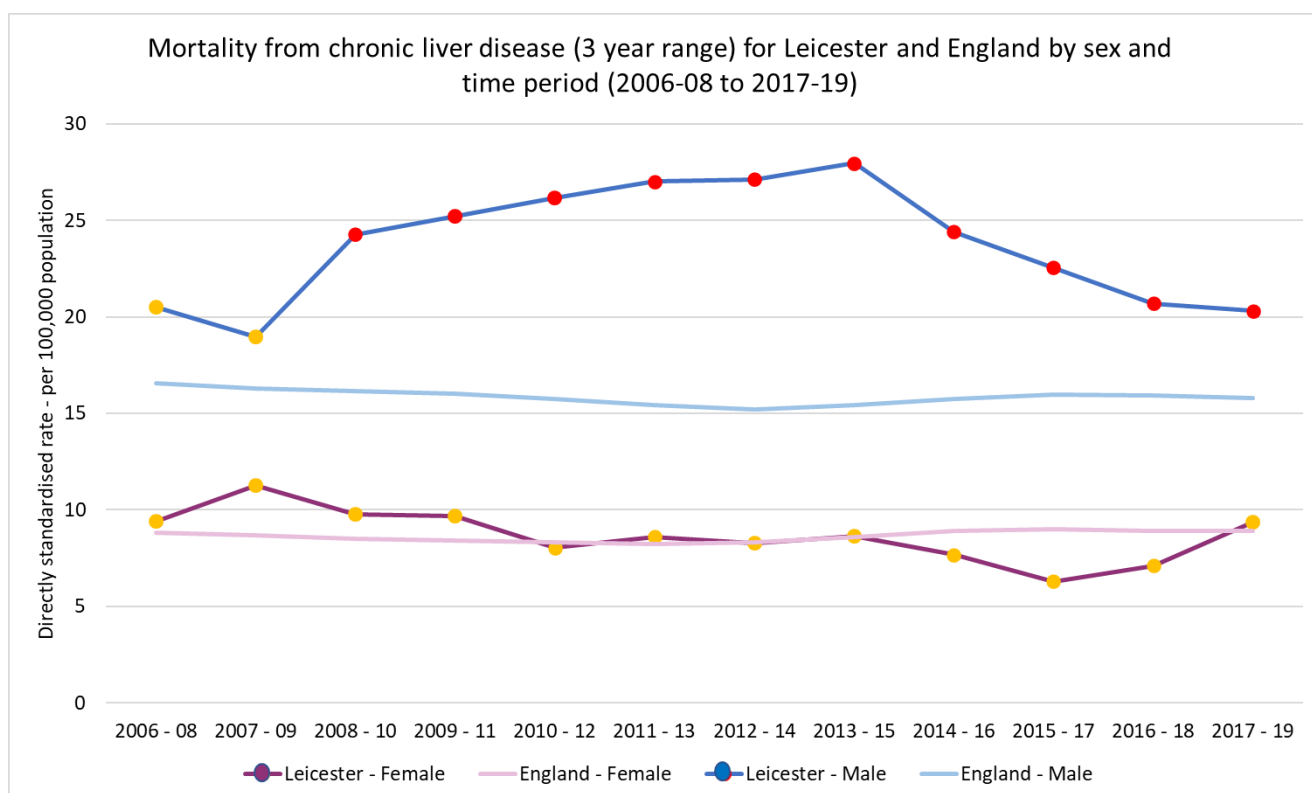
different to the rate for England overall (12.2 per 100,000 population). As shown in Figure 52, the rate in Leicester was also not significantly different to any of its comparators in 2017-19.

Figure 52: Mortality from chronic liver disease in Leicester, Leicester's comparators and England (2017-19)<sup>94</sup>



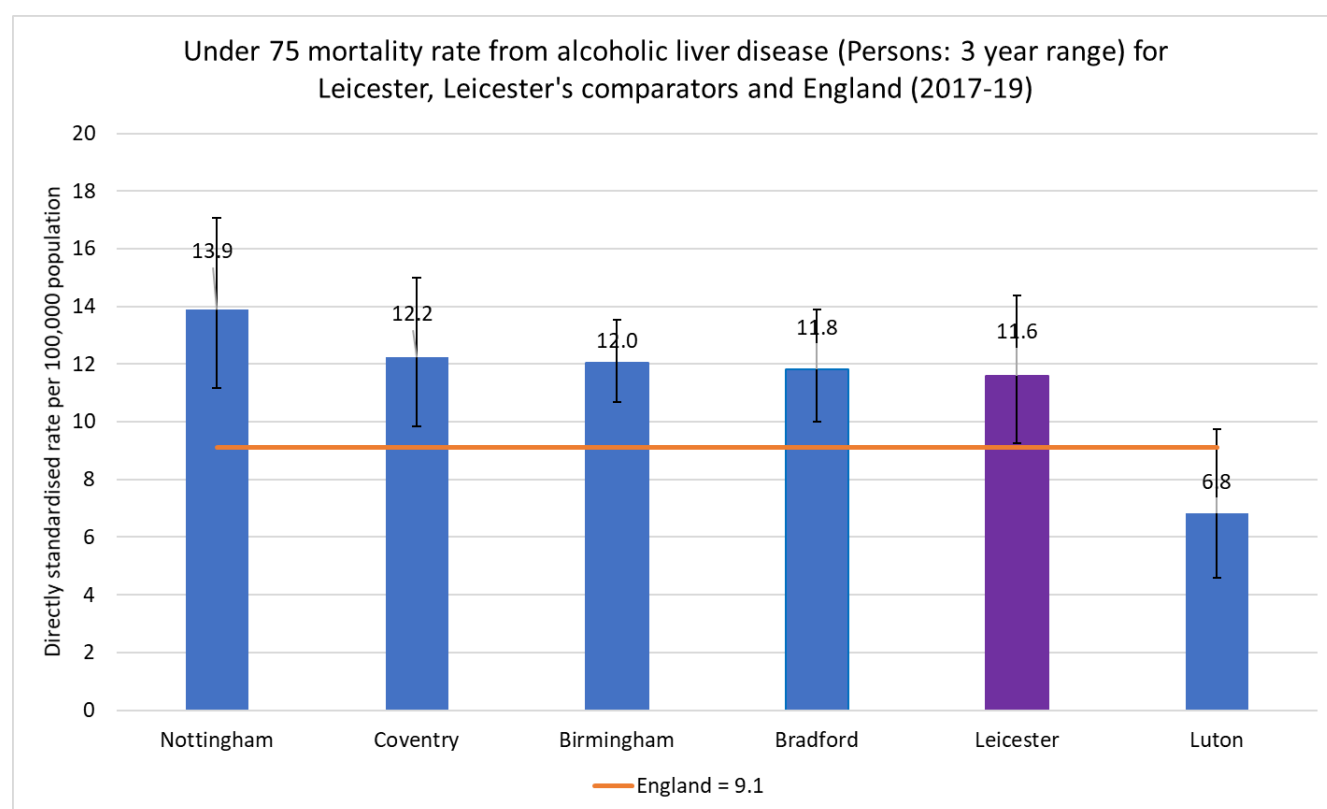
In 2017-19 in Leicester there were 76 deaths from chronic liver disease in males and 38 in females. Figure 53 shows that between 2008-10 and 2017-19 the rate of mortality from chronic liver disease in males in Leicester was significantly higher (worse) than the rate in males in England overall. The rate of mortality from chronic liver disease in females in Leicester has not been significantly different to the value for England overall since recording of the indicator began in 2006-08. Between 2006-08 and 2017-19 the rate of mortality from chronic liver disease has been significantly higher in males than in females in both Leicester and England, with the exception of 2007-09 where the rate in males in Leicester was not significantly different to the rate in females in Leicester. Following a decrease between 2006-08 and 2007-09, the rate of mortality from chronic liver disease in males in Leicester showed an increasing trend between 2007-09 and 2013-15. Following this the rate in males in Leicester decreased each time period between 2013-15 and 2017-19. In comparison, the rate in males in England remained fairly consistent. In females in Leicester the rate of mortality from chronic liver disease increased between 2006-08 and 2007-09 before showing a decreasing trend between 2007-09 to 2010-12. Between 2010-12 and 2013-15 the rate remained fairly stable before decreasing between 2013-15 and 2015-17 and then showing an increasing trend more recently since 2015-17.

Figure 53: Mortality from chronic liver disease for Leicester and England by sex and time period (2006-08 to 2017-19)<sup>9596</sup>



As shown in Figure 54, the under 75 mortality rate from alcoholic liver disease in Leicester in 2017-19 (11.6 per 100,000 population) was significantly higher (worse) than that of England (9.1 per 100,000 population). Leicester had the second lowest rate of it's comparators, although the rate in Leicester was not significantly different to any of it's comparators.

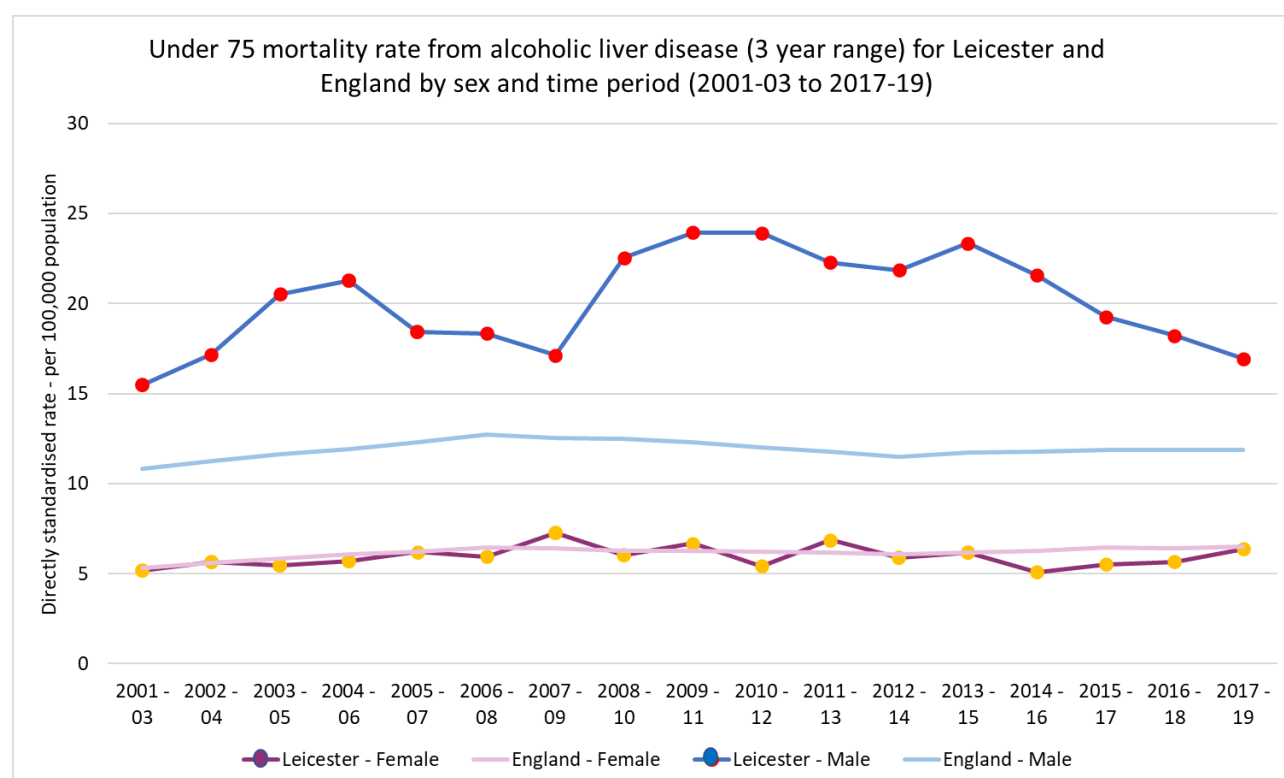
Figure 54: Under 75 mortality rate from alcoholic liver disease (Persons: 3 year range) for Leicester, Leicester's comparators and England (2017-19)<sup>97</sup>



As shown in Figure 55, under 75 mortality rate from alcoholic liver disease has been significantly higher in males than in females in Leicester and in England since recording of this indicator began in 2001-03. The under 75 mortality rate from alcoholic liver disease in females in Leicester has not been significantly different to the rate for females in England since recording of the indicator began. The under 75 mortality rate from alcoholic liver disease in males in Leicester has been significantly higher (worse) than the rate in males in England since 2001-03. Over the last 5 time periods the rate in males in Leicester has decreased year on year from 23.4 per 100,000 population in 2013-15 to 16.9 per 100,000 population in 2017-19. The rate in females in Leicester decreased from 6.2 per 100,000 population in 2013-15 to 5.1 per 100,000 in 2014-16, before increasing year on year to 6.4 per 100,000 in 2017-19.



Figure 55: Under 75 mortality rate from alcoholic liver disease (3 year range) for Leicester and England by sex and time period (2001-03 to 2017-19)<sup>9899</sup>



## 10.5. Impact of COVID-19

At a national level before the pandemic, there were already increased alcohol-related hospital admissions and deaths. The pandemic seems to have accelerated these trends. In 2020, the rates of unplanned admissions to hospital for alcohol specific causes decreased by 3.2% compared to 2019, which is related to reduced admissions for mental and behavioural disorders due to alcohol use. In 2020, there was a 20.0% increase in total alcohol specific deaths compared to 2019. This was brought about by increases in deaths from alcoholic liver disease, which accounted for 80.3% of total alcohol specific deaths in 2020 and saw a 20.8% increase between 2019 and 2020. Deaths from mental and behavioural disorders due to alcohol increased by 10.8% (compared to a 1.1% increase between 2018 and 2019), and deaths from alcohol poisoning increased by 15.4% (compared to a decrease of 4.5% between 2018 and 2019).<sup>39</sup>

Although alcohol related cirrhosis can take a decade or more to develop, most deaths occur as a result of acute-on-chronic liver failure due to recent alcohol intake, which is strongly linked to heavy drinking. Liver mortality rates respond rapidly to changes in population level alcohol consumption and particularly to changes in drinking patterns of heavy drinkers, as was seen during this pandemic. Liver mortality rates in England have increased by 43% between 2001 and 2019, so that liver disease is now the second leading disease causing premature death among people of working age.<sup>39</sup>

At a local level, during the pandemic, admissions for alcohol specific and alcohol-related admissions saw a decline, however this is likely to be related to the 'lockdown effect' where people reported avoiding hospitals to ease pressure on the more concerned hospitals were high-risk settings for catching COVID-19. Annual increases were witnessed in alcohol specific mortality, alcohol related mortality and mortality due to chronic liver disease. Surveillance of data indicators is required to understand the longer-term impact of the pandemic on the drinking levels locally and to understand if commissioned services are equipped to deal with the current and projected level of need.

## 11. Patterns of Drug Misuse

Under the Misuse of Drugs Act 1971, illegal drugs are placed into one of 3 classes - A, B or C. This is broadly based on the harms they cause either to the user or to society when they are misused.

- Class A drugs include: heroin (diamorphine), cocaine (including crack), methadone, ecstasy (MDMA), LSD and magic mushrooms
- Class B drugs include: amphetamines, barbiturates, codeine, cannabis, cathinones (including mephedrone), synthetic cannabinoids, Ketamine
- Class C drugs include: anabolic steroids, benzodiazepines, gamma hydroxybutyrate (GHB), gamma-butyrolactone (GBL), piperazines (BZP) and khat.

Not all drugs are illegal, however their being legal does not mean that they are not harmful. The use of novel psychoactive substances (NPS) represents an evolving risk and the extent of the impact of these substances is not yet fully understood.

### 11.1. National Patterns of Drug Misuse

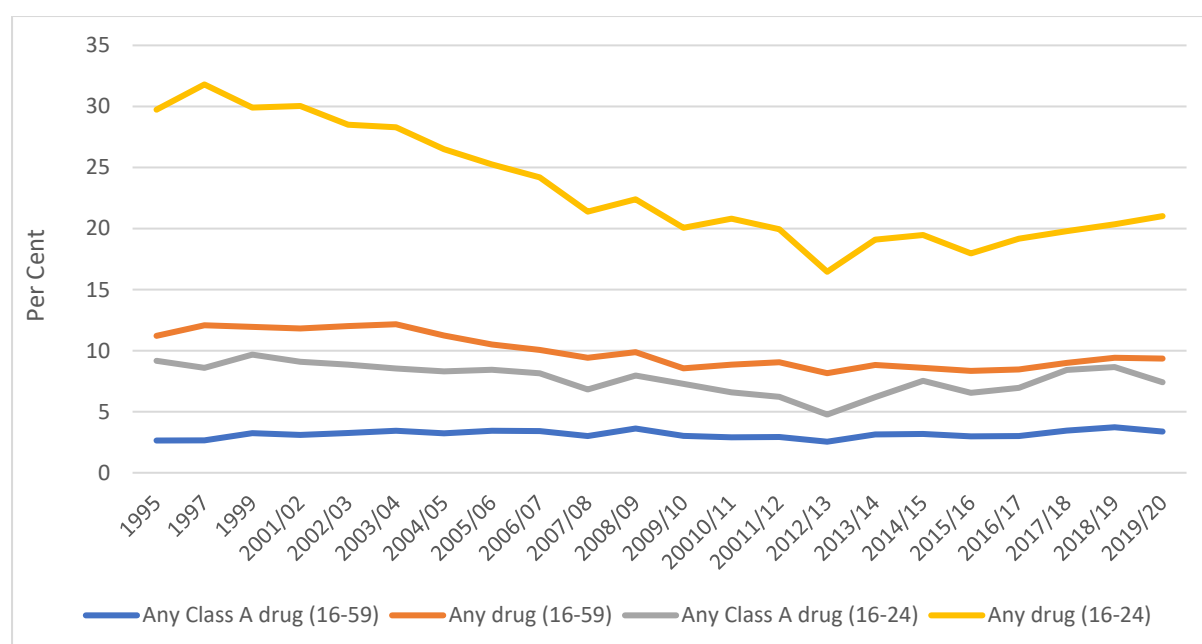
The Crime Survey for England and Wales (CSEW) is an important monitor of the extent of crime in England and Wales. The crucial value of the survey is its ability to find out about crimes which do not get reported to, or recorded by, the police. The survey has previously shown that only 4 in 10 crimes are actually reported to the police, so conducting the survey is incredibly valuable in understanding all of the other crimes which go unreported. It is also used to evaluate and develop crime reduction policies as well as providing vital information about the changing levels of crime over the last 30 years.

One of the survey's strengths is the ability to measure long-term trends as it is unaffected by changes in reporting rates or police activity. The sample size is large with approximately 50,000 households across England and Wales invited to participate in the survey in 2021/22. In previous years three quarters of households invited to take part agreed to participate. However, the CSEW sample size is relatively small in terms of very low volume crimes, estimates of less frequently occurring crime

types which can be subject to substantial variability (or "noise") making it difficult to detect short-term trends. A further limitation of the survey include the risk of sampling error as it is based on a sample not a census. Recall bias also be apparent as participants are recalling past events. The CSEW does not cover crimes that are resident in households (for example, people living in institutions) and also excludes crimes often termed as "victimless" for example, possession of drugs. These two reasons are likely to cause are under-reporting of drug use as individuals at greatest risk are likely to be the transient population.

The CSEW found that drug use in 16 to 24 year olds is more than double the use in 16 to 59 year olds, for all drugs and Class A drugs specifically. In 2019/20 an estimated 1 in 11 adults aged 16 to 59 years had taken a drug in the last year (9.4%) compared to one in five adults aged 16 to 24 years (21%). In terms of Class A drug use, 3.4% of adults aged 16 to 59 years and 7.4% of adults aged 16 to 24 years had taken a Class A drug in the last year. Figure 54 shows there was no change in the overall level of any drug use in the last year in adults in England and Wales between 2018/19 and 2019/20, however, the proportion of adults aged 16 to 24 years who reported any drug use in the last year was higher (20.3% to 21.0%).<sup>100</sup>

Figure 56: Proportion of adults aged 16 to 59 years and 16 to 24 years reporting use of any drug in the last year, England and Wales, year ending December 1995 to year ending March 2020<sup>100</sup>



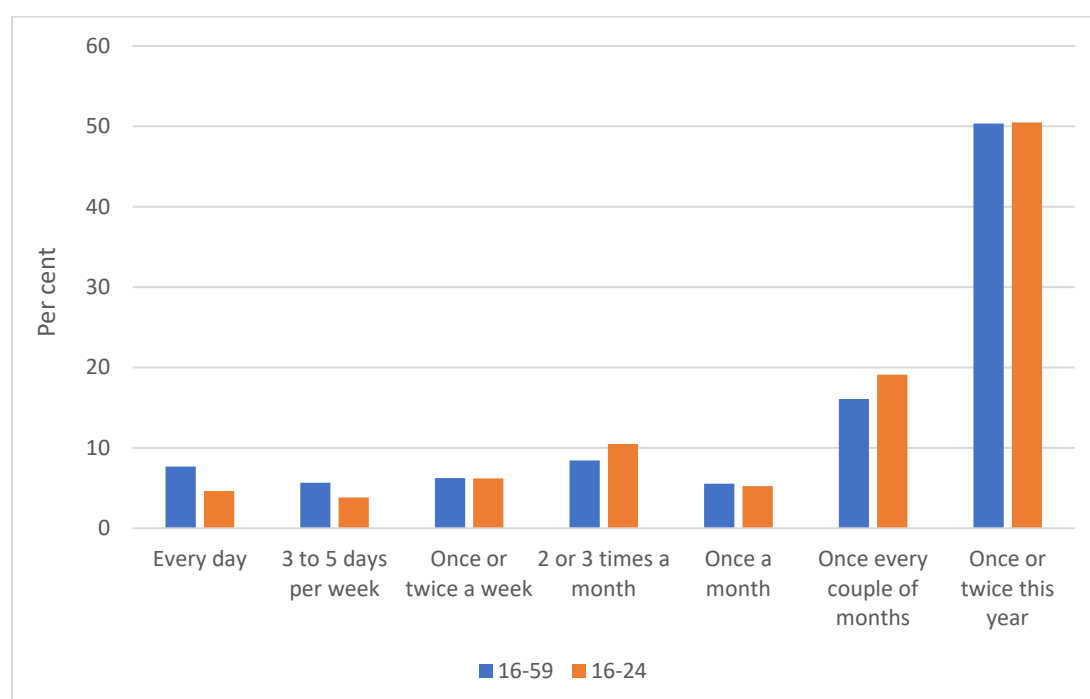
In 2019/20 cannabis continues to be the most common drug used in the last year among adults aged 16 to 59 years and 16 to 24 years, 7.8% and 18.7% respectively. The second most prevalent drugs used in the last year was powder cocaine use for 16 to 59 year olds (2.6%) and nitrous oxide use

among 16 to 24 year olds (8.7%). Powder cocaine was the third most prevalent drug used in the last year for 16 to 24 year olds (5.3%).<sup>100</sup>

Amphetamine and anabolic steroid use among 16 to 59 year olds has fallen compared to previous year, by 42% and 50%. Amphetamine use has continued the long-term decline which began in 1995 whereas anabolic steroid use was relatively flat over the last decade, until now. Although there was no change in powder cocaine use among adults aged 16 to 59 years between 2018/19 and 2019/20, the proportion of frequent users fell from 14.4% to 8.7% in the same time period.<sup>100</sup>

In 2019/20, 4.3% of young adults (16 to 24 years) reported frequent drug use (taking any drug more than once a month in the last year), while 2.1% of all adults (aged 16 to 59 years) are frequent drug users. Figure 55 examines the frequency of illicit drugs use by age group. It shows a higher proportion of adults compared to young adults were likely to use drugs daily, multiple times a week, or once or twice a week. However, young adults have a higher proportion of using drugs 2 or 3 times a month compared to all adults.<sup>100</sup>

Figure 57: Frequency of illicit drug use in the last year, 16 to 59 and 16 to 24 year olds, 2019/20<sup>100</sup>



#### 11.1.1. By Demographics

In 2019/20, the prevalence of any drug use in the last year was highest amongst 16 to 19 year olds and 20 to 24 year olds (21.1% and 21.0% respectively). The use of any drug in the last year also generally declined by age, as the oldest age category (55 to 59 years) was much lower than the youngest (16 to 19 years) at 2.8% compared with 21.1%.<sup>100</sup>

Any drug use in the last year was also higher among men than women aged 16 to 59 years. In 2020/21 one in eight men (11.9%) reported taking any drug in the last year compared with 6.9% of women. There was a similar pattern when examined by individual drug types:

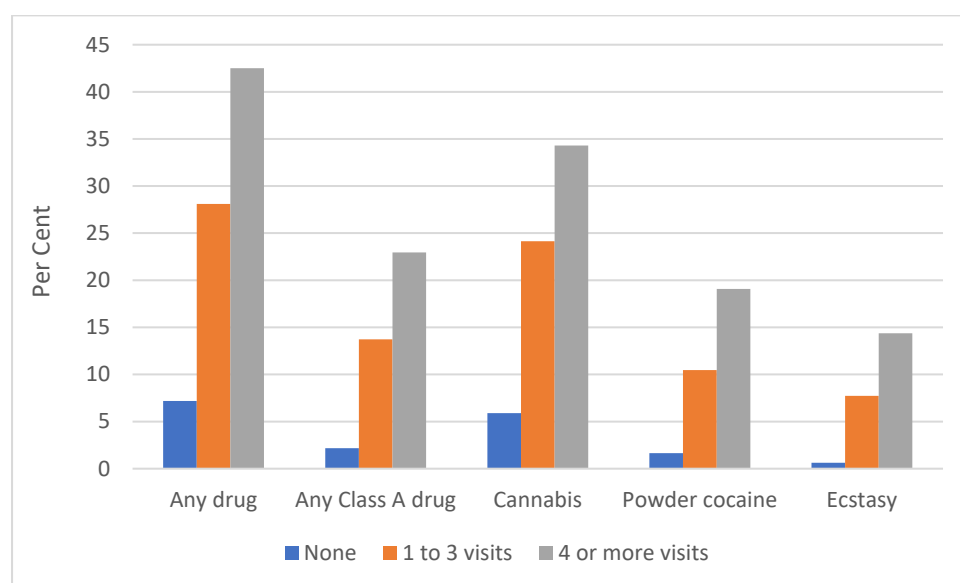
- 9.8% of men reported using cannabis in the last year compared with 5.7% of women
- men were nearly twice as likely than women to have taken powder cocaine in the last year (3.4% compared with 1.8%)
- 1.7% of men reported having taken ecstasy in the last year compared with 1.1% of women

In terms of relationship status, those who were single (17.7%) were more likely to have used a drug in the last year compared with those who were married or in a civil partnership (3.2%).<sup>100</sup>

#### 11.1.2. By Lifestyle Factors

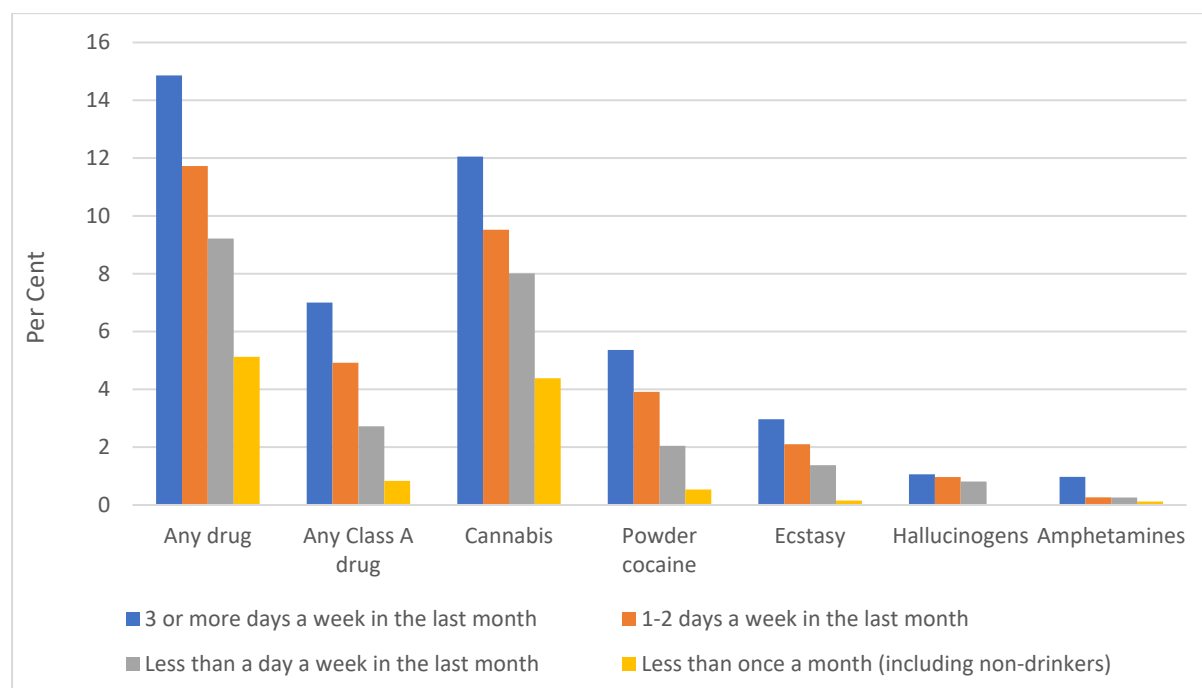
Using any drug was highest in adults aged 16 to 59 years who reported visiting nightclubs more than four times in the past month (42.5%) and lowest in adults not visiting nightclubs in the past month (7.2%). Interestingly, the survey showed that the use of powder cocaine was around 12 times higher among those who had visited a nightclub at least four times in the past month (19.1%) compared with those who had not visited a nightclub in the past month (1.6%). Use of ecstasy (14.4%) and cannabis (34.3%) were also higher for those who visited a nightclub at least four times in the last month, compared with those who had not been to a nightclub in the last month (0.6% and 5.9% respectively). There was also a similar picture for adults visiting the pub, where the use of drugs increased in line with the frequency of visits. In 2019/20, a quarter (26.3%) of adults who had visited a pub or bar at least nine times in the last month had used any drug in the last year, compared to 5.5% who had not visited a pub or bar.<sup>100</sup>

Figure 58: Proportion of adults aged 16 to 59 years who reported using a drug in the last year by frequency of nightclub visits, England and Wales, 2019/20<sup>100</sup>



The CSEW has found that drug use was higher in those who consumed alcohol more frequently. It showed there were higher proportions of any drug use in the last year among those with more frequent alcohol consumption. Adults aged 16 to 59 years who reported drinking alcohol three or more days per week in the last month were more than twice as likely to have used any drug (14.9%) than those drinking less than once a month (including non-drinkers) (5.1%).<sup>100</sup>

Figure 59: Proportion of adults aged 16 to 59 years who reported using a drug in the last year by frequency of alcohol consumption, England and Wales, 2019/20<sup>100</sup>



In 2019/20, the CSEW showed drug use decreases as life satisfaction increases. Of those who reported low levels of satisfaction with life, 23.3% also reported last-year use of any drug. This was significantly higher than those who reported medium life satisfaction (13.2%), high life satisfaction (11.7%) or very high life satisfaction (4.8%). Any drug use was also higher among those who experienced high levels of anxiety (15.7%) compared with those who had low levels (9.1%).<sup>100</sup>

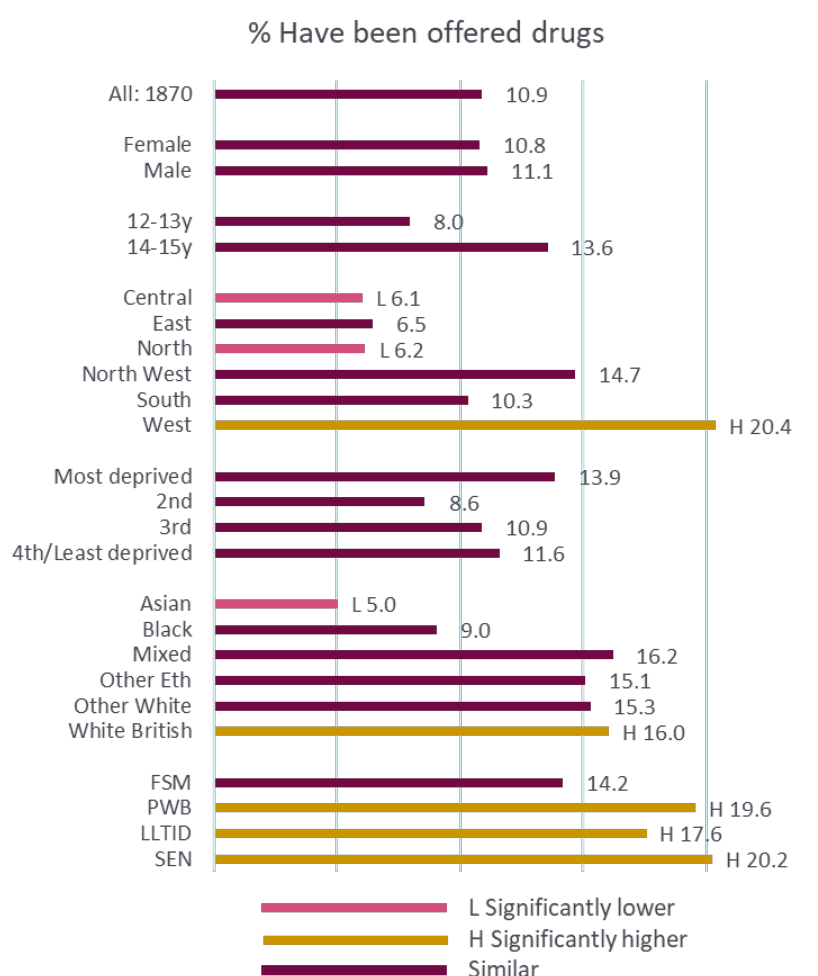
## 11.2. Local Patterns of Drug Misuse

### 11.2.1. Children and Young People

Over 3,000 10 to 15 year old children participated in the Leicester Children's Health and Wellbeing Survey in 2021/22. The survey sample was weighted against the known school aged population using the Leicester School Census (Spring 2022) to ensure survey responses were representative of the Leicester school population.

Secondary aged children (aged 12-15 years old) were asked 'Have you ever been offered drugs? E.g. cannabis, ecstasy'. Around one in ten secondary aged children reported that they have been offered drugs. The proportion of secondary aged children reporting that they have been offered drugs was significantly larger in the 14-15 year age group than the 12-13 year age group. A significantly smaller proportion of secondary aged children in the Central and North locality areas of Leicester have been offered drugs, whilst those in the West are significantly more likely to have been offered drugs. Children of White British ethnicity are significantly more likely to have been offered drugs, whilst those of Asian heritage are significantly less likely to have been offered drugs. Children reporting a poor mental wellbeing, a long term illness or special educational needs are significantly more likely to have been offered drugs.

Figure 60: The proportion of secondary aged children that have been offered drugs by demographic



**Deprivation Quintiles:** Most deprived (Living in 20% most deprived areas nationally and 4<sup>th</sup>/Least deprived (living in the 40% least deprived areas nationally)  
**Additional groups:** FSM- Free School Meals  
 PWB – Poor Wellbeing  
 LLTID – Long term limiting illness or disability  
 SEN Special Educational Need

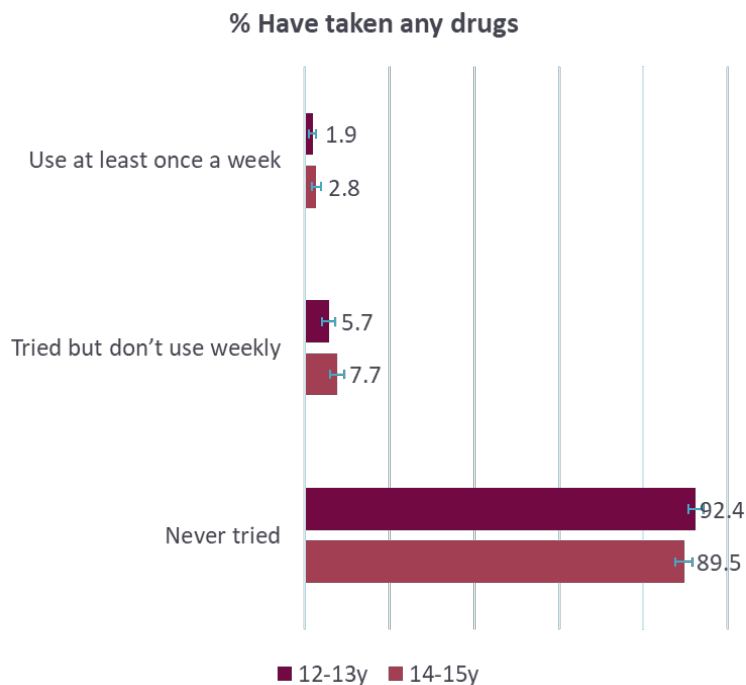
Secondary aged children were also asked ‘Have you taken any drugs? (not tobacco, alcohol or medicine prescribed for you by a doctor)’. Around one in ten secondary aged children reported that they have taken drugs. A significantly larger proportion of secondary aged children have never tried drugs (91%) than have tried drugs (9%). There were no significant differences between 12-13 year olds and 14-15 year olds in the proportion that use drugs at least once a week, have tried drugs but don’t use them weekly and have never taken any drugs. A significantly larger proportion of children had tried drugs but don’t use them weekly than use drugs at least once a week in both the 12-13 and 14-15 year age groups.

The proportion of secondary aged children that reported that they had taken drugs in the 2021/22 survey (9%) was significantly larger than the one in twenty (5%) secondary aged children that



reported that they had taken any drugs to change the way they feel at the time of the 2016/17 survey.

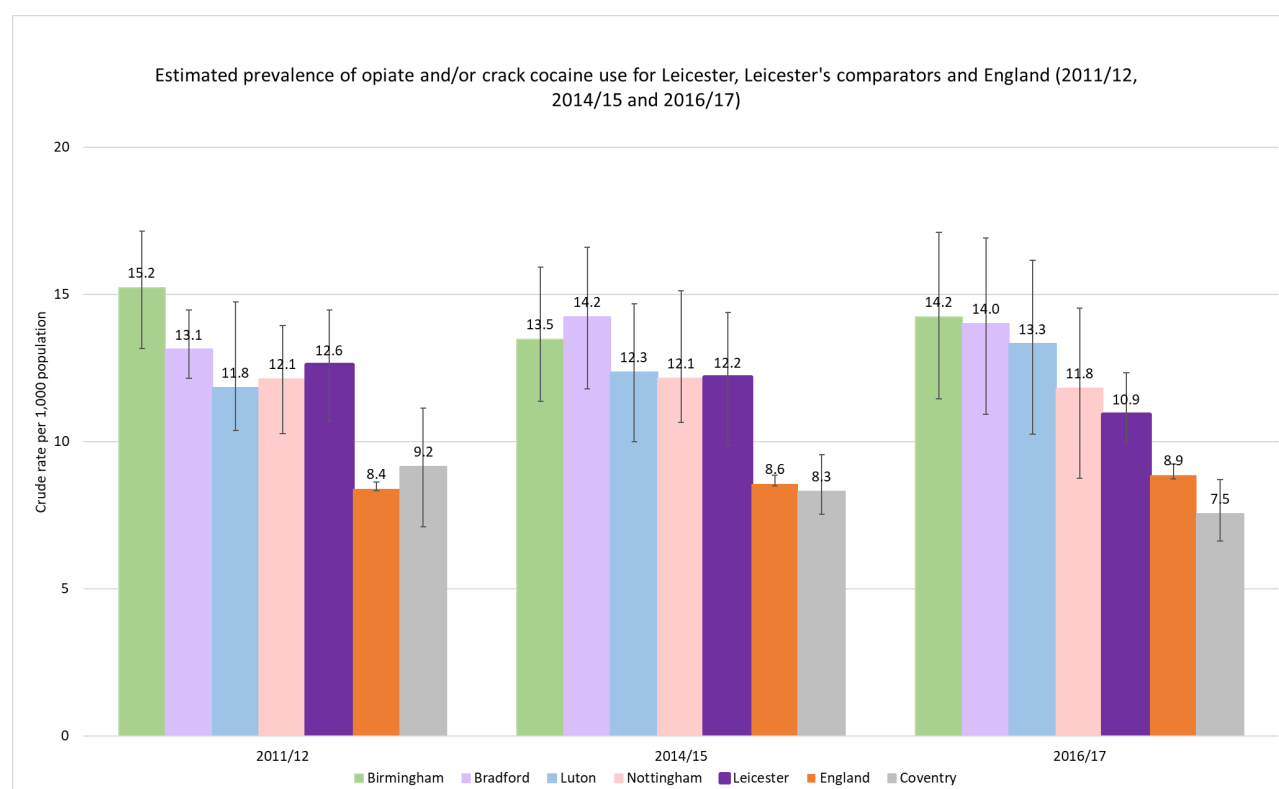
Figure 61: The proportion of secondary aged children that have taken drugs



### 11.2.2. Adults

In Leicester there were an estimated 2,859, 2,798 and 2,594 opiate and/or crack cocaine users (OCUs) aged between 15-64 years old in 2011/12, 2014/15 and 2016/17 respectively. As shown in Figure 60, in 2011/12, 2014/15 and 2016/17 the estimated prevalence of opiate and/or crack cocaine use in Leicester (12.6, 12.2 and 10.9 per 1,000 population respectively) was significantly higher (worse) than the estimated prevalence in England overall (8.4, 8.6 and 8.9 per 1,000 population respectively). Leicester had the 5<sup>th</sup> highest estimated prevalence when compared to its five comparators in 2016/17. In 2016/17, the estimated prevalence of opiate and/or crack cocaine use in Leicester (10.9 per 1,000 population) was significantly higher than that of Coventry (7.5 per 1,000 population).

Figure 62: Estimated prevalence of opiate and/or crack cocaine use for Leicester, Leicester's comparators and England (2011/12, 2014/15 and 2016/17)<sup>101</sup>



### 11.3. Current Context

The white paper “Swift, Certain, Tough: New consequences for drug possession” published in July 2022<sup>102</sup> proposes reforms to strengthen the response of the police and the criminal justice system to drug possession offences for so-called recreational users. A new three-tier framework will apply to all drug users, except where users have a drug dependence and treatment is the most relevant intervention. This aims to bring about large-scale behaviour change causing a generational shift and a reduction in the demand for drugs. This may have particular implications for young people if this is their drug of use.

## 12. Drug Related Harm

### 12.1.1. Injecting and Blood Borne Viruses

Sharing injecting equipment can spread blood-borne viruses. Providing opioid substitution treatment (OST), sterile injecting equipment and antiviral treatments protects people who use drugs and communities, and provides long-term health savings. Rates of infection with blood-borne viruses (BBVs) are high among people with drug use disorders, specifically those who inject drugs through the sharing of needles and other injecting equipment. The spread of BBVs, such as Human Immunodeficiency virus (HIV) and hepatitis blood borne viruses can be interrupted and prevented

through harm reduction policies such as needle exchange and vaccination. Vaccination can protect against hepatitis B and carrying out testing to diagnose infection with blood-borne viruses is the first step in preventing transmission and accessing treatment.

Eliminating hepatitis C as a major public health threat requires the identification and treatment of many more infected people who use drugs. Hepatitis C is a liver infection caused by the hepatitis C virus (HCV). For some people, hepatitis C is a short-term illness, but for more than half of people who become infected with the hepatitis C virus, it becomes a long-term, chronic infection which can lead to cirrhosis, liver failure or cancer.

Injecting drug use is the main driver of HCV transmission in England and a significant proportion of people who inject drugs remain unaware of their HCV infections. Injecting drug users are typically a transient population who may no longer be in contact with services that would normally offer HCV testing. In recent years, the development of direct acting antivirals (DAA) drugs has revolutionised the treatment landscape of HCV by providing an effective orally administrative cure. As DAA drugs are rolled out, the possibility of treatment as prevention<sup>103104</sup> becomes a reality provided individuals with new and re-infections engage with services and undertake treatment.

In May 2016, the UK signed up to the WHO Global Health Sector Strategy on Viral Hepatitis<sup>105</sup> committing to meet targets of an 80% reduction in incidence of HCV infection and a 65% reduction in mortality from HCV by 2030 from a 2015 baseline. The NHS England HCV Elimination Programme is working to eliminate HCV in advance of the WHO goal of 2030, and to enable this, a number of elimination initiatives have been established. These initiatives include extensive programmes of work, in partnership with stakeholders, in areas drug treatment services, needle and syringe provision and through the early detection of liver cancer.

In 2021-22 in Leicester, of the 723 adults starting drug treatment 71.5% had never injected, 19.5% had previously injected but were not currently injecting and 9.0% were currently injecting, this is not significantly different to the proportions for England (72.3%, 18.9% and 8.1% respectively). This data refers to the injecting status across the treatment journey based on the hierarchy where currently injecting is prioritised over previously injected which is prioritised over never injected.

Of the total number of new drug treatment journeys in Leicester in 2021-22 (723), almost half (46.5%) had been offered a hepatitis C intervention but had refused, this is not significantly different to the proportion in England (43.4%). In Leicester 24.3% of those on new drug treatment journeys in 2021-22 had been offered and had accepted a hepatitis C intervention but had not yet had a test whilst 10.4% had been offered, had accepted and had received the hepatitis C test, this is not

significantly different to the proportions in England (23.9% and 9.5% respectively). Of all those in drug treatment in Leicester in 2021-22 (1696), 8.4% tested positive for HCV antibodies which is significantly lower than the proportion of those in treatment testing positive in England (15.4%). There was no significant difference between the proportion testing negative in Leicester (34.1%) when compared to England (34.4%). In Leicester in 2021-22, 3.7% of clients in drug treatment tested positive for the presence of active HCV infection on an HCV PCR test, this is not significantly different to the proportion testing positive in England (4.3%). Of those in drug treatment in Leicester in 2021-22, 7.5% were referred to hepatitis C treatment, this was a significantly smaller proportion than was referred in England overall (10.7%).

Almost half (46.3%) of those starting a new drug treatment in Leicester in 2021-22 had been offered the hepatitis B intervention but had refused, which was significantly higher than the 39.3% in England overall. In Leicester of those starting a new drug treatment journey in 2021-22 (723), almost one quarter (24.6%) had been offered and had accepted a hepatitis B intervention but had not yet received any interventions (significantly higher than the 19.6% in England). There was no significant difference between the proportion of those starting a drug treatment in 2021-22 who had been assessed as not appropriate to have the hepatitis B intervention offered to them in Leicester (13.4%) compared to England overall (15.2%). Leicester had a significantly smaller proportion of those starting a new drug treatment journey in 2021-22 who were immunised already (8.4%) than England overall (15.7%). A significantly higher proportion of those in Leicester (3.2%) compared to those in England (1.8%) had been offered, had accepted and had completed vaccination, whilst a significantly smaller proportion of those starting drug treatment in 2021-22 in Leicester had not been offered the hepatitis B intervention (2.2%) than in England overall (5.3%). Around 1.8% of those starting drug treatment in 2021-22 in Leicester had been offered, had accepted and had started having vaccinations, this was not significantly different to the 1.1% in England.

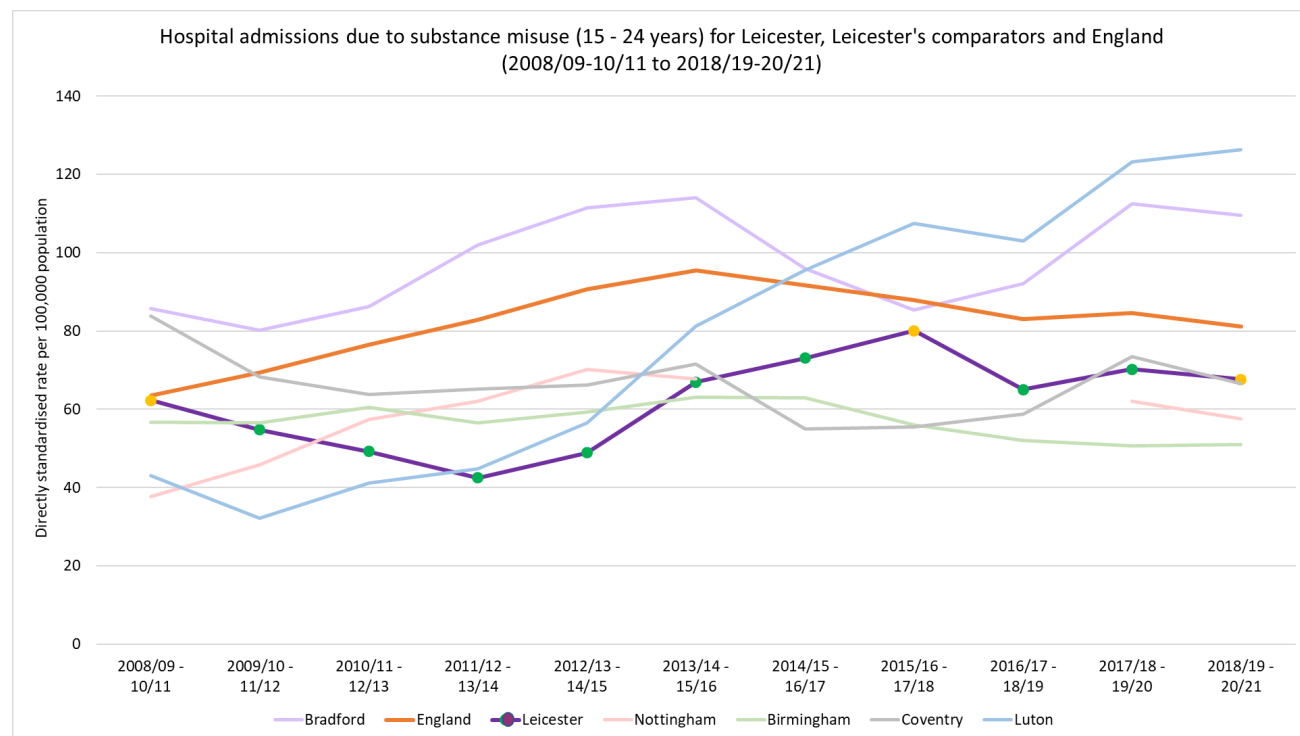
## 12.2. Drug Related Hospital Admissions

### 12.2.1. Children and Young People

In 2018/19 -2020/21 in Leicester there were 135 hospital admissions due to substance use in those aged 15-24 years. As shown in Figure 61, since 2009/10-11/12 the rate of hospital admissions due to substance use in those aged 15-24 years in Leicester has been significantly lower (better) than the value for England with the exception of 2015/16-17/18 and 2018/19-20/21 where the rate for Leicester was not significantly different to the value for England. In 2018/19-20/21 Leicester had the 3<sup>rd</sup> highest rate of hospital admissions due to substance use in 15-24 year olds when compared to its five comparators. In the same year, the rate in Leicester (67.6 per 100,000 population) was

significantly lower than that of Bradford (109.5 per 100,000 population) and Luton (126.3 per 100,000 population).

Figure 63: Hospital admissions due to substance use (15-24 years) for Leicester, Leicester's comparators and England (2008/09-10/11 to 2018/19-20/21)<sup>106</sup>

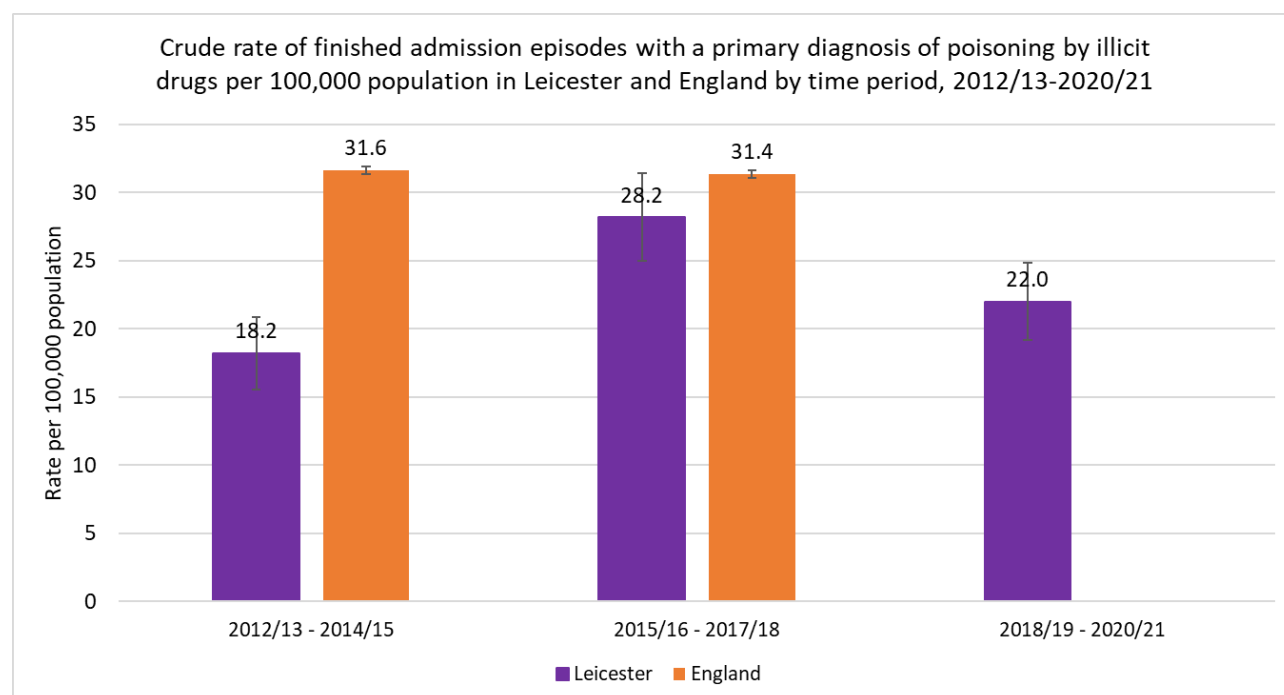


### 12.2.2. Adults

In Leicester there were 183, 295 and 234 admission episodes with a primary diagnosis of poisoning by illicit drugs in 2012/13-2014/15, 2015/16-2017/18 and 2018/19-2020/21 respectively. As shown in Figure 62, the rate of admission episodes with a primary diagnosis of poisoning by illicit drugs in Leicester increased significantly from 18.2 per 100,000 population in 2012/13-2014/15 to 28.2 per 100,000 population in 2015/16-2017/18, this increase was followed by a significant decrease to 22.0 per 100,000 population in 2018/19-2020/21. In 2012/13-2014/15, the rate of admission episodes with a primary diagnosis of poisoning by illicit drugs in Leicester (18.2 per 100,000 population) was significantly lower (better) than the rate in England (31.6 per 100,000 population). There was no significant difference between the rate in Leicester (28.2 per 100,000 population) and England (31.4 per 100,000 population) in 2015/16-2017/18. Data for England is only available up to 2019/20. Therefore, the data for England cannot be presented for the latest three-year period (2018/19-2020/21) alongside the data for Leicester, as an alternative the most recent two years of data for England (2018/19 and 2019/20) has been grouped and used in the comparisons below. When combining the two most recent periods of data for England (2018/19 and 2019/20) the rate in England was 31.2 per 100,000 population, this was not significantly different to the value in

2012/13-2014/15 or 2015/16-2017/18 in England. The rate in Leicester in 2018/19-2020/21 (22.0 per 100,000 population) was significantly lower than the rate in England in 2018/19-2019/20 (31.2 per 100,000 population).

Figure 64: Crude rate of admission episodes with a primary diagnosis of poisoning by illicit drugs in Leicester and England by time period (rate per 100,000 population) (2012/13-2020/21) <sup>107108</sup>



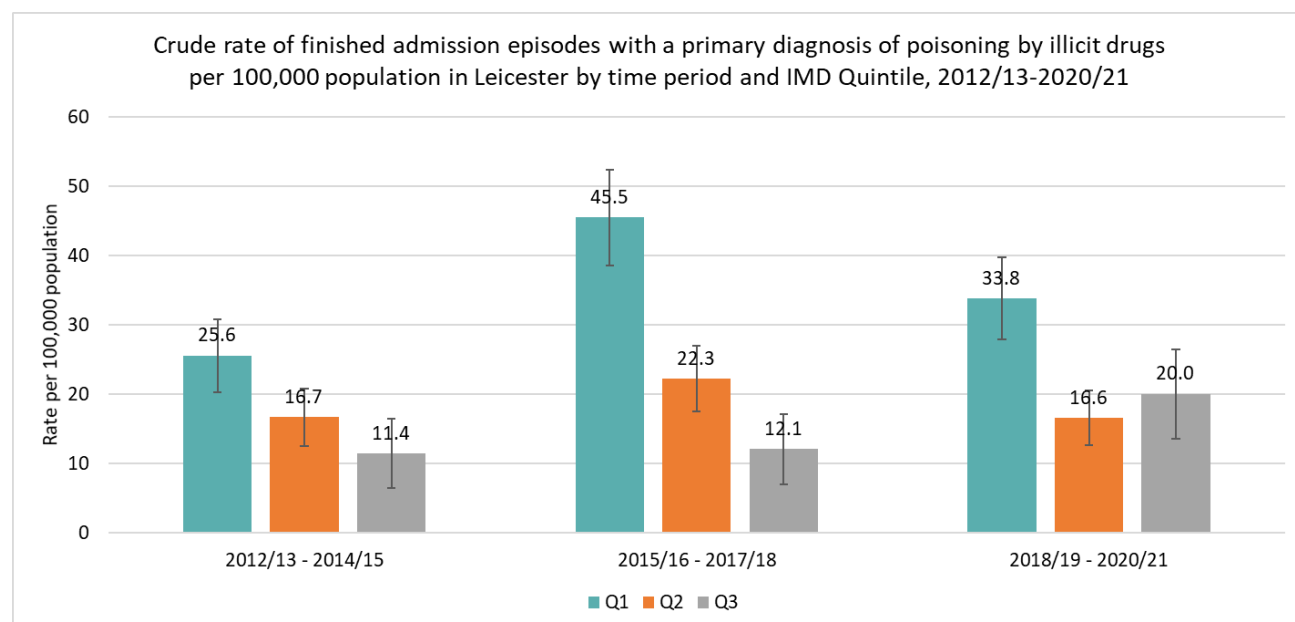
The rate of admission episodes with a primary diagnosis of poisoning by illicit drugs in males in Leicester significantly increased from 21.1 per 100,000 population in 2012/13-2014/15 to 34.3 per 100,000 population in 2015/16-2017/18, before significantly decreasing to 23.6 per 100,000 population in 2018/19-2020/21. The rate in females in Leicester did not change significantly across the same three time periods. In 2015/16-2017/18 the rate of admission episodes with a primary diagnosis of poisoning by illicit drugs in males in Leicester (34.3 per 100,000 population) was significantly higher than the rate for females in Leicester (22.1 per 100,000 population), there was no significant difference between the rates in males and females in 2012/13-2014/15 or 2018/19-2020/21. The rate of admission episodes with a primary diagnosis of poisoning by illicit drugs in Leicester has not shown a consistent significant pattern by age group.

As shown in Figure 63, in 2012/13-2014/15 and 2015/16-2017/18 the rate of admission episodes with a primary diagnosis of poisoning by illicit drugs decreased with each decreasing level of deprivation from quintile 1 (most deprived) to quintile 3, the decrease with each decrease in deprivation decile was significant in 2015/16-2017/18. In 2018/19-2020/21 the rate of admission episodes with a primary diagnosis of drug poisoning by illicit drugs was significantly higher (worse) in

quintile 1 (most deprived) than in both quintile 2 and quintile 3, there was no significant difference between the rate in quintile 2 and quintile 3.

*Note: the data for quintile 4 and quintile 5 was suppressed in Figure 63 due to small counts.*

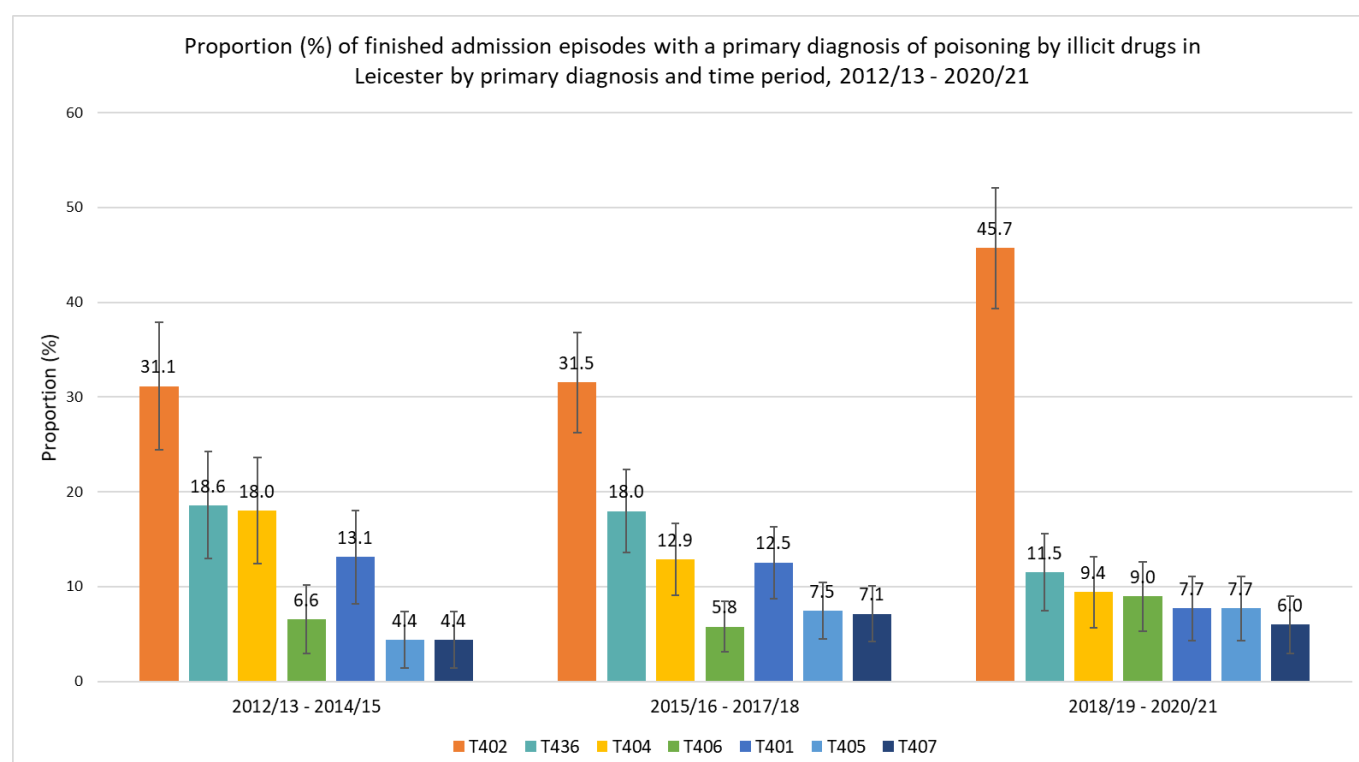
*Figure 65: Crude rate of admission episodes with a primary diagnosis of poisoning by illicit drugs per 100,000 population in Leicester by time period and IMD quintile, 2012/13-2020/21*



In 2012/13-2014/15, 2015/16-2017/18 and 2018/19-2020/21 admission episodes with a primary diagnosis of poisoning by, adverse effect of and underdosing of other opioids (T402) contributed the highest proportion of admission episodes with a primary diagnosis of poisoning by illicit drugs in Leicester, the proportion of admissions with this primary diagnosis was significantly higher (worse) than the other primary diagnoses. In 2018/19-2020/21 there were no significant differences between the proportion of admission episodes with a primary diagnosis of T402 and the proportion of admission episodes with any of the other primary diagnoses. As shown in Figure 64, between 2015/16-2017/18 and 2018/19-2020/21 the proportion of admission episodes with a primary diagnosis of poisoning by illicit drugs where the primary diagnosis was T402 increased significantly from 31.5% to 45.7%. There has been no significant change in the proportion of admission episodes with a primary diagnosis of poisoning by illicit drugs with any of the other primary diagnoses across the three time periods.

*Note: the data for T403, T408 and T409 was suppressed in Figure 64 due to small counts.*

Figure 66: Proportion of admission episodes with a primary diagnosis of poisoning by illicit drugs in Leicester by primary diagnosis and time period, 2012/13-2020/21



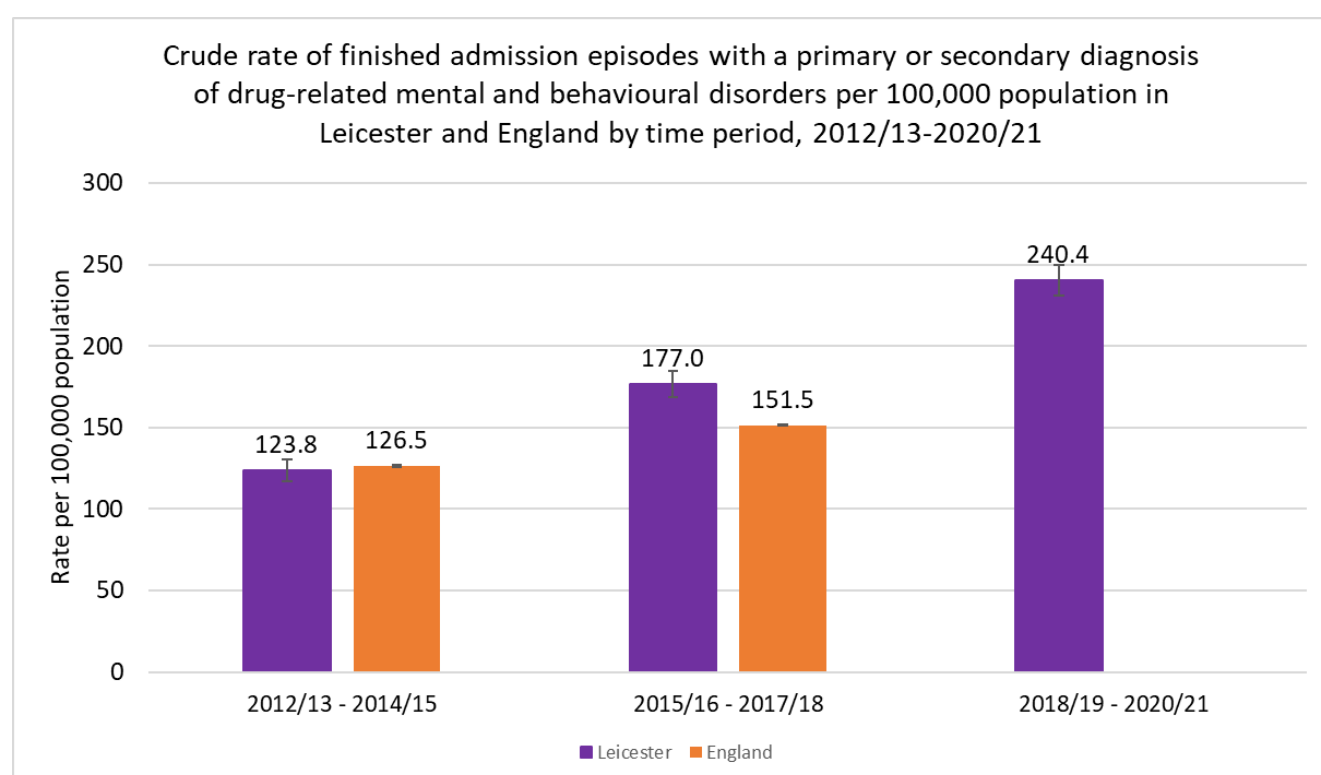
T400=Poisoning by, adverse effect of and underdosing of opium  
T401=Poisoning by, and adverse effect of heroin  
T402=Poisoning by, adverse effect of and underdosing of other opioids  
T403=Poisoning by, adverse effect of and underdosing of methadone  
T404=Poisoning by, adverse effect of and underdosing of other synthetic narcotics  
T405=Poisoning by, adverse effect of and underdosing of cocaine  
T406=Poisoning by, adverse effect of and underdosing of other and unspecified narcotics  
T407=Poisoning by, adverse effect of and underdosing of cannabis (derivatives)  
T408=Poisoning by, adverse effect of lysergide (LSD)  
T409=Poisoning by, adverse effect of and underdosing of other and unspecified psychodysleptics (hallucinogens)  
T436 =Poisoning by, adverse effect of and underdosing of systemic antibiotics

In Leicester there were 1,244, 1,853 and 2,557 admission episodes with a primary or secondary diagnosis of drug-related mental and behavioural disorders in 2012/13-2014/15, 2015/16-2017/18 and 2018/19-2020/21 respectively. As shown in Figure 65, the rate of admission episodes with a primary or secondary diagnosis of drug-related mental and behavioural disorders in Leicester increased (worsened) significantly from 123.8 per 100,000 population in 2012/13-2014/15 to 177.0 per 100,000 population in 2015/16-2017/18 to 240.4 per 100,000 population in 2018/19-2020/21. In 2012/13-2014/15 the rate in Leicester was not significantly different to the value in England (126.5 per 100,000 population), however, in 2015/16-2017/18 the rate in Leicester was significantly higher (worse) than the value for England (151.5 per 100,000 population). Data for England is only currently available up to 2019/20 and as such the data for 2018/19-2020/21 for England cannot be presented. Data for England is only available up to 2019/20. Therefore, the data for England cannot be



presented for the latest three-year period (2018/19-2020/21) alongside the data for Leicester, as an alternative the most recent two years of data for England (2018/19 and 2019/20) has been grouped and used in the comparisons below. When combining the two most recent periods of data for England (2018/19 and 2019/20) the rate in England was 175.0 per 100,000 population, this was significantly higher than the rate in 2012/13-2014/15 and 2015/16-2017/18 in England and shows an increasing trend in rate across the three (unequal) time periods. The rate in Leicester in 2018/19-2020/21 (240.4 per 100,000 population) was significantly higher than the rate in England in 2018/19-2019/20 (175.0).

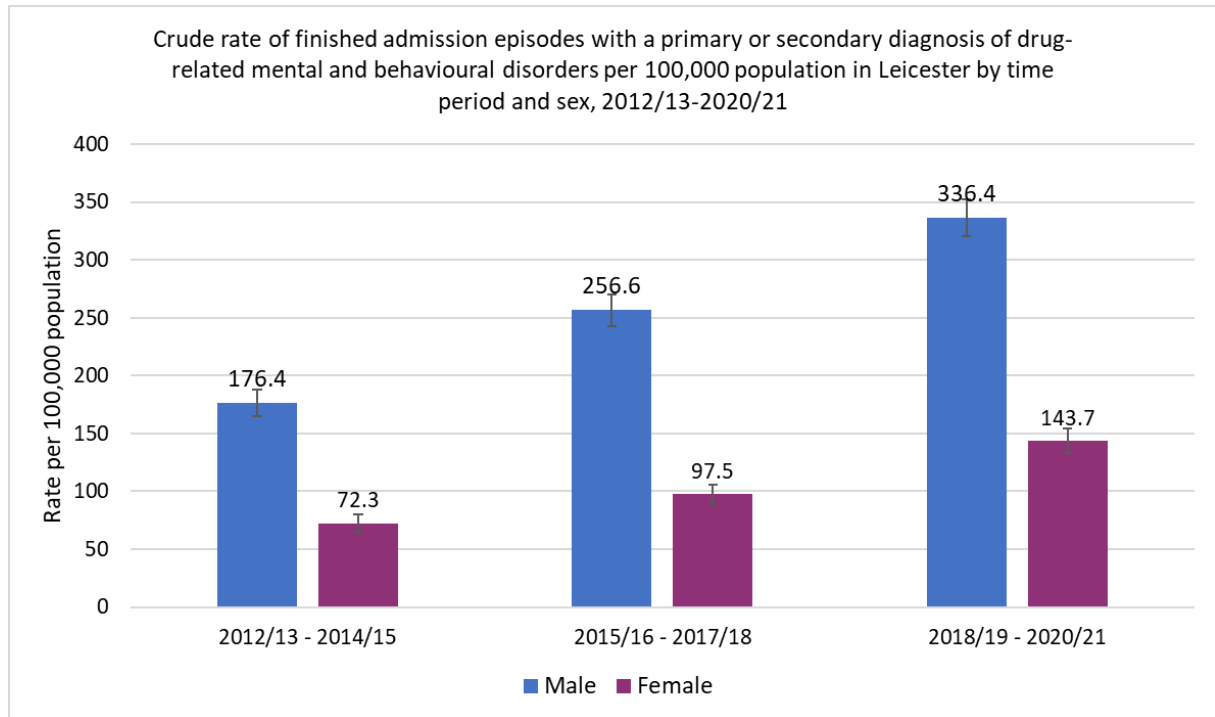
Figure 67: Crude rate of admission episodes with a primary or secondary diagnosis of drug-related mental and behavioural disorders per 100,000 population in Leicester and England by time period, 2012/13-2020/21<sup>109110</sup>



In all of 2012/13-2014/15, 2015/16-2017/18 and 2018/19-2020/21, the rate of admission episodes with a primary or secondary diagnosis of drug-related mental and behavioural disorders in Leicester was significantly higher (worse) in males (176.4, 256.6 and 336.4 per 100,000 population respectively) than in females (72.3, 97.5 and 143.7 per 100,000 population respectively). As shown in Figure 66, the rate of admission episodes with a primary or secondary diagnosis of drug-related

mental and behavioural disorders in Leicester increased significantly in both males and females across the three time periods.

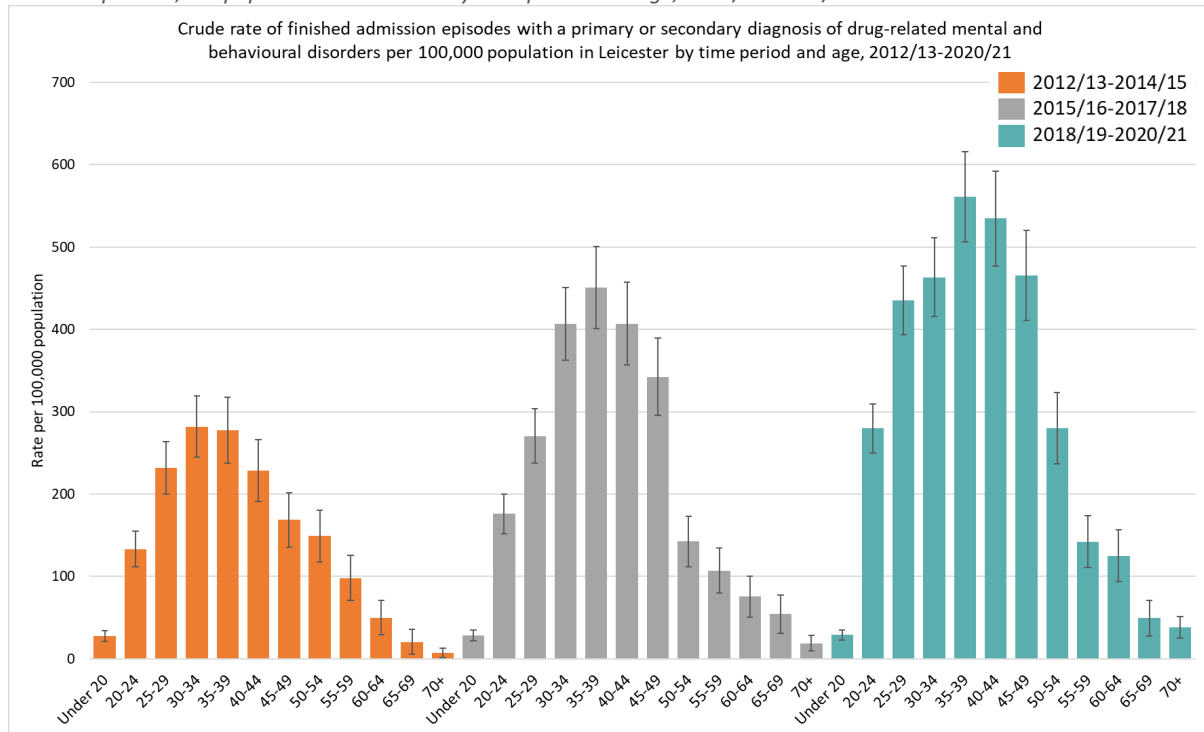
Figure 68: Crude rate of admission episodes with a primary or secondary diagnosis of drug-related mental and behavioural disorders per 100,000 population in Leicester by time period and sex, 2012/13-2020/21



As shown in Figure 67, the rate of admission episodes with a primary or secondary diagnosis of drug-related mental and behavioural disorders in Leicester increased significantly by age from the Under 20 age group up to and including the 25-29 year age group in all three time periods. In all three time periods, the rate of admission episodes with a primary or secondary diagnosis of drug-related mental and behavioural disorders in Leicester was higher (worse) in the 25-49 year age groups than in the younger or older age groups, this difference was significant with the exception of the 2012/13-2014/15 time period. Across all three time periods, the rate in Leicester decreased by each increasing age band from the 35-39 year age group to the 70+ age band. In Leicester in 2018/19-

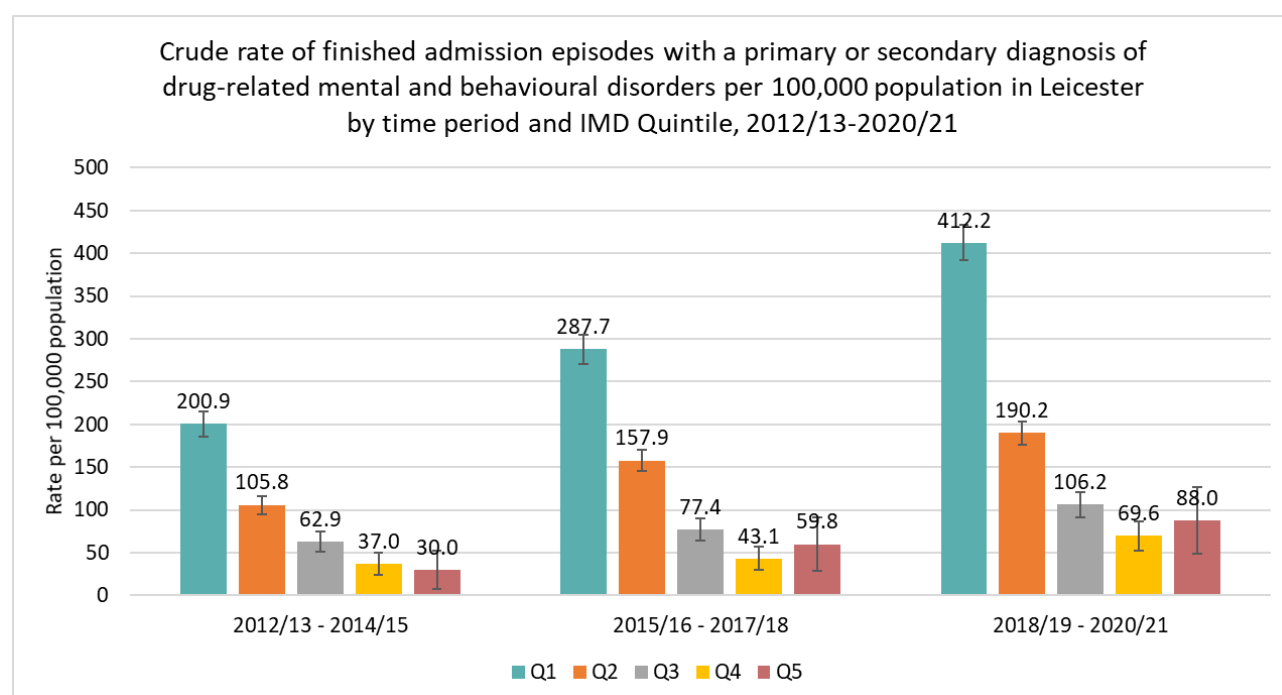
2020/21 the rates in the 20-29 and 35-54 year age bands were significantly higher than the rates in the same age bands in 2015/16-2017/18.

Figure 69: Crude rate of admission episodes with a primary or secondary diagnosis of drug-related mental and behavioural disorders per 100,000 population in Leicester by time period and age, 2012/13-2020/21



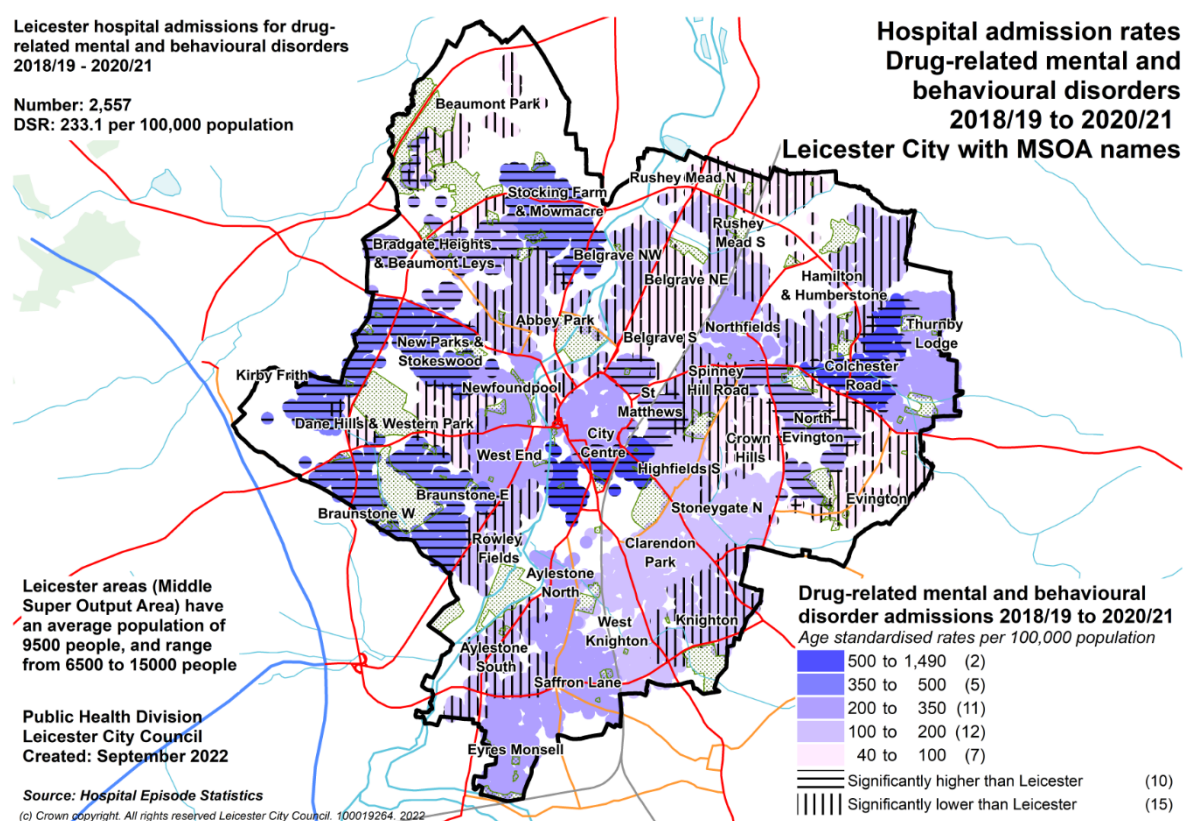
As shown in Figure 68, across all three time periods the rate of admission episodes with a primary or secondary diagnosis of drug-related mental and behavioural disorders in Leicester decreased significantly with each decreasing level of deprivation from quintile 1 to quintile 4. In 2018/19-2020/21, the rates in quintile 1 (412.2 per 100,000 population), quintile 2 (190.2 per 100,000 population) and quintile 3 (106.2 per 100,000 population) were significantly higher (worse) than the rates in 2015/16-2017/18 for the same quintiles (quintile 1: 287.7, quintile 2: 157.9 and quintile 3: 77.4 per 100,000 population).

Figure 70: Crude rate of admission episodes with a primary or secondary diagnosis of drug-related mental and behavioural disorders per 100,000 population in Leicester by time period and IMD Quintile, 2012/13-2020/21



In Leicester there were 2,557 admission episodes with a primary or secondary diagnosis of drug-related mental and behavioural disorders in 2018/19-2020/21. Figure 69 shows that ten Middle Layer Super Output Areas (MSOAs) in Leicester have a significantly higher rate of hospital admissions with a primary or secondary diagnosis of drug-related mental and behavioural disorders than Leicester in 2018/19-2020/21, whilst fifteen MSOAs have rates which are significantly lower than the value for Leicester. Of the six locality areas across Leicester, in 2018/19-2020/21 the West of the city has the largest proportion of MSOAs where the rate of hospital admissions with a primary or secondary diagnosis of drug-related mental and behavioural disorders is significantly higher than that of Leicester (4 out of 7 MSOAs), whilst the North of the city has the largest proportion of MSOAs where the rate is significantly lower than that of Leicester overall (6 out of 7 MSOAs). The highest rate of hospital admissions for drug-related mental and behavioural disorders in 2018/19-2020/21 in Leicester was in the centre of the city in the Leicester City South MSOA with a rate of 1484.8 per 100,000 population which was significantly higher than the value for Leicester overall (233.1 per 100,000 population). Following this, the highest rates in Leicester were in Colchester Road (598.7 per 100,000 population) in the East of the city, Stocking Farm & Mowmacre (493.1) in the North West of the city and New Parks & Stokeswood (488.7) and Braunstone Park West (407.6) MSOAs in the West locality area of the city. Of the 15 MSOAs with rates of hospital admissions for drug-related mental and behavioural disorders which were significantly lower than the value for Leicester in 2018/19-2020/21, Evington (40.5 per 100,000 population) in the East of the city and Belgrave South (42.8) and Belgrave North East (52.6) in the North of the city had the lowest rates.

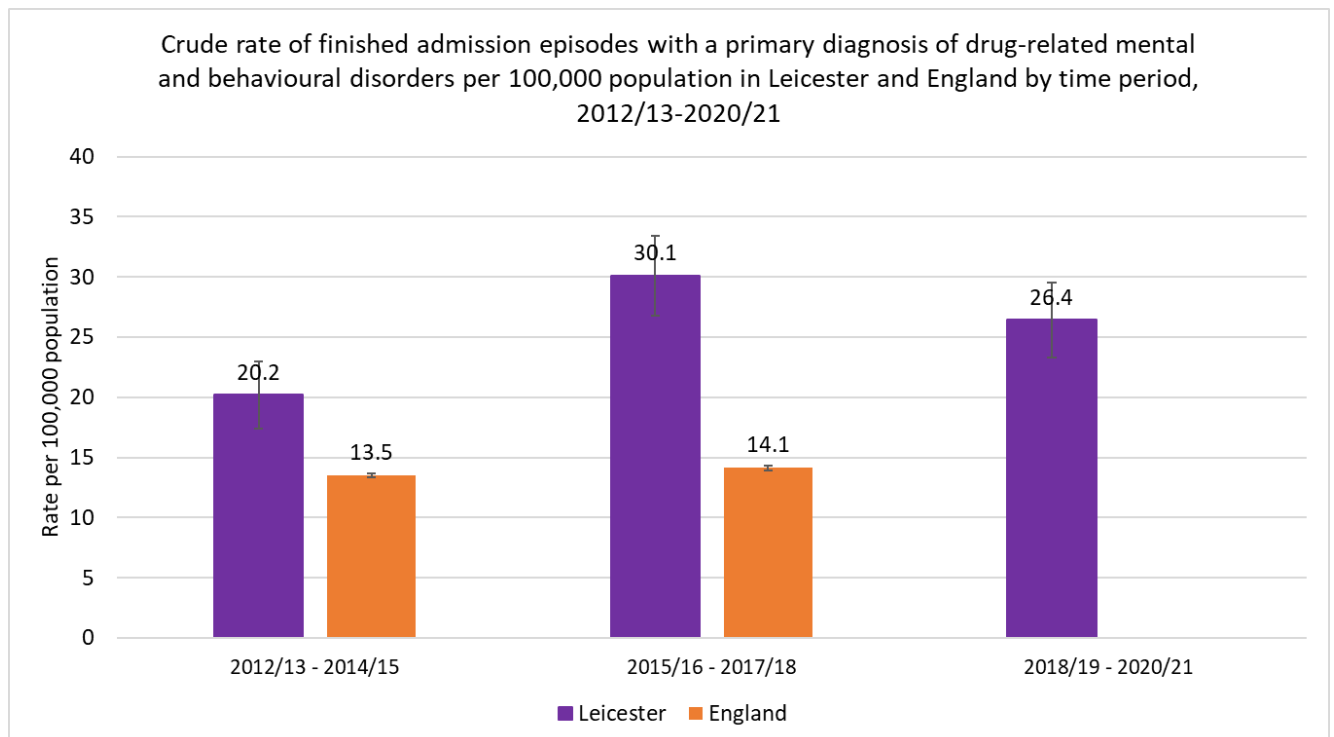
Figure 71: Age-standardised rates of hospital admissions with a primary or secondary diagnosis of drug-related mental and behavioural disorders by MSOA in Leicester, 2018/19 to 2020/21



In Leicester there were 203, 315 and 281 admission episodes with a primary diagnosis of drug-related mental and behavioural disorders in 2012/13-2014/15, 2015/16-2017/18 and 2018/19-2020/21 respectively. As shown in Figure 70, the rate of admission episodes with a primary diagnosis of drug-related mental and behavioural disorders in Leicester in 2012/13-2014/15 (20.2 per 100,000 population) and 2015/16-2017/18 (30.1 per 100,000 population) was significantly higher (worse) than England (13.5 and 14.1 per 100,000 population respectively). Data for England is only available up to 2019/20 and as such the data for 2018/19-2020/21 for England cannot be presented. The rate of admission episodes with a primary diagnosis of drug-related mental and behavioural disorders in Leicester increased significantly from 20.2 per 100,000 population in 2012/13-2014/15 to 30.1 per 100,000 population in 2015/16-2017/18, in line with the significant increase witnessed in England (from 13.5 to 14.1 per 100,000 population). In 2018/19-2020/21 the rate in Leicester had decreased from the rate in 2015/16-2017/18, however this difference was not significant. Data for England is only available up to 2019/20. Therefore, the data for England cannot be presented for the latest three-year period (2018/19-2020/21) alongside the data for Leicester, as an alternative the most recent two years of data for England (2018/19 and 2019/20) has been grouped and used in the comparisons below. When combining the two most recent periods of data for England (2018/19 and 2019/20) the rate in England was 12.8 per 100,000 population, this was significantly lower than the

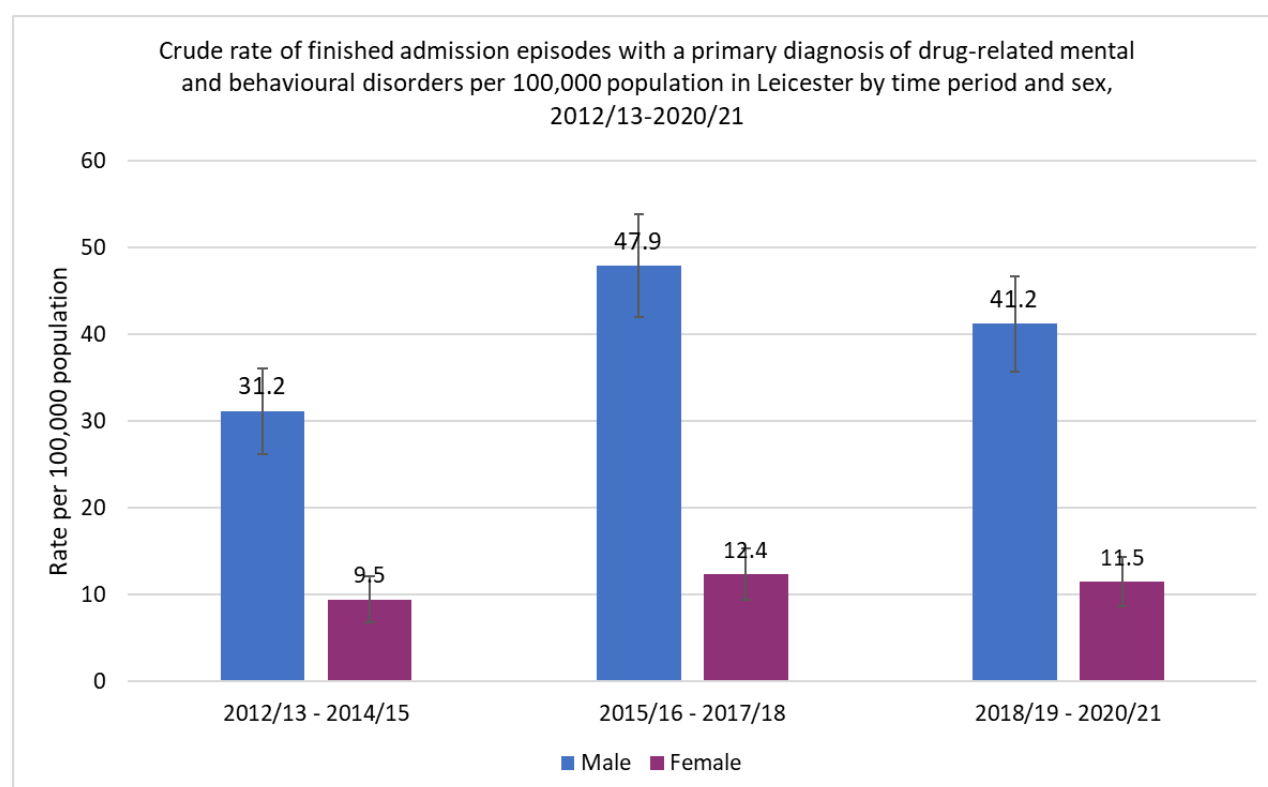
rate in 2012/13-2014/15 and 2015/16-2017/18 in England. The rate in Leicester in 2018/19-2020/21 (26.4 per 100,000 population) was significantly higher than the rate in England in 2018/19-2019/20 (12.8 per 100,000 population).

Figure 72: Crude rate of admission episodes with a primary diagnosis of drug-related mental and behavioural disorders per 100,000 population in Leicester and England by time period, 2012/13-2020/21



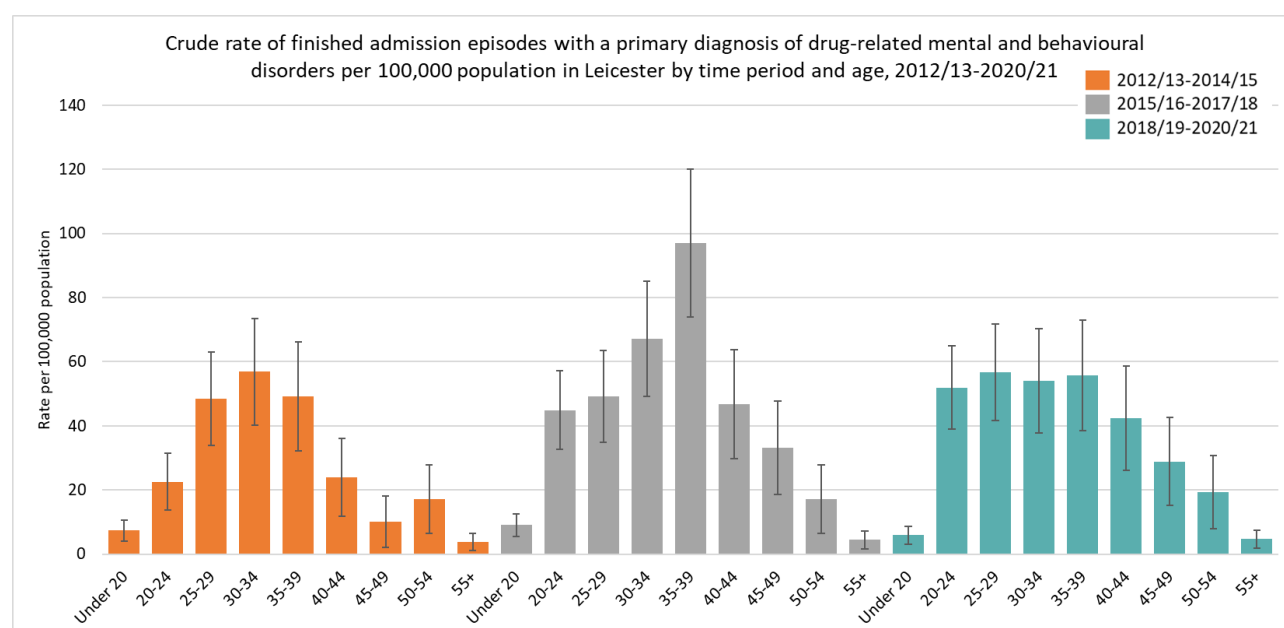
The rate of admission episodes with a primary diagnosis of drug-related mental and behavioural disorders in males in Leicester increased significantly from 31.2 per 100,000 population in 2012/13-2014/15 to 47.9 per 100,000 population in 2015/16-2017/18. In females in Leicester, there were no significant differences in the rate across the three time periods. As shown in Figure 71, in Leicester the rate in males was significantly higher (worse) than the rate in females across all three time periods.

Figure 73: Crude rate of finished admission episodes with a primary diagnosis of drug-related mental and behavioural disorders per 100,000 population in Leicester by time period and sex, 2012/13-2020/21



As shown in Figure 72, in 2018/19-2020/21 the rate of admission episodes with a primary diagnosis of drug-related mental and behavioural disorders per 100,000 population in Leicester was significantly higher (worse) in the 20-54 year age groups than the under 20 and 55+ year age groups. Between 2012/13-2014/15 and 2015/16-2017/18, the rate in the 35-39 year age band increased significantly from 49.1 per 100,000 population to 97.0 per 100,000 population, before decreasing significantly in 2018/19-2020/21 to 55.7 per 100,000 population.

Figure 74: Crude rate of admission episodes with a primary diagnosis of drug-related mental and behavioural disorders per 100,000 population in Leicester by time period and age, 2012/13-2020/21

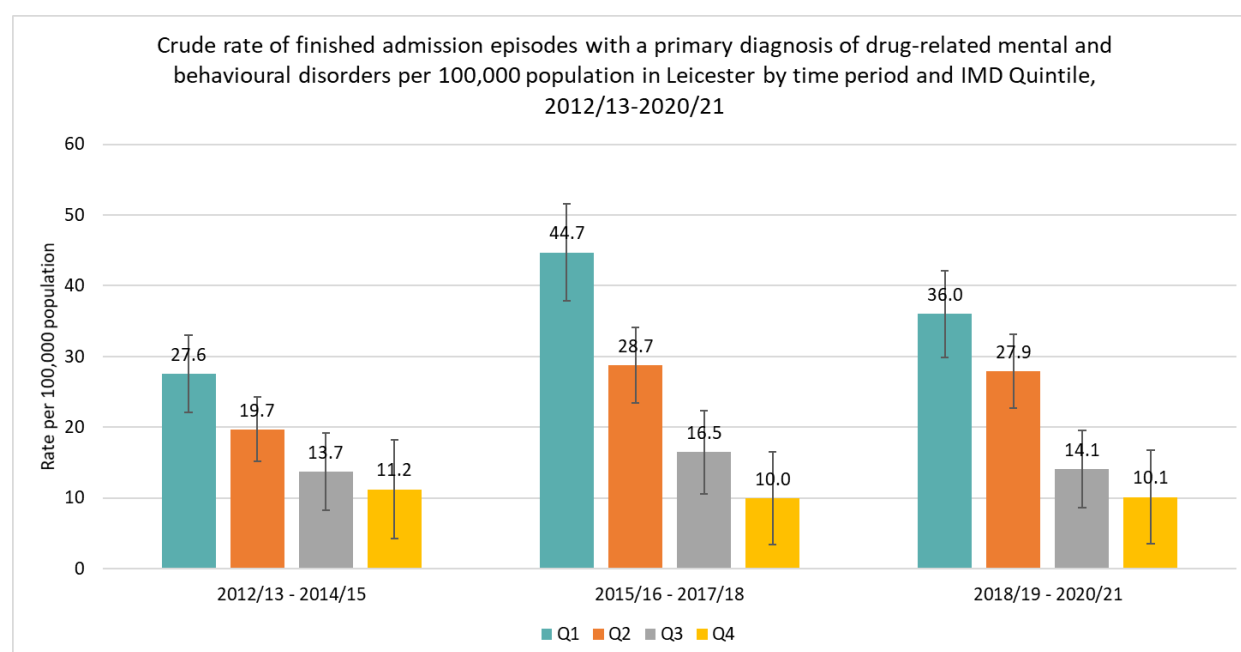


As shown in Figure 73, across all three time periods the rate of admission episodes with a primary diagnosis of drug-related mental and behavioural disorders in Leicester decreased (improved) with each decreasing level of deprivation (from quintile 1 to quintile 4), the decreases between quintile 1 and 2 and quintile 2 and 3 in 2015/16-2017/18 and the decrease between quintile 2 and 3 in 2018/19-2020/21 were significant. Between the three time periods, the only significant difference was the increase in rate in quintile 1 from 27.6 per 100,000 population in 2012/13-2014/15 to 44.7 per 100,000 population in 2015/16-2017/18.

*Note: the data for quintile 5 has been suppressed in Figure 73 due to small counts.*



Figure 75: Crude rate of admission episodes with a primary diagnosis of drug-related mental and behavioural disorders per 100,000 population in Leicester by time period and IMD Quintile, 2012/13-2020/21

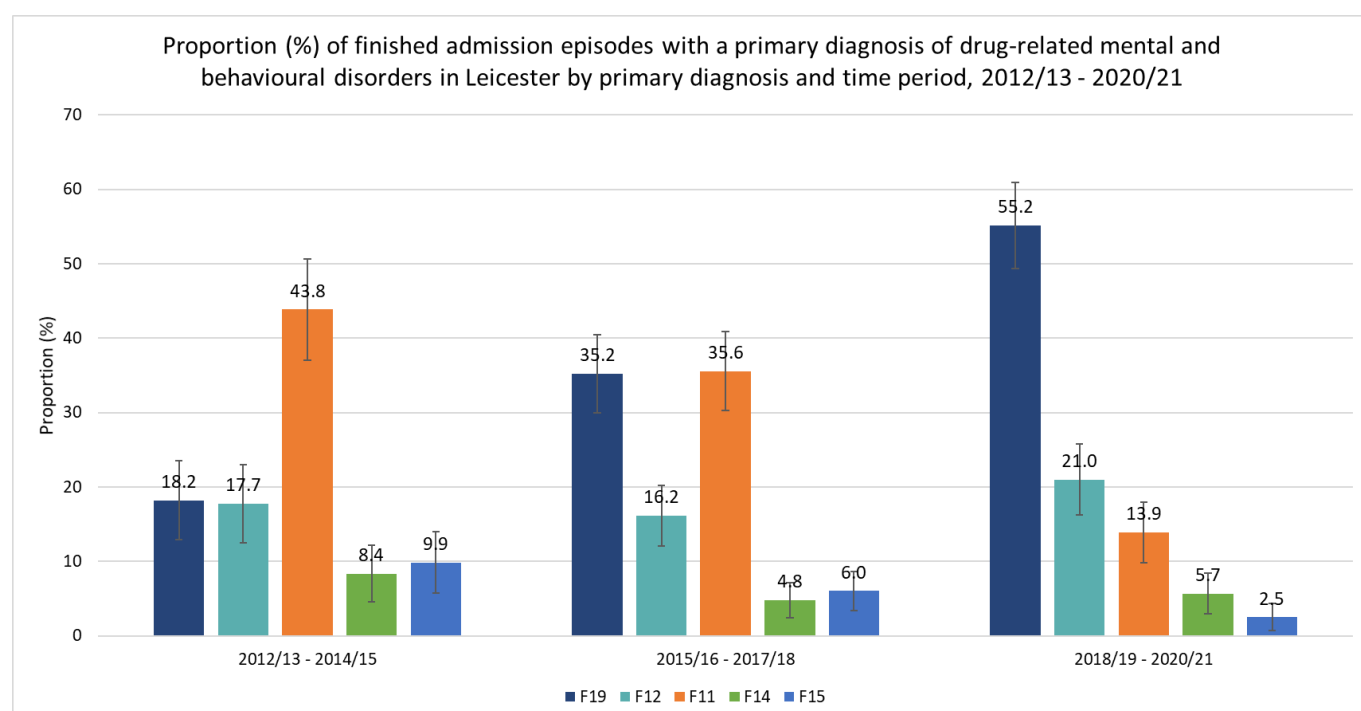


As shown in Figure 74 below, the proportion of admission episodes with a primary diagnosis of mental and behavioural disorders due to multiple drug use and use of other psychoactive substances in Leicester has increased (worsened) significantly from 18.2% in 2012/13-2014/15 to 35.2% in 2015/16-2017/18 to 55.2% in 2018/19-2020/21. Between 2015/16-2017/18 and 2018/19-2020/21, the proportion of admission episodes with a primary diagnosis of drug-related mental and behavioural disorders in Leicester that had a primary diagnosis of mental and behavioural disorders due to the use of opioids decreased (improved) significantly from 35.6% to 13.9%. Over the same time period, the proportion of admission episodes with a primary diagnosis of drug-related mental and behavioural disorders in Leicester that had a primary diagnosis of mental and behavioural disorders due to multiple drug use and use of other psychoactive substances increased (worsened) significantly from 18.2% to 55.2%. In 2018/19-2020/21, admission episodes with a primary diagnosis of mental and behavioural disorders due to multiple drug use and use of other psychoactive substances contributed the highest proportion of admission episodes with a primary diagnosis of drug-related mental and behavioural disorders in Leicester, the proportion of admissions with this primary diagnosis was significantly higher (worse) than the other primary diagnoses. In 2018/19-2020/21 in Leicester, the proportion of admission episodes with a primary diagnosis of drug-related mental and behavioural disorders in Leicester which had a primary diagnosis of mental and behavioural disorders due to the use of cannabinoids or mental and behavioural disorders due to the use of opioids was significantly higher (worse) than both the proportion which had a primary

diagnosis of mental and behavioural disorders due to the use of cocaine or mental and behavioural disorders due to the use of other stimulants (including caffeine).

*Note: the data for F13, F16 and F18 has been suppressed in Figure 74 due to low counts.*

*Figure 76: Proportion of admission episodes with a primary diagnosis of drug-related mental and behavioural disorders in Leicester by primary diagnosis and time period, 2012/13-2020/21*

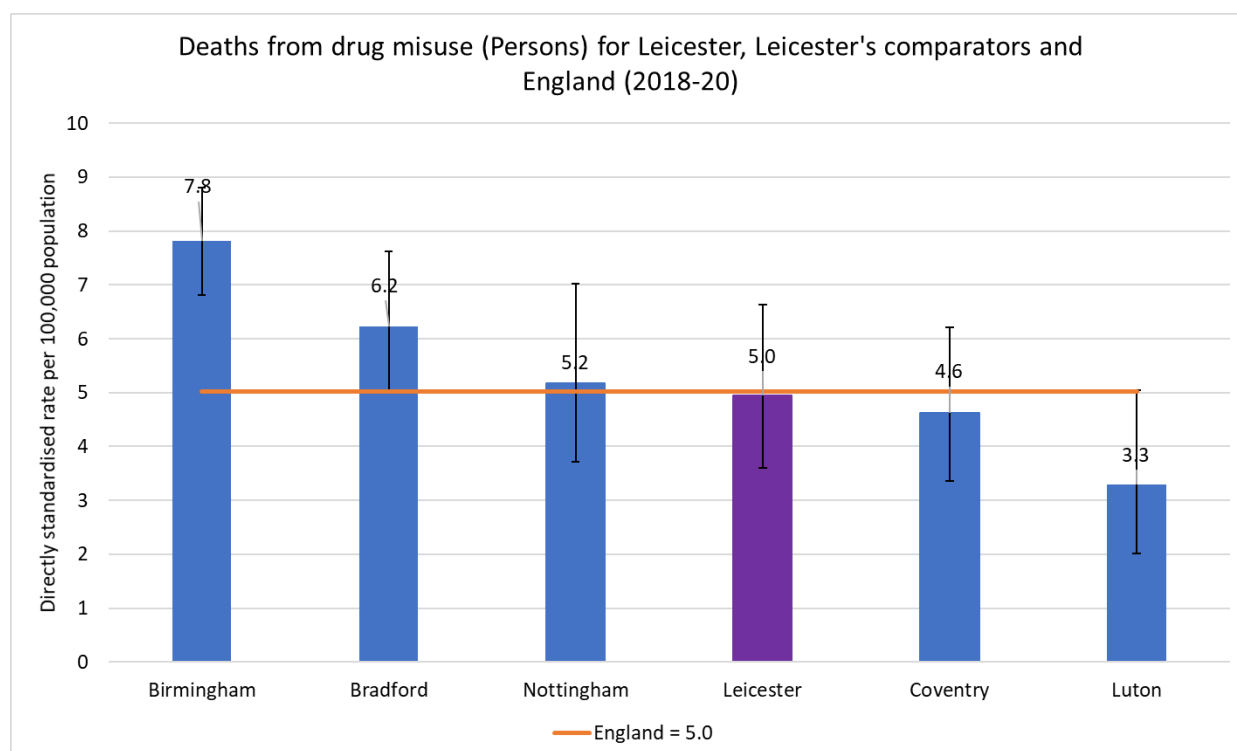


- F11 Mental and behavioural disorders due to use of opioids
- F12 Mental and behavioural disorders due to use of cannabinoids
- F13 Mental and behavioural disorders due to use of sedatives or hypnotics
- F14 Mental and behavioural disorders due to use of cocaine
- F15 Mental and behavioural disorders due to use of other stimulants, including caffeine
- F16 Mental and behavioural disorders due to use of hallucinogens
- F18 Mental and behavioural disorders due to use of volatile solvents
- F19 Mental and behavioural disorders due to multiple drug use and use of other psychoactive substances

### 12.3. Drug Related Deaths

In Leicester in 2018-20 there were 47 deaths from drug misuse. Figure 75 shows that the rate of deaths from drug misuse in Leicester in 2018-20 (5.0 per 100,000 population) was not significantly different to the rate in England (5.0 per 100,000 population). The rate of deaths from drug misuse in Leicester in 2018-20 was significantly lower (better) than that of Birmingham (7.8 per 100,000 population) but was not significantly different to any of its other comparators.

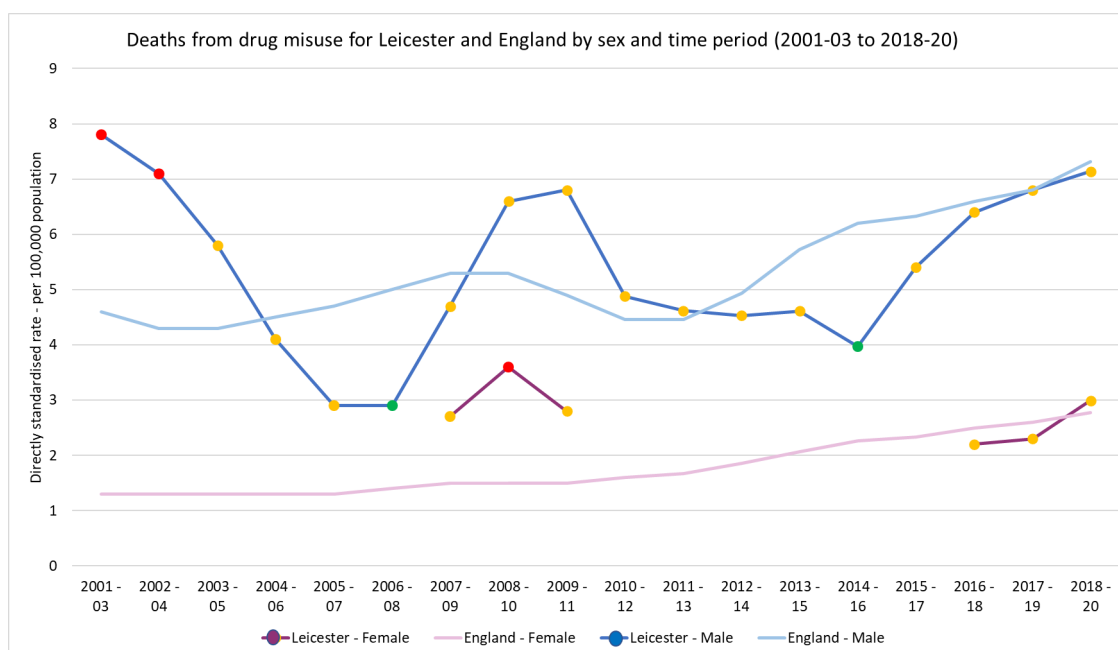
Figure 77: Deaths from drug misuse (Persons) in Leicester, Leicester's comparators and England in 2018-20<sup>111</sup>



In Leicester in 2018-20 there were 33 deaths from drug misuse in males and 14 in females. Figure 76 shows that the rate of deaths from drug misuse in males in Leicester has fluctuated since 2001-03. In 2014-16 the rate of deaths from drug misuse in males in Leicester (4.0 per 100,000 population) was significantly lower (better) than the rate in males in England (6.2 per 100,000 population). Since 2014-16, the rate in males in Leicester has shown an increasing trend and between 2015-17 and 2018-20 the rate in males in Leicester was not significantly different to the rate in males in England overall. In 2008-10 the rate of deaths from drug misuse in females in Leicester was significantly higher (worse) than the rate in females in England overall. Across the last three time periods (2016-18 to 2018-20) the rate of deaths from drug misuse in females in Leicester has not been significantly different to the rate in females in England, within this period the rate in females in Leicester increased with each more recent time period.

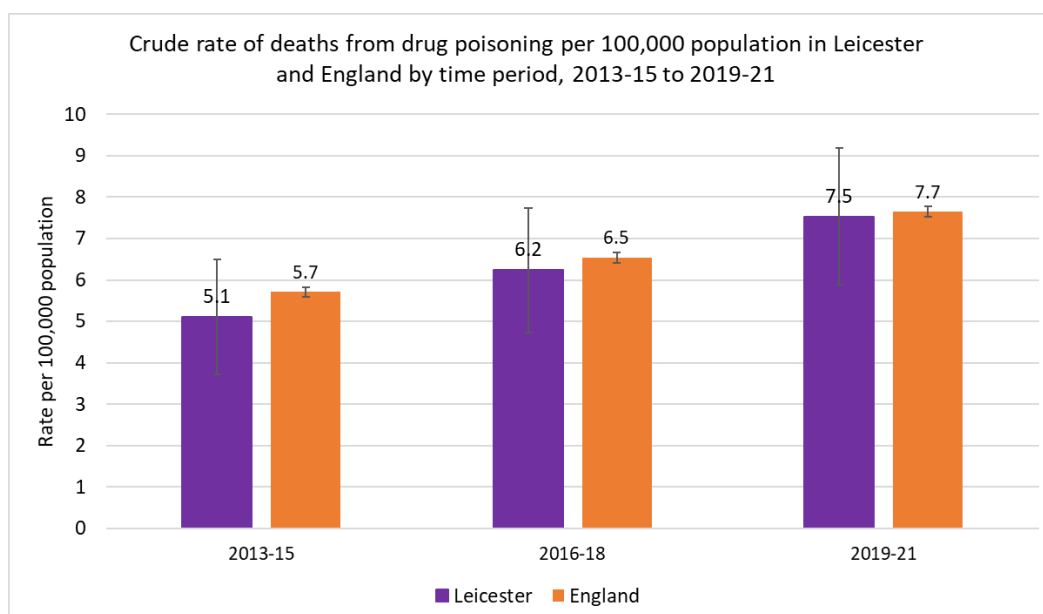
*Note: the value for females in Leicester between 2001-03 and 2006-08 and 2010-12 and 2015-17 were not calculated due to small counts.*

Figure 78: Deaths from drug misuse for Leicester and England by sex and time period between 2001-03 and 2018-20<sup>112113</sup>



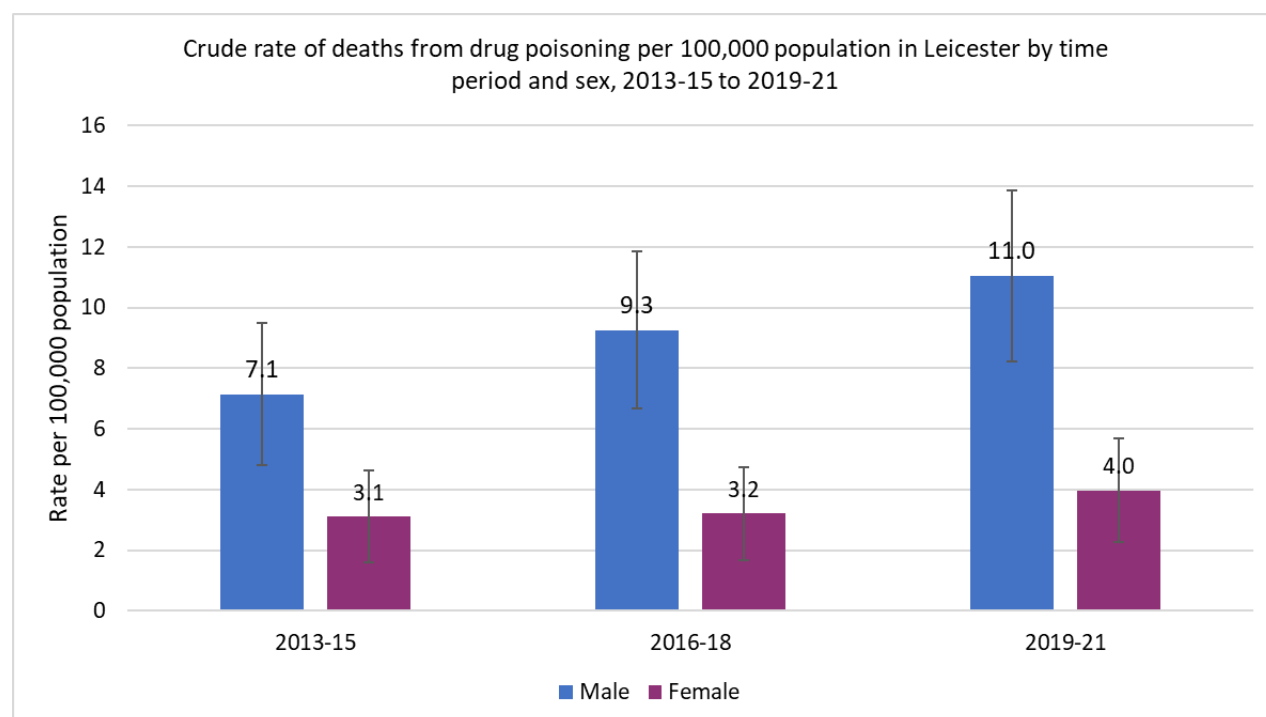
In Leicester there were 52, 66 and 80 deaths from drug poisoning in 2013-15, 2016-18 and 2019-21 respectively. As shown in Figure 77 below, the rate of deaths from drug poisoning in Leicester was not significantly different to the rate in England in 2013-15, 2016-18 or 2019-21. The rate of deaths from drug poisoning in both Leicester and England has increased with each time period – in Leicester from 5.1 per 100,000 population in 2013-15 to 6.2 in 2016-18 to 7.5 in 2019-21 and in England from 5.7 per 100,000 population to 6.5 and to 7.7 respectively, the increases in England were significant but the increases in Leicester were not.

Figure 79: Crude rate of deaths from drug poisoning per 100,000 population in Leicester and England by time period, 2013-15 to 2019-21<sup>114115</sup>



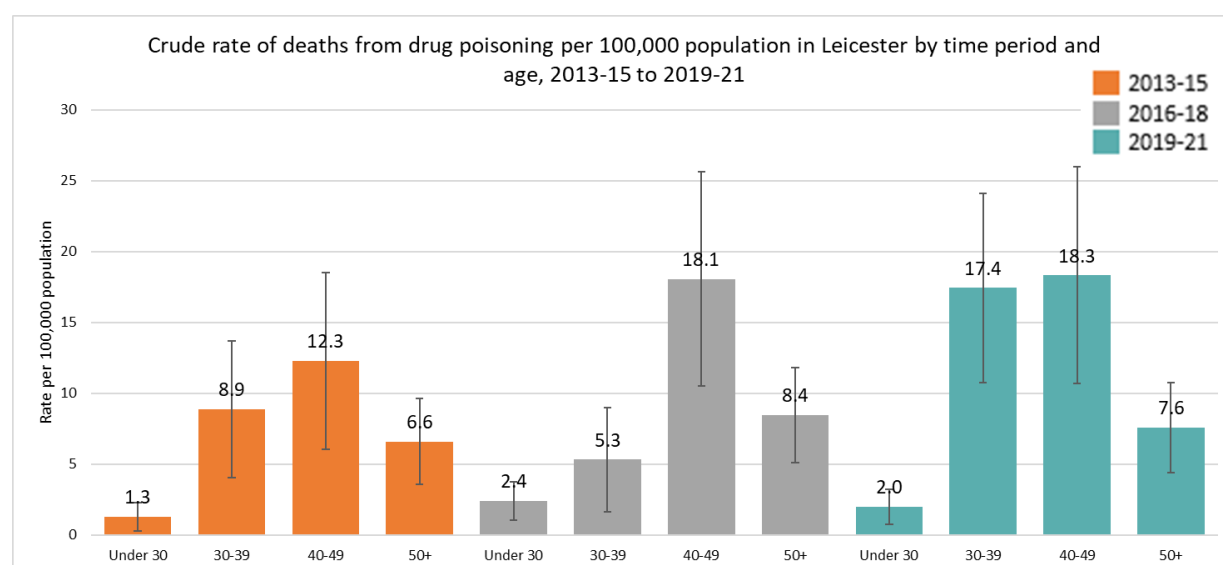
As shown in Figure 78, in all of 2013-15, 2016-18 and 2019-21, the rate of deaths from drug poisoning in Leicester was significantly higher (worse) in males (7.1, 9.3 and 11.0 per 100,000 population respectively) than in females (3.1, 3.2 and 4.0 per 100,000 population respectively). Although the rate of deaths from drug poisoning in Leicester increased with each time period in both males and females, there were no significant differences in the rates across time.

Figure 80: Crude rate of deaths from drug poisoning per 100,000 population in Leicester by time period and sex, 2013-15 to 2019-2021



As shown in Figure 79, the rate of deaths from drug poisoning in Leicester increased with age from the under 30 age group to the 40-49 year age group – the increase between the under 30 and 30-39 year age group in 2013-15, the 30-39 and 40-49 year age group in 2016-18 and the under 30 to 30-39 year age group in 2019-21 was significant. The rate of deaths from drug poisoning in Leicester decreased between the 40-49 and 50+ year age group in 2013-15, 2016-18 and 2019-21, however, the change was not significant for any of the three time periods. Between 2016-18 and 2019-21, the rate of deaths from drug poisoning in Leicester in the 30-39 year age group increased significantly.

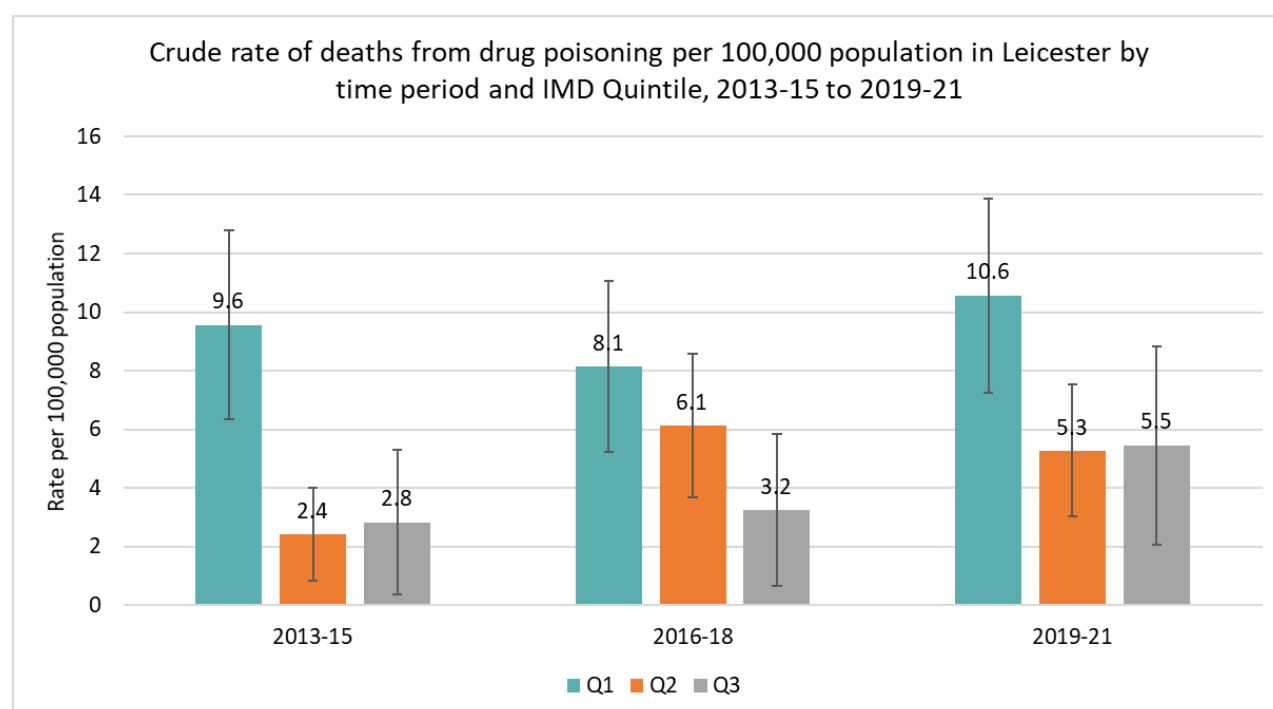
Figure 81: Crude rate of deaths from drug poisoning per 100,000 population in Leicester by time period and age, 2013-15 to 2019-21



As shown in Figure 80, across 2013-15, 2016-18 and 2019-21 the rate in quintile 1 (the most deprived areas) was higher than the rate in quintile 2 and quintile 3, although this difference was only significant in 2013-15.

*Note: the data for quintile 4 and quintile 5 was suppressed in Figure 80 due to small counts.*

Figure 82: Crude rate of deaths from drug poisoning per 100,000 population in Leicester by time period and IMD quintile, 2013-15 to 2019-21



With the exception of deaths from drug poisoning with an underlying cause of accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances (X44), the

proportion of deaths from drug poisoning with an underlying cause of accidental poisoning by and exposure to narcotics and psychodysleptics (hallucinogens) not elsewhere classified (X42) was significantly higher (worse) than the proportion of deaths from drug poisoning with the other underlying causes defined below across 2013-15, 2016-18 and 2019-21. The proportion of deaths from drug poisoning with an underlying cause of X44 was significantly higher (worse) than the proportion of deaths from drug poisoning with the other underlying causes defined below in 2019-21 and in 2016-18, with the exception of deaths from drug poisoning with an underlying cause of accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs not elsewhere classified (X41) in 2016-18. The proportion of deaths with an underlying cause of X44 increased from 21.2 in 2013-15 to 25.8 in 2016-18 and to 36.8 in 2019-21, although these changes were not significant.

F19	Mental and behavioural disorders due to multiple drug use and use of other psychoactive
X40	Accidental poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
X41	Accidental poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified
X42	Accidental poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
X44	Accidental poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
X60	Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics
X61	Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified
X62	Intentional self-poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified
X64	Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
Y10	Poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics, undetermined
Y11	Poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, undetermined intent
Y12	Poisoning by and exposure to narcotics and psychodysleptics [hallucinogens], not elsewhere classified, undetermined intent
Y14	Poisoning by and exposure to other and unspecified drugs, medicaments and biological substances, undetermined intent

#### 12.4. Impact of COVID-19

The local impact of the Covid-19 pandemic on the use of drugs and levels of drug use is currently unknown. Published data on hospital admissions for deaths from drug misuse runs is available for 2018 to 2020 (combined) so the impact of pandemic cannot be witnessed. This represents a local gap in knowledge and should be prioritised for investigation when data becomes available.

For many individuals, the lockdown and measures implemented to contain the spread of the COVID-19 virus resulted in changes in drug and alcohol use and associated behaviours. Globally, cross-sectional surveys identified increases in the consumption of some substances (e.g. cannabis, tramadol and benzodiazepines) and decreases in the use of others (e.g. MDMA and cocaine).

Increases were linked to feelings of stress, fear, isolation and boredom and were more common among dependent users. Decreases were linked to the closure of pubs, bars and nightclubs where “recreational” drugs are often consumed and were more common among occasional users.<sup>116117118</sup>

In response to the pandemic, treatment services for people with drug and/or alcohol problems were disrupted. While some were forced to close their doors others remained open and rapidly adapted to the “extraordinarily challenging circumstances” by developing innovative methods of delivery and implementing new forms of treatment.<sup>119</sup> There is some evidence to suggest that the pandemic led to a decline in the number of people seeking treatment for substance use problems.<sup>119</sup> However, the picture is mixed as some services reported increases in referrals while others reported decreases.<sup>120</sup>

## 13. Substance Use Treatment Population

PHE estimated that alcohol treatment reflects a return on investment of £3 for every £1 invested, which can increase to £26 over 10 years. Drug treatment provides a return on investment of £4 for every £1 invested, which can increase to £21 over 10 years.<sup>121</sup> Treatment can be provided through a range of evidence-based mechanisms, such as psychosocial interventions including Cognitive Behaviour Therapy (CBT), motivational interviewing and relapse prevention. More information on these evidence-base interventions are available in Section 13.1 NICE Guidance.

### 13.1. Young People in Treatment

While the majority of young people do not use drugs, and most of those who do are not dependent, substance use can have a major impact on young people’s health, their education, their families and their long-term chances in life. The below data examines information about young people (under the age of 18 years) from Leicester City accessing specialist substance use interventions alongside national and similar area comparisons. Much of the data is taken from the NDTMS which, for young people, reflects specialist treatment activity reported for those with problems around substance use. The importance of specialist treatment is huge as evidence suggests that effective specialist substance use interventions contribute to improved health and wellbeing, better educational attainment, reductions in the numbers of young people not in education, employment or training (NEET) and reduced risk-taking behaviour, such as offending<sup>122</sup>. The below data gives a comprehensive overview of these specialist interventions.

#### 13.1.1. Numbers in Treatment

The numbers of young people (under 18) in community structured treatment in young people’s services during any part of 2020/21 was 44. Provisional data suggests the number of young people using treatment services has declined to 27 in 2021/22. Figure 81 examines the trend in rate of



number of young people in specialist substance use services in England, Leicester and by its young people comparator areas. The figure shows a declining trend at both a national and local level. Between 2009/10 and 2020/21, the number of young adults using specialist substance services have declined by -54% in England and -50% in Leicester. Including provisional figures for 2021/22 sees the decline increase further, to -69% in Leicester City and -55% in England. The figure also reveals wide variations in rates of young people in specialist treatment services exist across the comparator areas. In 2020/21 rates ranged from 24.4 per 10,000 population in Peterborough to 1.1 per 10,000 population in Slough. Leicester City has the fourth lowest rate of treatment at specialist substance use services (5.2 per 10,000 population) when compared to its ten comparators. In 2021/22, the difference in rate between national and local has widened due to the faster decline in the rate of young people in specialist treatment services in Leicester City. Despite this, Figure 82 shows Leicester City has improved to have the fifth lowest rate out of its ten comparators.

*Figure 83: Rate of Young People in treatment at specialist substance use services (aged under 18 years) by time period for Leicester and Leicester's comparators (2009/10 to 2021/22)*

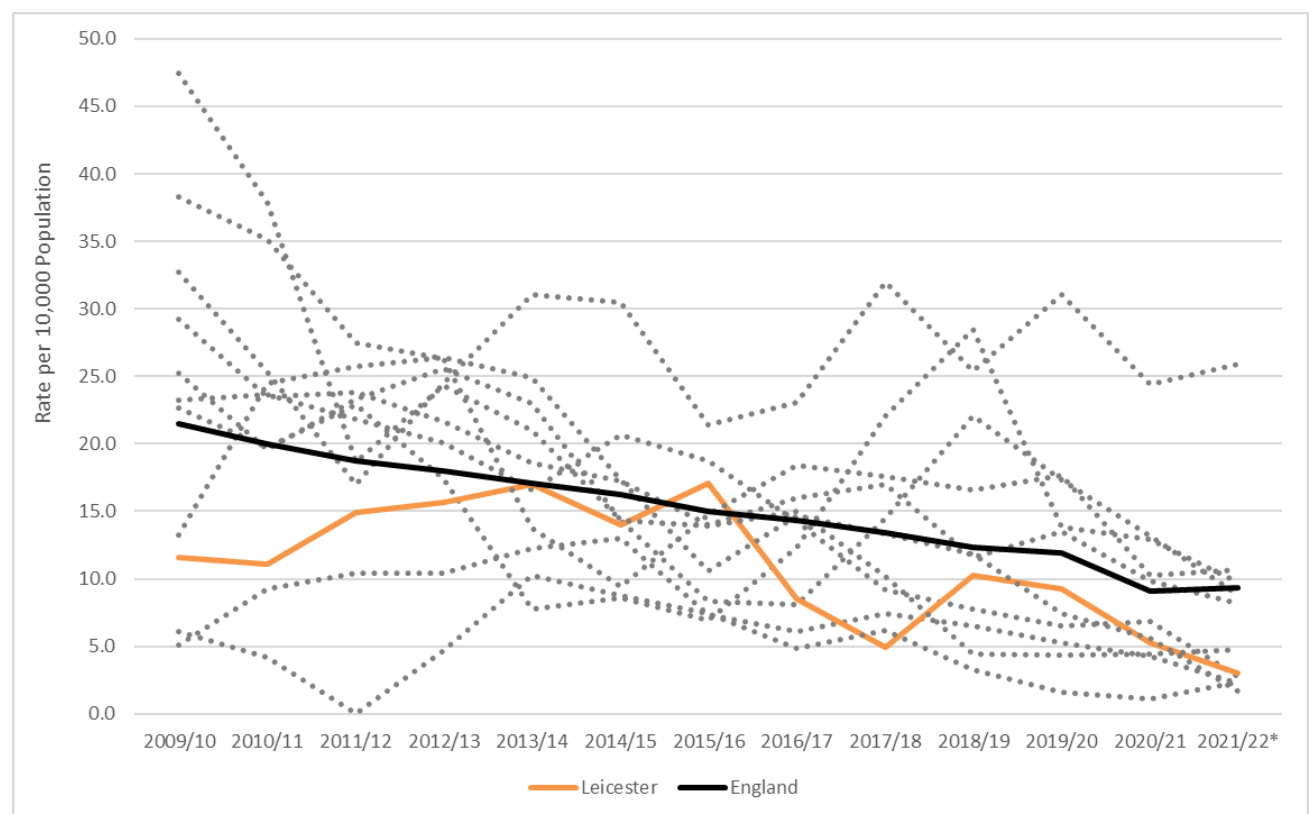
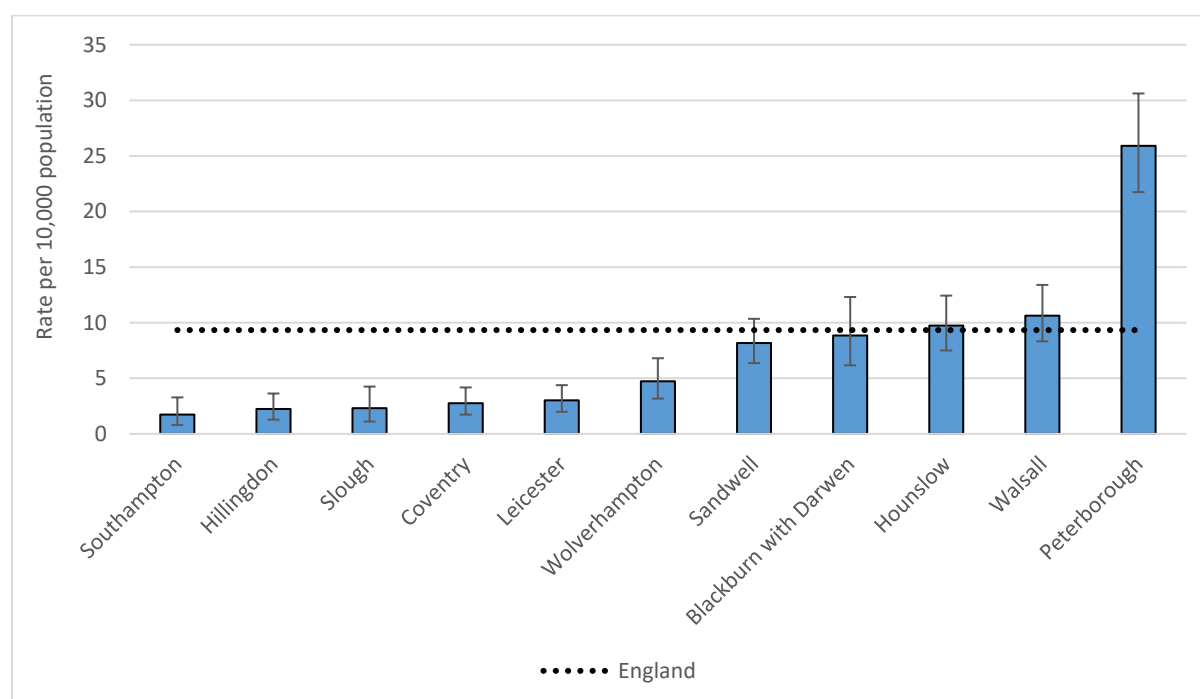


Figure 84: Rate of Young People in treatment at specialist substance use services (aged under 18 years) for Leicester and Leicester's comparators in 2021/22



### 13.1.2.Young People Starting Treatment

Numbers of young people newly presenting to specialist substance use services during any part of 2020/21 was 29. Provisional data suggests the number of young people new to treatment has declined to 11 in 2021/22. Figure 83 examines the trend in rate of young people newly presenting to specialist substance use services in England, Leicester and by its young people comparator areas. The figure shows a declining trend at both a national and local level. Between 2009/10 and 2020/21, the number of young adults using specialist substance services have declined by -59% in England and -50% in Leicester. Including provisional figures for 2021/22 sees the decline increase further, to -81% in Leicester City and -55% in England. The figure highlights locally a sharp decline in rate has been witnessed in newly presenting young people in Leicester City between 2018/19 and 2021/22. Between this time, counts of young people have declined from 75 to 11 annually.

Figure 83 reveals wide variations in rates of young people newly presenting to specialist treatment services exist across the comparator areas. In 2020/21 rates ranged from 18.1 per 10,000 population in Peterborough to 1.1 per 10,000 population in Slough. Leicester City has the fourth lowest rate of treatment at specialist substance use services (3.4 per 10,000 population) when compared to its ten comparators. In 2021/22, the difference in the national and local rate has widened due to a decline in the rate of young people newly presenting to specialist treatment services in Leicester City coupled with an increase in this rate nationally. Figure 84 shows Leicester City has declined to have the second lowest rate out of its ten comparators.

Young people newly presenting to specialist treatment services as a proportion of all those in specialist treatment is examined in Figure 85 for 2021/22. This shows Leicester City has the lowest proportion of newly presenting young people (41%) compared the ten comparators. Please note, this data is still provisional.

Figure 85: Rate of Young People newly presenting to specialist substance use services (aged under 18 years) by time period for Leicester and Leicester's comparators (2009/10 to 2021/22)

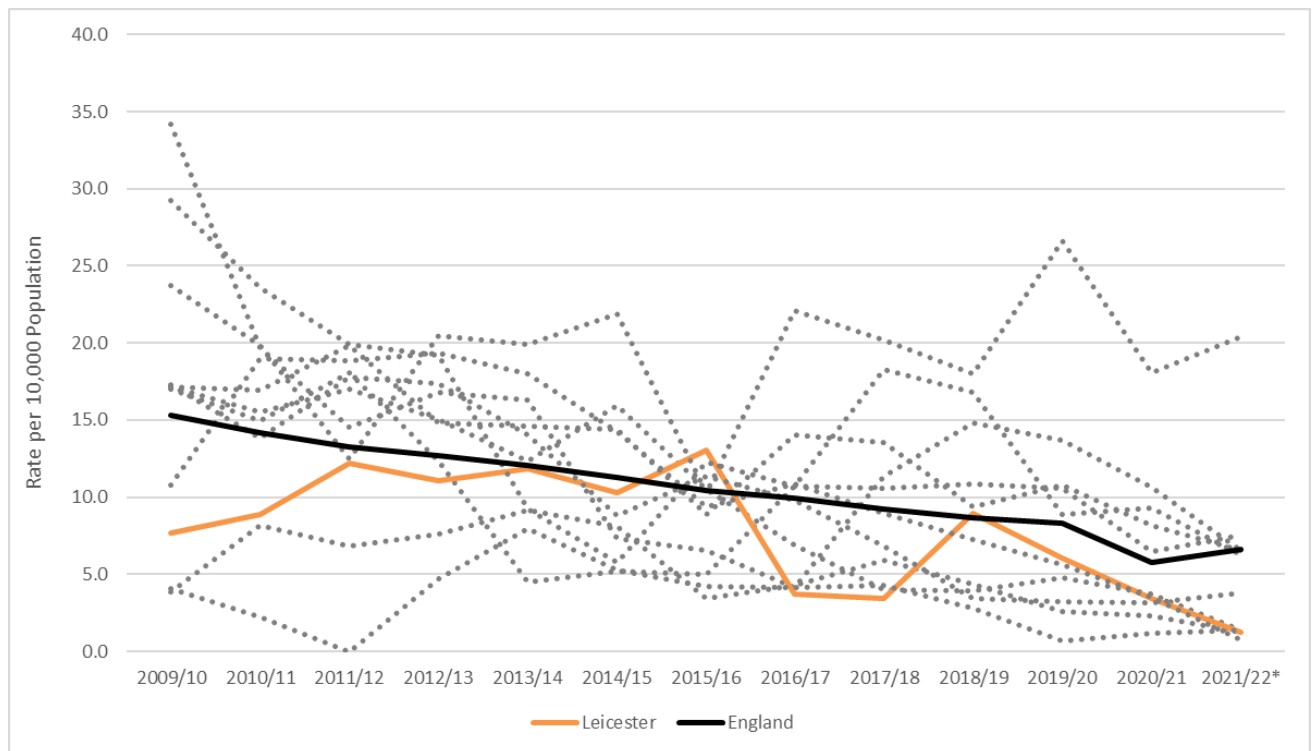


Figure 86: Rate of Young People newly presenting at specialist substance use services (aged under 18 years) for Leicester and Leicester's comparators in 2021/22

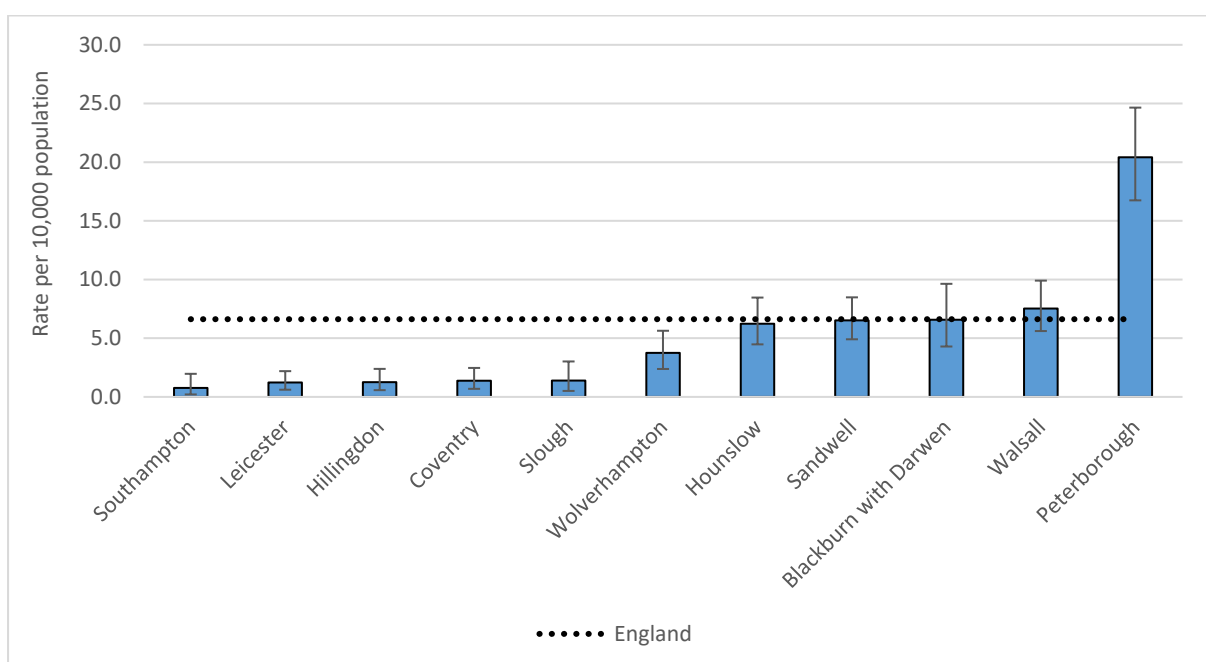
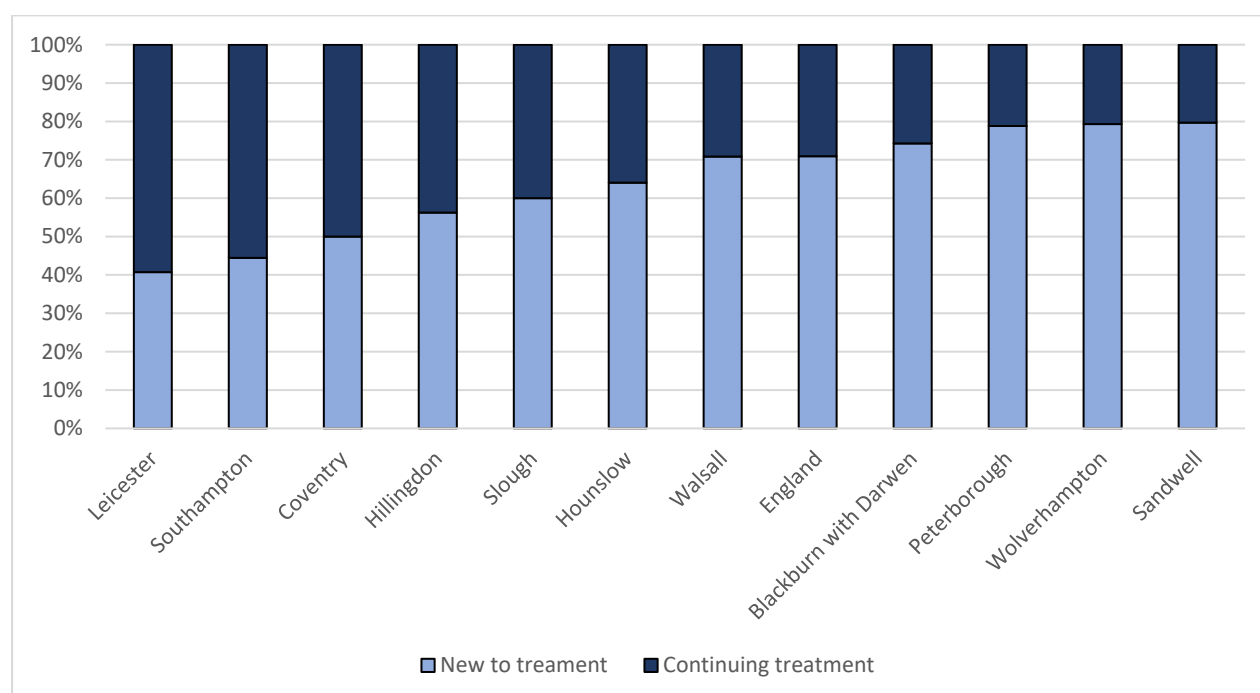


Figure 87: Proportion of Young People presenting at specialist substance use services (aged under 18 years) by new presentations and continuing treatment for Leicester and Leicester's comparators in 2021/22



### 13.1.3. Demographics of Young People in Treatment

Table 2 shows the counts of young people in treatment by age group in Leicester compared to the national breakdown in 2021/22. It shows Leicester City has a significantly higher proportion of seventeen year olds in treatment compared to national. Specialist services must deliver age-appropriate interventions and promote the safeguarding and welfare of children and young people. Although it must be noted that services should be based on developmental need rather than age.

Table 6: Young people (under 18) in treatment by Age for Leicester and England, 2021/22

	Leicester		England	
	N	%	n	%
Aged 15 and under	9	33%	5605	51%
Aged 16	5	19%	2586	24%
Aged 17	13	48%	2796	25%

	Significantly lower than national
	Significantly higher than national
	No significant difference to national

In terms of ethnicity, the proportion of young people in treatment at specialist substance use services from a white background in Leicester City was 67%, lower than the national percentage of

78% (but not significantly different). The remaining 33% of young people in treatment in Leicester City were from Mixed, Asian and Other ethnicities.

#### 13.1.4. Drugs




In Leicester City in 2021/22, cannabis is the most prevalent substance for young people's substance use (96%), followed by alcohol (22%). This pattern is replicated nationally, however national proportions are lower for cannabis (87%) and higher for alcohol (46%). It is important for service planning that other substances (e.g. cannabis edibles, LEAN, Nitrous Oxide) should be taken in account, including educating young people about their dangers, and planning for some young people requiring prescribing as part of their substance use treatment.

#### 13.1.5. Education and Employment

The below data show the education and employment status of young people at the start of treatment. This includes those not in education, employment or training and who are persistent absentees or excluded. Being NEET can have adverse effects on young people's wellbeing and life chances. Table 3 shows the proportion of all young people in treatment in education at the start of the treatment is significantly lower (56%) than the national percentage (78%). In Leicester a significantly higher proportion of young people were in apprenticeship or training (22%) compared to nationally (3%). The local variation is likely to be a reflection of the higher average age range of young people in Leicester using the specialist treatment service compared to England. All other education or employment status showed no significant difference to nationally.

*Table 7: Proportion of young people (under 18) in treatment by Education and Employment status in Leicester and England, 2021/22*

	Leicester	England
Education	56%	78%
Apprenticeship / training	22%	3%
Not in employment, education or training (NEET)	19%	12%
Regular employment	0%	3%
Other	4%	2%
<b>Total</b>		

	Significantly lower than national
	Significantly higher than national
	No significant difference to national

### 13.1.6.Housing

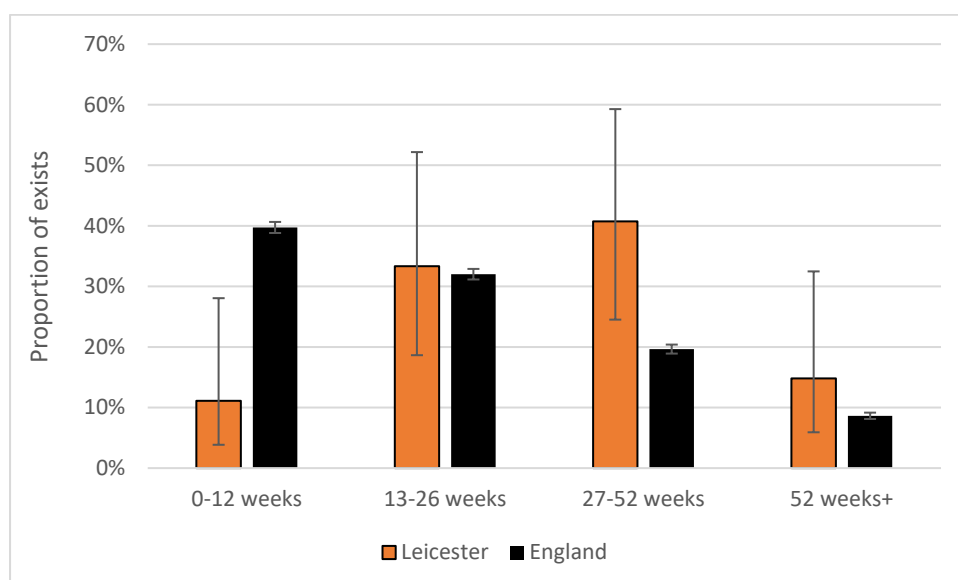
The accommodation data collected by NDTMS shows self-reported housing status of young people when they started in treatment services. A safe, stable home environment enables people to sustain their recovery. In 2021/22, the 89% of young people in treatment in Leicester City were living with parents or relatives. This is statistically similar to the national percentage of 82%. The remaining 11% of young people in Leicester City were living in care or settled accommodation.

### 13.1.7.Length of Time in Treatment

Figure 86 shows the time young people in Leicester spent receiving specialist interventions in 2021/22 by their latest contact. It is regarded that young people generally spend less time in specialist interventions than adults because their substance use is not as entrenched. However, those with complex care needs often require support for longer.

The average length of time in treatment in Leicester City in 2021/22 was 31 weeks whereas nationally, average treatment was shorter at 23 weeks. The reason for this is explained in Figure 86 which shows locally, there was a significantly lower proportion of exits between 0-12 weeks (11%) compared to nationally (40%). Conversely, young people in Leicester had a significantly higher proportion of exits from treatment lasting 27-52 weeks (41%) compared to nationally (20%). No significant difference exists in the proportion of young people exiting treatment between 13-26 weeks and 52 weeks and above.

*Figure 88: Length of time in treatment for young people (under 18) exiting treatment for Leicester and England in 2021/22*






### 13.1.8. Interventions Delivered

Young people have better outcomes when they receive a range of interventions as part of their package of care. Psychosocial interventions are an example of one of these, which involves a range of talking therapies designed to encourage behaviour change. If a pharmacological intervention is required, it should always be delivered alongside appropriate psychosocial support.

Table 4 shows all young people (100%) in treatment in Leicester received psychosocial support in 2021/22, similar to national percentage of 94%. The proportion of individuals who received harm reduction (4%) and multi-agency working (26%) was significantly lower than the national percentages of 67% and 62% respectively. It is important to note that an individual may have received more than one intervention type so percentages may sum to more than 100%

*Table 8: Proportion of young people (under 18) in treatment in high level interventions across the treatment journey for Leicester and England, 2021/22*

	<b>Leicester</b>	<b>England</b>
Psychosocial	100%	94%
Harm Reduction	4%	67%
Multi-agency Working	26%	62%

	Significantly lower than national
	Significantly higher than national
	No significant difference to national

At both a national and local level, the vast majority of structured treatment took place in community settings (both 97%), followed by home treatment (both 3%).

### 13.1.9. Successful Completions




This section shows the number of young people who have left specialist interventions successfully and the proportion that return to treatment, referred to as re-presentations. Young people's circumstances can change, as does their ability to cope. If they re-present to treatment, this is not necessarily a failure and they should be rapidly re-assessed to inform a new care plan that addresses their problems.

Of the 44 young people in treatment in 2020-21 in Leicester, 39% left successfully which is similar to the proportion that left successfully in England overall (53%). In Leicester in 2020-21, 63% of young people leaving treatment were leaving treatment successfully, although lower than the proportion leaving treatment successfully as a proportion of all exits in England (79%) this difference was not significant.

The re-presentation information available is based on planned exits between 1 January 2020 and 31 December 2020, with re-presentations up to 6 months after exiting. It is included to help with monitoring the effectiveness of specialist interventions; a high re-presentation rate may suggest a problem with the treatment system, or an outside factor driving young people to need to return to treatment. The proportion of young people non-representing in Leicester was 88%, similar to the national percentage of 96%.

*Table 9: Number and proportion of young people completing their period of treatment in 2020-21 by completion category for Leicester and England*

	Total in Treatment	Total Leaving Treatment	Total Leaving Treatment Successfully	% Leaving Treatment	% Leaving Treatment Successfully	% Leaving Treatment Successfully, as a Proportion of all Exits
<b>Local</b>	44	27	17	61%	39%	63%
<b>England</b>	10881	7237	5725	67%	53%	79%

	Significantly lower than national
	Significantly higher than national
	No significant difference to national

### 13.1.10. Wider health behaviours

#### 13.1.10.1. Drinking levels

Most young people who require structured treatment for alcohol dependence will be drinking at higher risk levels. Drinking levels can be used as a rough proxy for level of dependence and levels of alcohol health risk. An indication of drinking levels in treatment may be useful in understanding which groups of young people are receiving treatment and whether those with the highest levels of harm are receiving effective interventions.

Consumption is based on drinking levels over the 28 days prior to assessment. There is a strong association between levels of consumption and severity of dependence, but they are not equivalent. For example, women are likely to become dependent at lower levels of consumption than men. It is important to note that there may be some moderately or severely dependent young people who have stopped or reduced consumption prior to treatment (for example in hospital or prison) so will appear in the lowest category even though they are alcohol dependent and will require treatment.

NDTMS data examines the number of units of alcohol consumed by young people in the 28 days prior to commencing treatment. In 2020/21 in Leicester, 63% of young people in treatment



consumed zero units 28 days prior to treatment, statistically similar to the national percentage of 50%. Furthermore, less than a quarter (23%) of young people in treatment in Leicester consumed between 1-199 units in the 28 days prior to commencing treatment, this is significantly lower than the national percentage of 44%. The proportion of young people drinking above 200 units 28 days prior to treatment was 13% in Leicester and 6% nationally, but due to the small numbers contained in the samples, the proportions are not significantly different.

#### 13.1.10.2. Tobacco Use

Smoking rates in the adult general population is currently 15.4% in Leicester but is much higher in adults who misuse substances such as drug and alcohol, where smoking is a major cause of illness and death. Surveys of school pupils show rates of smoking have strongly decreased over the last two decades at a national level, with 16% of pupils aged 11-15 having ever smoked.<sup>123</sup> However, that survey also showed that pupils who use substances are more likely to smoke as well; a quarter of those who recently used alcohol also recently smoked, and a third of those who recently took drugs also recently smoked. In Leicester in 2020/21, the proportion of young people smoking tobacco at the start of treatment was 7%, significantly lower than the national percentage of 27%.

#### 13.1.11. Co-occurring Mental Health

In 2020/21, the proportion of young people in treatment who were identified as having a mental health treatment need at the start of treatment was 43% in Leicester, this is similar to the national percentage of 42%. Of those individuals identified as having a mental health need, 84% were receiving treatment for their mental health. This is similar to the national percentage of 67%.

#### 13.1.12. Vulnerabilities of Young People in specialist substance use services

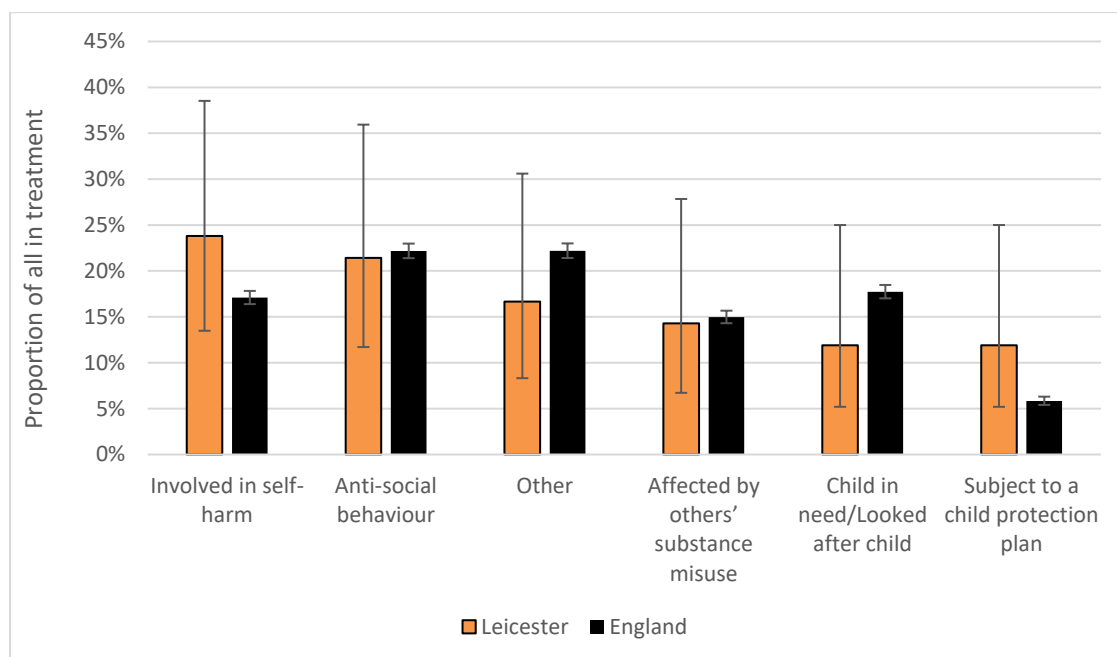
Many young people receiving specialist interventions for substance use have a range of vulnerabilities. Examples of these include, NEET, in contact with the youth justice system, experience of domestic abuse and sexual exploitation. Engaging with substance use is also associated with early sexual initiation and other risky sexual behaviours.

Figure 87 shows the proportion of young people in treatment with wider vulnerabilities in Leicester and England in 2020/21. At a local level, 24% of all young people in treatment were involved in self-harm, similar to the national percentage of 17%. At both a national and local level, the prevalence of self harm in the treatment population has been increasing. The issue of self harm further emphasises the differences in the treatment population by gender, with the prevalence four times higher in females than males in Leicester City. It is important that services are tailored to the specific

needs of genders within these services and ensure that young people with multiple vulnerabilities receive additional support if required.

Anti-social behaviour (21%), Other, which includes affected by domestic abuse and child sexual exploitation (17%) and affected by others' substance use (14%) were the next most common vulnerabilities in the young people treatment population in Leicester. The prevalence from these vulnerabilities did not differ significantly to the national prevalence.

Figure 89: Proportion of young people (under 18) in treatment with wider vulnerabilities in Leicester and England, 2020-21



## 13.2. Adults in Alcohol Only Treatment

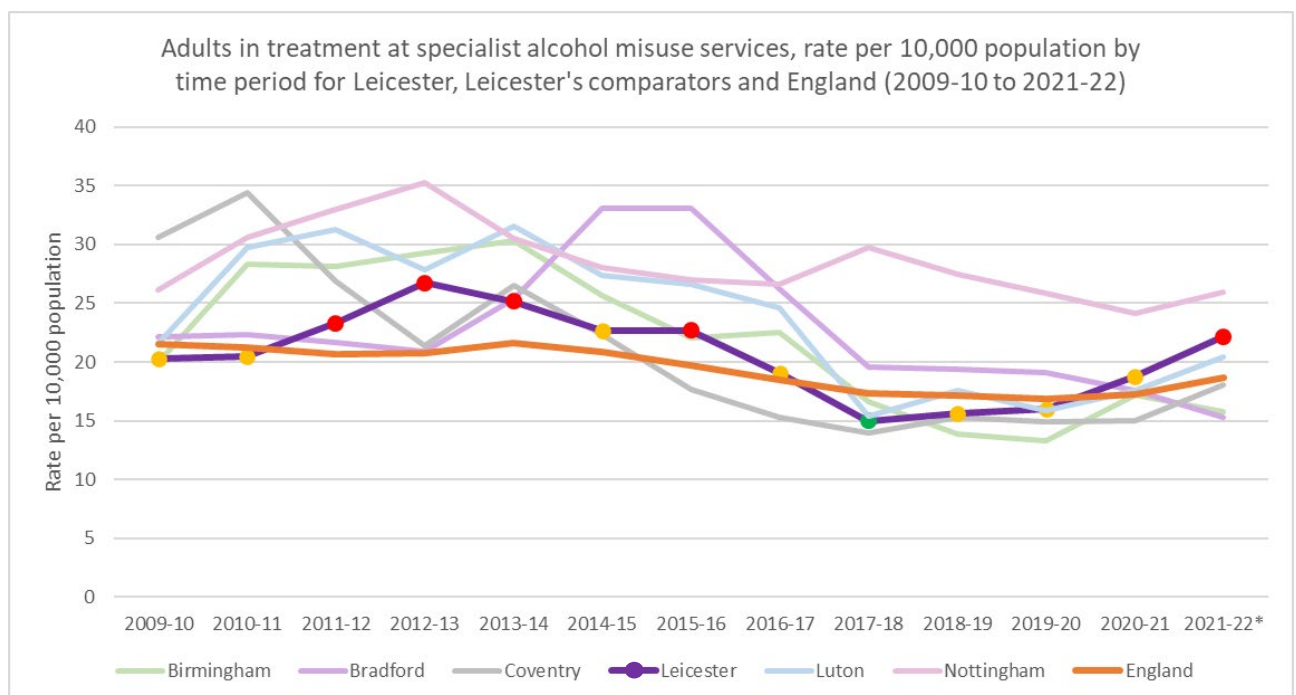
The data below examines information about adults (aged 18+) who are receiving structured alcohol only treatment in Leicester City alongside national and similar area comparisons. The data below covers only those who cited alcohol as their only substance use problem. This NDTMS data has been taken either directly from NDTMS or through the Office for Health Improvement & Disparities Fingertips site.

### 13.2.1. Numbers in Alcohol Only Treatment

In Leicester in 2020/21 there were 507 adults in community structured alcohol misuse treatment services. Provisional data suggests that the number of adults using alcohol misuse treatment services in Leicester has increased to 618 in 2021/22. Between 2009/10 and 2020/21, the rate of adults using specialist alcohol misuse treatment services has declined by 7.5% in Leicester and 19.7% in England. When including the provisional figures for 2021/22, the rate in Leicester has increased by 9.2% since 2009/10 and the rate in England has decreased by 13.1%. Figure 88 shows an increasing

trend in the rate of adults in treatment at specialist alcohol misuse treatment services in Leicester since 2017/18, with an increasing trend also witnessed in England since 2019-20. In 2017-18 the rate of adults in alcohol misuse treatment services in Leicester (15.0 per 10,000 population) was significantly lower (better) than the rate for England (17.3 per 10,000 population). Between 2018-19 and 2020/21 the rate in Leicester was not significantly different to England. The provisional data for 2021/22 suggests that the difference between the rate in England and Leicester has widened due to the faster increase in the rate in Leicester. The suggested rate in Leicester in 2021/22 (22.2 per 10,000 population) was significantly higher (worse) than the rate for England (18.7 per 10,000 population). The figure also reveals similar rates of adults in specialist alcohol misuse treatment services across Leicester's comparator areas since 2017-18, with the exception of Nottingham which has had a significantly higher rate than Leicester since 2009-10. Leicester City has the second highest rate of adults in specialist alcohol misuse treatment services when compared to its comparators in both 2020/21 (18.8 per 10,000 population) and the provisional data for 2021/22 (22.2 per 10,000 population).

*Figure 90: Rate of adults in treatment at specialist alcohol misuse services in Leicester, Leicester's comparators and England by time period (2009-10 to 2021-22)*

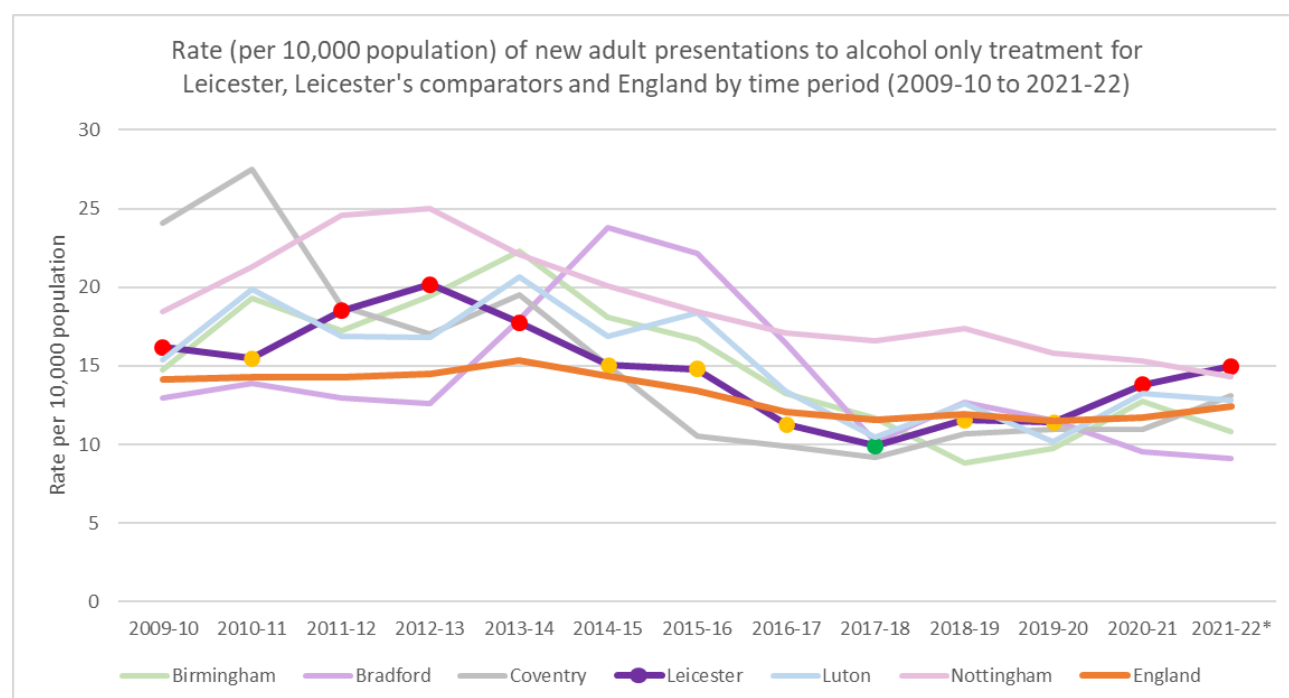


### 13.2.2. Adults Starting Alcohol Only Treatment

In 2020/21 in Leicester 372 adults newly presented to specialist alcohol misuse treatment services. Provisional data for 2021-22 suggests that an increased number of 418 adults newly presented to treatment during this year. Between 2009-10 and 2020-21, the rate of adults newly presenting to alcohol only treatment declined by 14.9% in Leicester and 17.1% in England. Including the

provisional figures for 2021-22 reduces the decline to 7.5% in Leicester and 12.0% in England. As shown in Figure 89 the rate of adults newly presenting to specialist alcohol misuse treatment services in Leicester has fluctuated since 2009-10, with an increasing trend witnessed since 2017-18. In 2017-18 the rate in Leicester (9.9 per 10,000 population) was at its lowest since 2009-10 and was significantly lower (better) than the national rate (11.6 per 10,000 population). Following a significant increase in the rate in Leicester since 2017-18 the rate in 2020/21 (13.7 per 10,000 population) and in the provisional data for 2021/22 (15.0 per 10,000 population) was significantly higher (worse) than the rate in England (11.7 and 12.5 per 10,000 population respectively). In 2020-21 Leicester had the second highest rate of adults newly presenting to alcohol only treatment of its five comparators and England, following an increase in the rate in the provisional data for 2021-22 Leicester is suggested to have the highest rate of its comparators.

*Figure 91: Rate of adults newly presenting to specialist alcohol misuse treatment services in Leicester, Leicester's comparators and England by time period (2009-10 to 2021-22)*

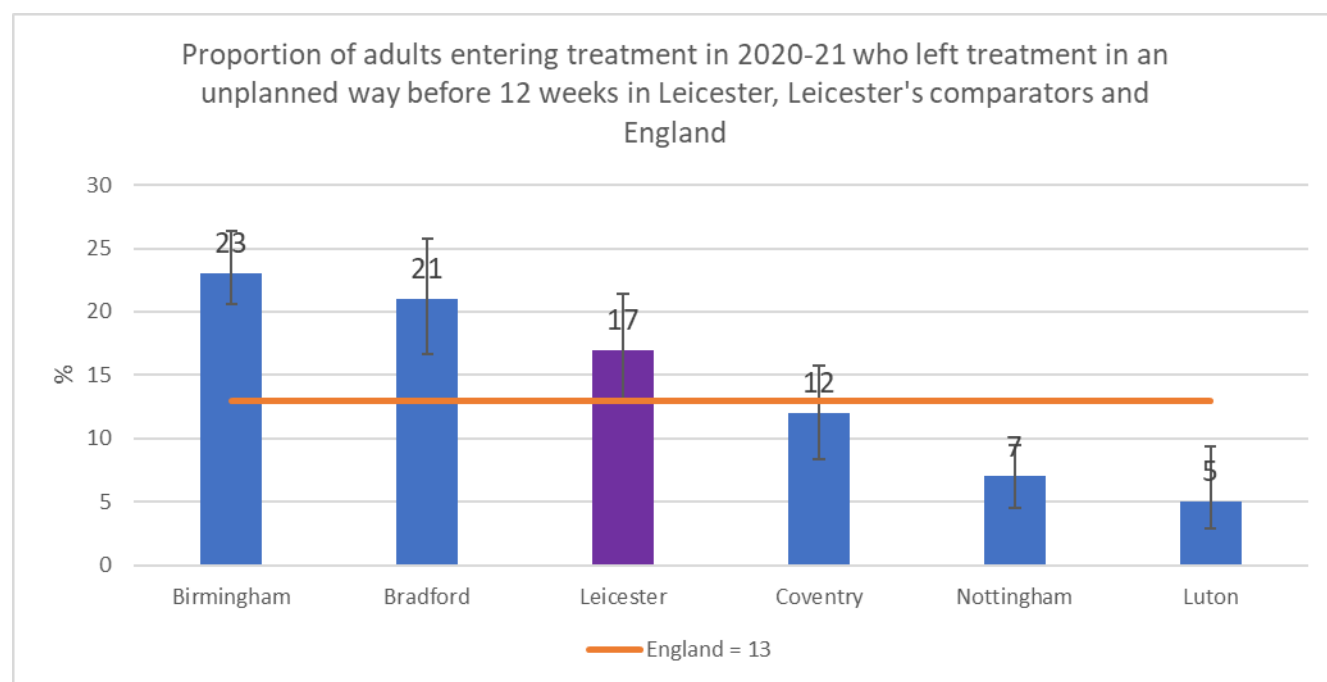


### 13.2.3.Unplanned Exits

When in treatment, people use alcohol and illegal drugs less, commit less crime, improve their health, and manage their lives better – which also benefits the community. Preventing unplanned drop out and keeping people in treatment long enough to benefit contributes to these improved outcomes. As people progress through treatment, the benefits to them, their families and their community start to accrue. The data below shows the proportion of adults entering alcohol only treatment in Leicester, Leicester's comparators and England in 2020-21 who left treatment in an unplanned way before 12 weeks. In 2020-21 in Leicester, 17% of new presentations made an

unplanned exit from treatment within 12 weeks of starting treatment, this is a significantly higher (worse) proportion than the proportion of unplanned exits before 12 weeks in England overall (13%). Leicester had the 3<sup>rd</sup> highest proportion of adults entering treatment in 2020-21 who left treatment in an unplanned way before 12 weeks when compared to its comparators. Leicester had a significantly higher (worse) proportion (17%) than Nottingham (7%) and Luton (5%).

Figure 92: Proportion of adults entering alcohol only treatment in 2020-21 who left treatment in an unplanned way before 12 weeks in Leicester, Leicester's comparators and England

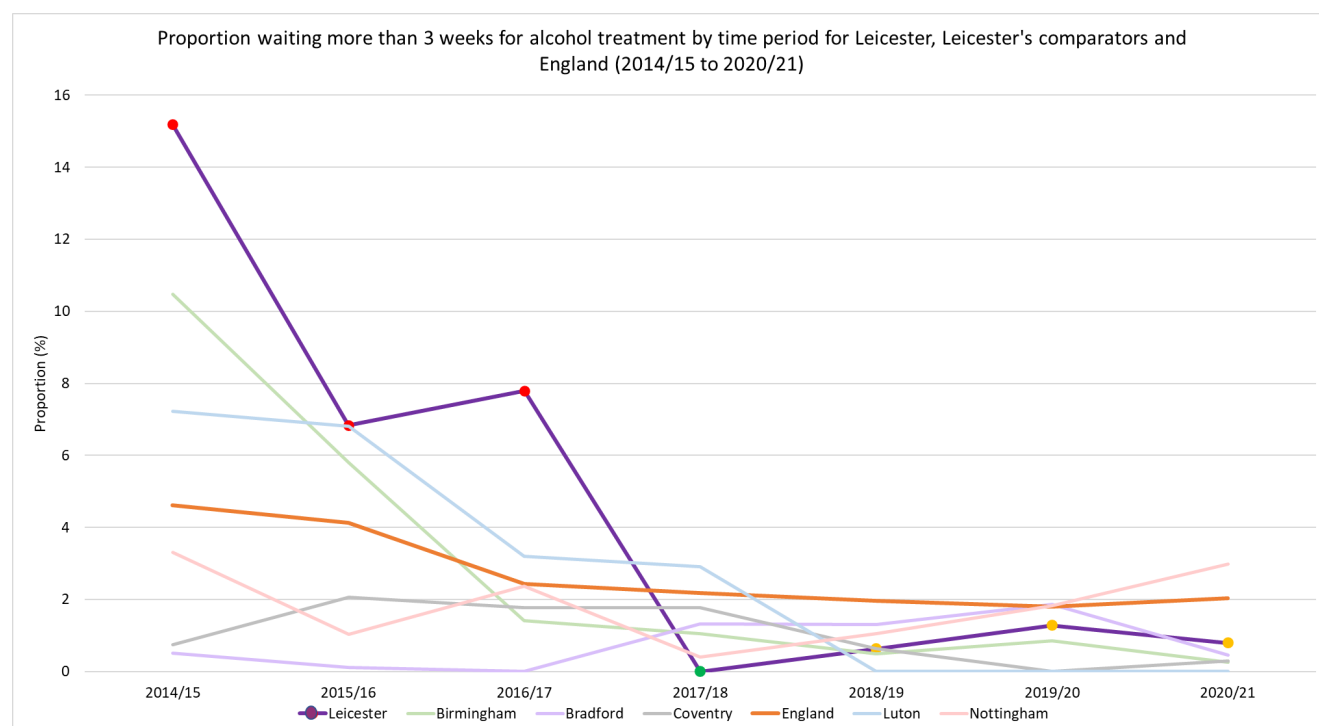


#### 13.2.4.Waiting Times

As shown in Figure 91, the proportion of individuals waiting more than 3 weeks for alcohol treatment in Leicester has decreased significantly from 15.2% in 2014/15 to 0.8% in 2020/21. Although not as substantial, all of Leicester's comparators have also witnessed a decrease in the proportion of individuals waiting more than 3 weeks for alcohol treatment since 2014/15. In 2020/21, Leicester has the 5<sup>th</sup> highest proportion of individuals waiting more than 3 weeks for alcohol treatment when compared to its five comparators. The proportion of individuals waiting more than 3 weeks for alcohol treatment in Leicester has not been significantly different to the proportion for England since 2018/19. Over the last five time periods there has been no significant change in the proportion of individuals waiting more than 3 weeks for alcohol treatment in Leicester.

In 2021-22 in Leicester, 100% of first interventions for alcohol only treatment were received within three weeks or less of referral.

Figure 93: Proportion waiting more than 3 weeks for alcohol treatment by time period for Leicester, Leicester's comparators and England (2014/15 to 2020/21)<sup>124</sup>



### 13.2.5. Demographics of Adults in and Starting Alcohol Only Treatment

The demographic data of those in alcohol only treatment below has not been standardised against the demographic profile of the general population. The proportions of different demographic groups within the treatment population may differ to that of comparator areas whilst being in line with the proportions witnessed in the general population structure of the particular area. Care should be taken when interpreting proportions where comparisons against the general population structure of the area have not been considered.

In Leicester, Leicester's comparators and England, a significantly larger proportion of the adults in alcohol only treatment in 2021-22 were male than were female. In 2021-22 Leicester's adult alcohol only treatment population consisted of the largest proportion of males and the smallest proportion of females when compared to its comparators and England. In Leicester, a significantly larger proportion of the adults in alcohol only treatment were male (69.6%) than in England (58.3%), Nottingham (60.3%), Coventry (59.6%) and Bradford (59.0%), with Leicester having a significantly smaller proportion of adults in alcohol only treatment that were female than these comparators. Below the Leicester adult alcohol misuse treatment population sex breakdown has been compared to the census 2021 Leicester 18+ general population estimate. A significantly larger proportion of the Leicester 2021-22 adult alcohol misuse treatment population was male (69.6%) than in the Census 2021 Leicester 18+ general population estimate (48.8%) and a significantly smaller

proportion of the Leicester 2021-22 adult alcohol only treatment population was female (30.4%) than in the Census 2021 Leicester 18+ general population estimate (51.2%).

Figure 94: Proportion of adults in alcohol only treatment in 2021-22 by sex in Leicester, Leicester's comparators and England

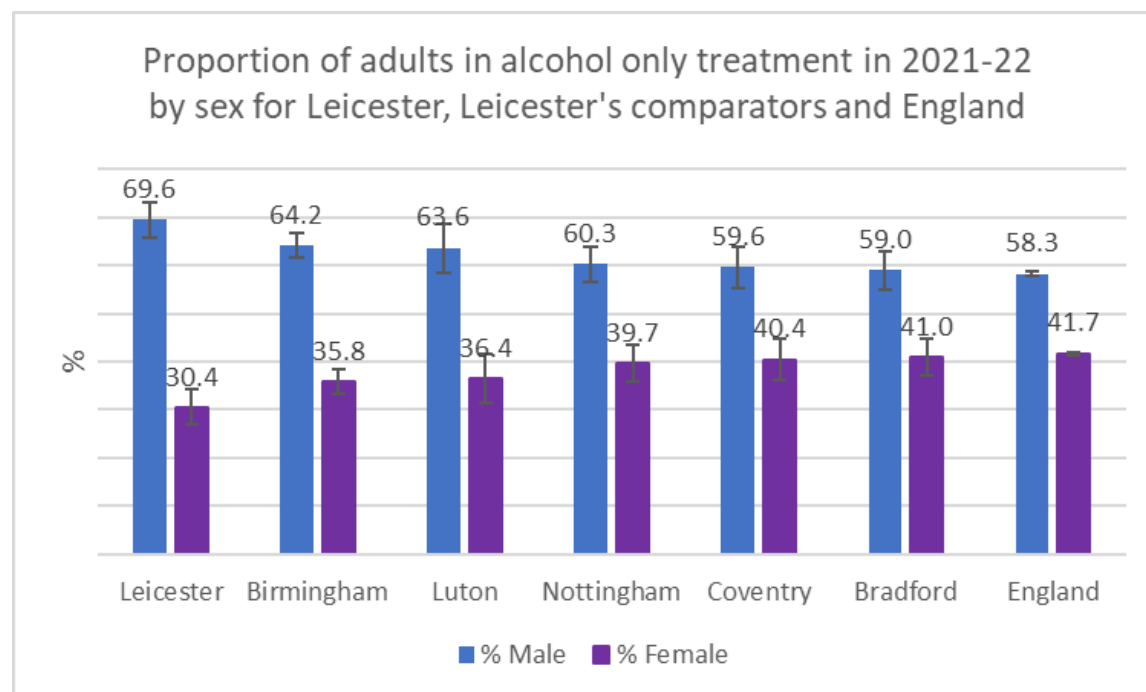





Table 6 shows the count and proportion of adults in alcohol only treatment by age group in Leicester and England in 2021/22. Leicester has a significantly larger proportion of 35-39 year olds in alcohol only treatment (16.8%) compared to England overall (12.9%). Below the Leicester adult alcohol misuse treatment population age breakdown has been compared to the census 2021 Leicester 18+ general population estimate, more details of which can be found in Appendix 2. The alcohol misuse treatment population in Leicester in 2021-22 had a significantly larger proportion of its population aged between 35-39, 40-44, 45-49, 50-54 and 55-59 years old than the Census 2021 Leicester 18+ general population estimate. The proportion of adults aged under 25, 25-29 and 65 and above in Leicester's alcohol misuse treatment population in 2021-22 was significantly smaller than the proportion of the population in these age bands in the Census 2021 Leicester 18+ general population estimate.

Table 10: Adults in alcohol only treatment for Leicester and England, 2021-22

Age group	Leicester		England	
	Count	%	Count	%
Under 25	27	4.4%	2751	3.3%
25-29	44	7.1%	4667	5.6%
30-34	60	9.7%	8424	10.1%
35-39	104	16.8%	10751	12.9%
40-44	100	16.2%	11523	13.8%
45-49	77	12.5%	12179	14.6%
50-54	75	12.1%	12200	14.6%
55-59	59	9.5%	9827	11.8%
60-64	43	7.0%	6167	7.4%
65 and above	29	4.7%	5093	6.1%
Total	618	100.0%	83582	100.0%

	Significantly lower than national
	Significantly higher than national
	No significant difference to national




As shown in Table 7, a significantly larger proportion of Leicester's adult alcohol only treatment population in 2021-22 were of an Asian (19.1%), Black (4.7%) or Mixed (3.6%) ethnic group than in England's treatment population (3.3%, 2.4% and 1.8% respectively). The proportion of adults in alcohol only treatment from a white ethnic background in Leicester (71.4%) was significantly lower than the proportion in England (89.5%). When compared to the Census 2021 population estimates, a significantly larger proportion of Leicester's adult alcohol only treatment population in 2021-22 were White (71.4%) than in the general Leicester population (40.9%). A significantly smaller proportion of Leicester's adult alcohol only treatment population in 2021-22 were Asian (19.1%) or Black (4.7%) than were Asian or Black in the general population in Leicester (43.4% and 7.8% respectively). The difference witnessed between the proportion of the alcohol only treatment population in 2021-22 and the general population which are of a White, Asian or Black ethnic background in Leicester was similar to that in England. There was no significant difference between the proportion of Leicester's adult alcohol only treatment population in 2021-22 that were of a Mixed ethnic background (3.6%) and the proportion of the general population in Leicester that were of a Mixed ethnic background (3.8%). At a national level there was a significantly lower proportion of those of Mixed ethnic background in alcohol only treatment in 2021-22 (1.8%) than in the general population (3.0%). This suggests at local level alcohol treatment clients are over-represented by individuals from a white ethnicity and under-represented from individuals from Asian or Black backgrounds. Please note, adjustments have not been made for confounders, such as deprivation or abstinence. It is important that work is undertaken with the specialist treatment provider to ensure treatment services are



meeting the needs of Leicester's diverse population and increasing uptake from ethnic minority groups. A table of the Census 2021 Leicester population estimate by ethnic breakdown is provided in Appendix 3 at the end of this document.

*Table 11: Adults in alcohol only treatment in 2021-22 in Leicester and England by ethnic group*

Ethnic Group	Leicester		England	
	Count	%	Count	%
White	441	71.4%	74797	89.5%
Asian	118	19.1%	2796	3.3%
Black	29	4.7%	1981	2.4%
Mixed	22	3.6%	1478	1.8%
Not stated	0	0.0%	1251	1.5%
Missing / inconsistent	0	0.0%	704	0.8%
Other	8	1.3%	547	0.7%
Chinese	0	0.0%	28	0.0%
Total	618	100.0%	83582	100.0%

	Significantly lower than national
	Significantly higher than national
	No significant difference to national

The majority (57.4%) of adults new to alcohol only treatment in Leicester in 2021-22 did not follow a religion. The most commonly recorded religion amongst those starting a new alcohol only treatment journey in 2021-22 was Christian (18.7%), followed by Sikh (6.7%), Hindu (6.2%) and Muslim (4.1%).

A large proportion (94.0%) of the adults starting a new alcohol only treatment journey in 2021-22 in Leicester had their sexuality recorded as heterosexual at the start of their treatment journey, whilst 3.3% were gay/lesbian and 1.7% were bisexual.

Around four in five (80.9%) adults entering alcohol only treatment in Leicester in 2021-22 cited no disability, so it can be inferred that around one in five (19.1%) cited at least one disability. A range of disabilities were cited by adults starting a new alcohol only treatment journey in Leicester in 2021-22. Mobility and gross motor disability was cited by 6.0% of adults starting treatment, whilst 5.3% cited a behavioural and emotional disability, 3.6% cited a learning disability, 2.9% cited progressive conditions and physical health and 1.7% cited sight disability. Other disabilities cited include hearing, manual dexterity, speech and personal, self-care and continence.

### 13.2.6. Drugs

Of the 1,013 adults receiving alcohol treatment in Leicester in 2020-21, 50% (507) are in treatment for alcohol only compared to 58% (76,740) of the 131,391 adults in treatment in England. The other

50% of adults in alcohol treatment in Leicester is made up of those using alcohol and non-opiates (28%), alcohol, opiates and non-opiates (16%) and alcohol and opiates (7%).

### 13.2.7. Employment

Table 8 below shows the number and proportion of adults starting a new treatment journey in alcohol only treatment in Leicester and England in 2021-22 by their employment status at the start of their treatment journey. Just over one third (34.7%) of clients in Leicester were in regular employment at the start of their alcohol only treatment journey in 2021-22, this is not significantly different to the value for England (37.3%). Almost one in five (18.9%) of new presentations to alcohol only treatment in Leicester in 2021-22 were on long term sick or disabled, this is similar to the proportion for England (18.1%). In Leicester in 2021-22, a significantly smaller proportion of adults starting a new treatment journey in alcohol only treatment were unemployed and seeking work (8.4%), unemployed (0.0%) or a homemaker (0.0%) than in England overall (12.0%, 1.3% and 1.5% respectively). A significantly larger proportion of adults starting a new alcohol only treatment journey in Leicester in 2021-22 were unemployed and not seeking work (28.0%) than in England overall (17.3%).

Table 12: Adults starting a new alcohol only treatment journey by employment status in Leicester and England, 2021-22

	Leicester		England	
	Count	%	Count	%
Regular Employment	145	34.7%	20760	37.3%
Long term sick or disabled	79	18.9%	10088	18.1%
Unemployed and not seeking work	117	28.0%	9665	17.3%
Unemployed and seeking work	35	8.4%	6681	12.0%
Retired from paid work	26	6.2%	3595	6.5%
Homemaker	*	*	828	1.5%
Unemployed	*	*	732	1.3%
Unknown	7	1.7%	645	1.2%
Missing / inconsistent	*	*	583	1.0%
Not receiving benefits	*	*	529	0.9%
Not stated	*	*	523	0.9%
Other	*	*	512	0.9%
Pupil / student	*	*	354	0.6%
Unpaid voluntary work	*	*	168	0.3%
Economically Inactive	*	*	54	0.1%
NEET	*	*	*	*
Pupil Referral Unit	*	*	*	*
Total	418	100.0%	55721	100.0%

	Significantly lower than national
	Significantly higher than national
	No significant difference to national

### 13.2.8.Housing

A safe and stable home environment enables people to sustain their recovery. Table 9 below shows that the majority of adults starting alcohol only treatment in 2021-22 in both Leicester and England had no housing problem at the start of their journey (84.4% and 89.3% respectively). A significantly larger proportion of adults starting alcohol only treatment in Leicester in 2021-22 had a housing problem (12.4%) than in England overall (7.0%). The proportions suggested in 2021-22 are similar to those of 2020-21 where 84% of adults starting alcohol treatment had no housing problem, 12% had a housing problem and 4% had an urgent housing problem.

*Table 13: Accommodation need at the start of treatment journey for adults starting alcohol only treatment in 2021-22 in Leicester and England*

	Leicester		England	
	Count	%	Count	%
No housing problem	353	84.4%	49777	89.3%
Housing problem	52	12.4%	3926	7.0%
NFA - urgent housing problem	13	3.1%	1125	2.0%
Other / Not answered	0	0.0%	893	1.6%
Total	418	100.00%	55721	100.0%

	Significantly lower than national
	Significantly higher than national
	No significant difference to national

### 13.2.9.Adults Who Are Parents/Carers and Their Children

The following data can help to identify the need to engage local antenatal and family support services to ensure appropriate support for families at risk.

In Leicester in 2021-22, 18.1% of adults in alcohol only treatment had children living with them.

A significantly larger proportion of those in treatment in 2021-22 with valid responses in their latest treatment journey records were recorded as parents in Leicester (36.5%) than in England (30.5%) and all of Leicester's comparators, with the exception of Luton where the rate was not significantly different to that of Leicester. In Leicester in 2021-22, of those with valid responses in the parental status section of their latest treatment journey records 35.6% had all of the children living with them, 7.1% had some of the children living with them and 53.1% had none of the children living with them. Of the adults new to alcohol only treatment in 2021-22 in Leicester, the majority were not a parent or had no child contact (60.0%), around one in five were parents not living with children (19.9%), 17.2% were parents living with their own children and 2.6% were living with other children.

Of all the female clients starting treatment within 2021-22 in Leicester, 2.3% were recorded as pregnant at the start of their treatment journey.

### 13.2.10. Criminal Justice Pathway

Of the adults in alcohol only treatment in Leicester in 2020-21, 8% were in contact with both a Criminal Justice Integrated Team and the community-based treatment system which is a significantly higher proportion than for England (3%). This must be viewed positively as it is opportunity to encourage that person to receive appropriate treatment and reflects a functioning referral pathway between the criminal justice and specialist treatment.

Table 14: Criminal Justice Integrated Teams adults in contact with the treatment system for Leicester and England, 2020-21

CJIT adults and proportion in contact with treatment system	Local (n)	Local (%)	England (n)	England (%)
Alcohol only	40	8%	2,182	3%
<b>Total</b>	<b>462</b>	<b>22%</b>	<b>24,408</b>	<b>9%</b>

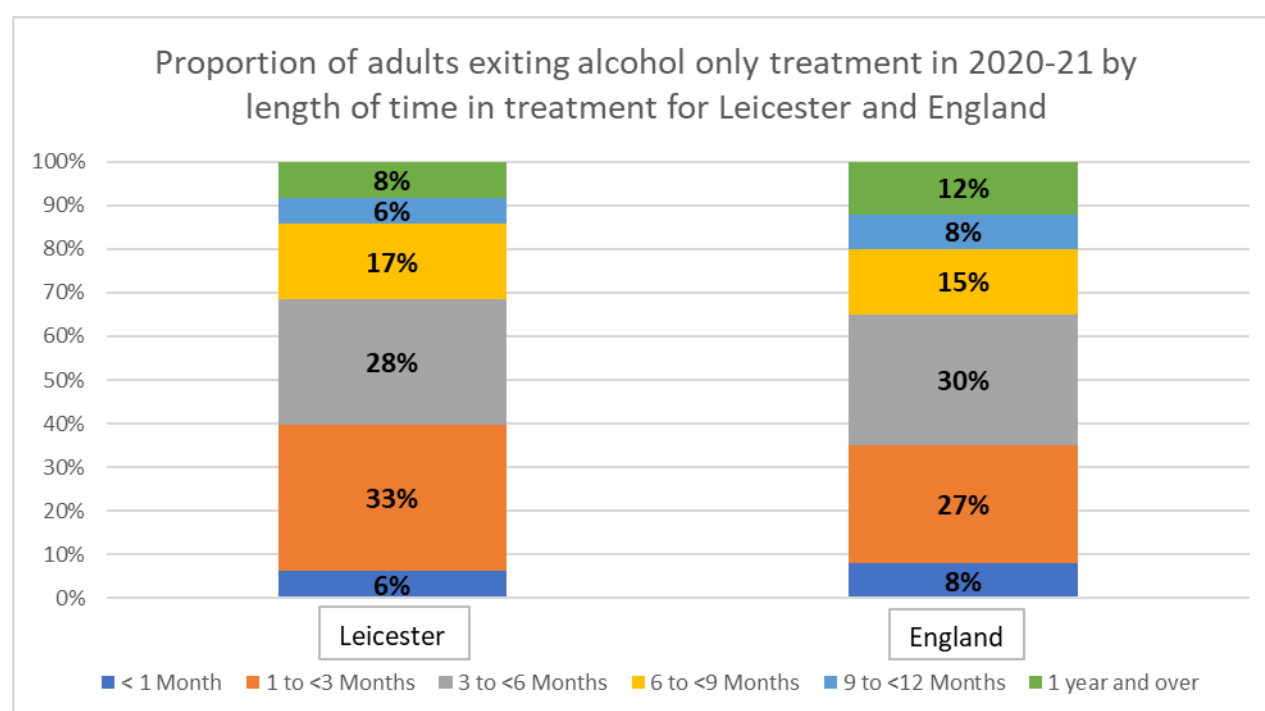
### 13.2.11. Length of Time in Treatment

According to the NICE Clinical Guideline CG115 mildly dependent and some higher risk drinkers should receive a treatment intervention lasting three months, those with moderate and severe dependence should usually receive treatment for a minimum of six months while those with higher or complex needs may need longer in specialist treatment. The optimum time in treatment will be discussed and agreed based on individual assessment of adult need.

Retaining adults for their full course of treatment is important in order to increase the chances of recovery and reduce rates of early treatment drop out. Conversely, having a high proportion of adults in treatment for more than a year may indicate that they are not moving effectively through and out of the treatment system.

In both Leicester and England the majority of adults exiting alcohol only treatment in 2020-21 had been in treatment for between 1 to 6 months (61% and 57% respectively). A small proportion of adults exiting alcohol only treatment in 2020-21 in Leicester and England had been in treatment for more than a year (8% and 12% respectively). There were no significant differences between Leicester and England in the proportion of adults exiting treatment in 2020-21 who had been in treatment for any of the length of time groups. On average adults exiting alcohol only treatment in 2020-21 in Leicester spent one month less in treatment than those in England overall, with an average of 164 days in Leicester and 192 days in England spent in alcohol only treatment on exit in 2020-21.

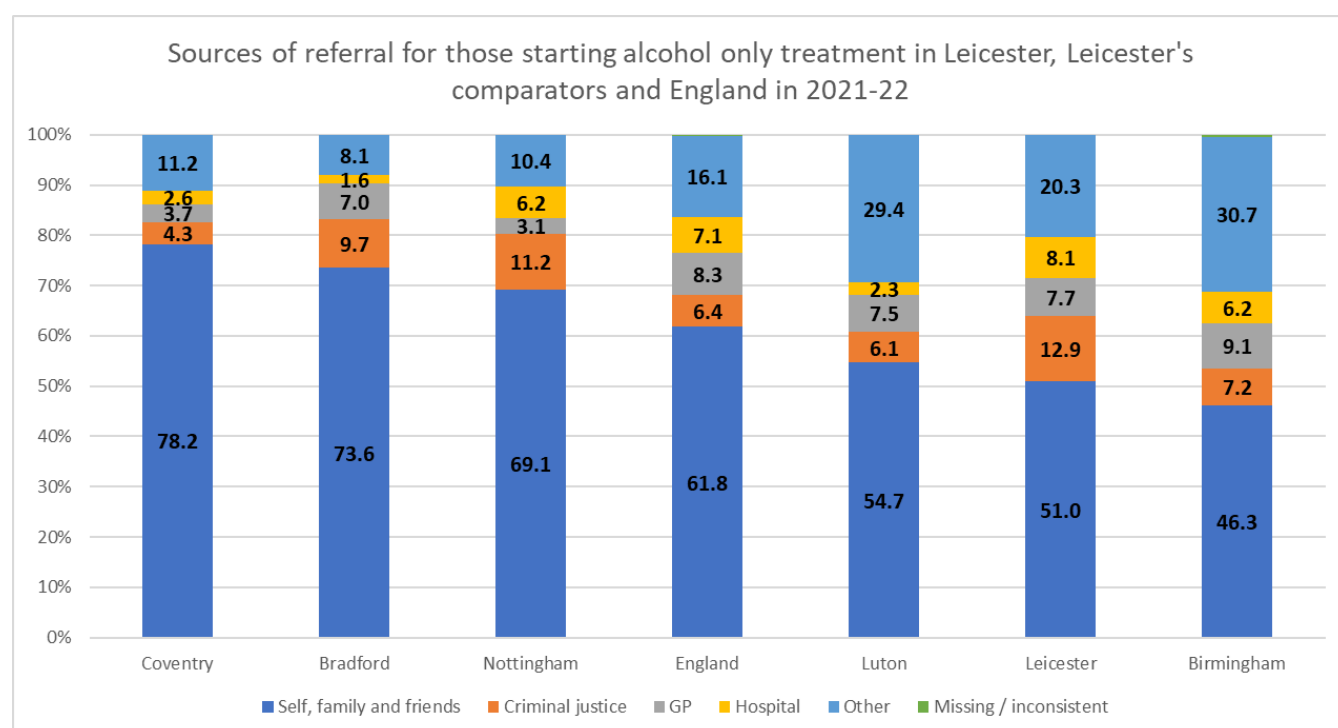
Figure 95: Length of time in treatment for adults exiting alcohol only treatment in Leicester and England, 2020-21



### 13.2.12. Referral Source

The majority of referrals for those starting alcohol only treatment in Leicester, Leicester's comparators and England in 2021-22 came from the individual themselves, their family and their friends, with the exception of Birmingham where 46.3% of referrals came from this source. In Leicester in 2021-22, the proportion of referrals from the individual themselves, their family and their friends (51.0%) was significantly lower than the proportion from this referral source in England (61.8%), Nottingham (69.1%), Bradford (73.6%) and Coventry (78.2%). In 2021-22 Leicester had the largest proportion of referrals from the criminal justice system for alcohol only treatment of its comparators. The proportion of referrals from the criminal justice system for alcohol only treatment in Leicester in 2021-22 (12.9%) was significantly higher than the proportion from this referral source in England (6.4%), Birmingham (7.2%) and Coventry (4.3%). Leicester had the largest proportion of referrals from the hospital for alcohol only treatment of its comparators in 2021-22, although the proportion in Leicester was only significantly different to that of Bradford (1.6%), Luton (2.3%) and Coventry (2.6%) where the proportion in Leicester was significantly higher.

Figure 96: Proportion of referrals by source for new alcohol only treatment journeys in Leicester, Leicester's comparators and England in 2021-22



### 13.2.13. Interventions Delivered

There were 440 psychosocial interventions started within 2021-22, with 94.5% of these taking place in community settings, 4.3% in inpatient units and 1.1% in residential settings. In 2021-22 in Leicester, 437 recovery support interventions (during treatment) were started, of which 94.7% were delivered in community settings with the rest delivered in either inpatient units or residential settings. In 2021-22 in Leicester, 32 adults in alcohol only treatment started a pharmacological intervention, the majority of these interventions (59.4%) took place in inpatient unit settings with just over a third (34.4%) taking place in a community setting. Recovery support interventions (post treatment) were also delivered in Leicester in 2021-22, 95.5% of this intervention was delivered in the community.

Overall, the majority of interventions started in 2021-22 in both Leicester and England were delivered in community settings (96.8% in both Leicester and England), the remaining interventions were delivered in inpatient units, residential settings, primary care and recovery houses.

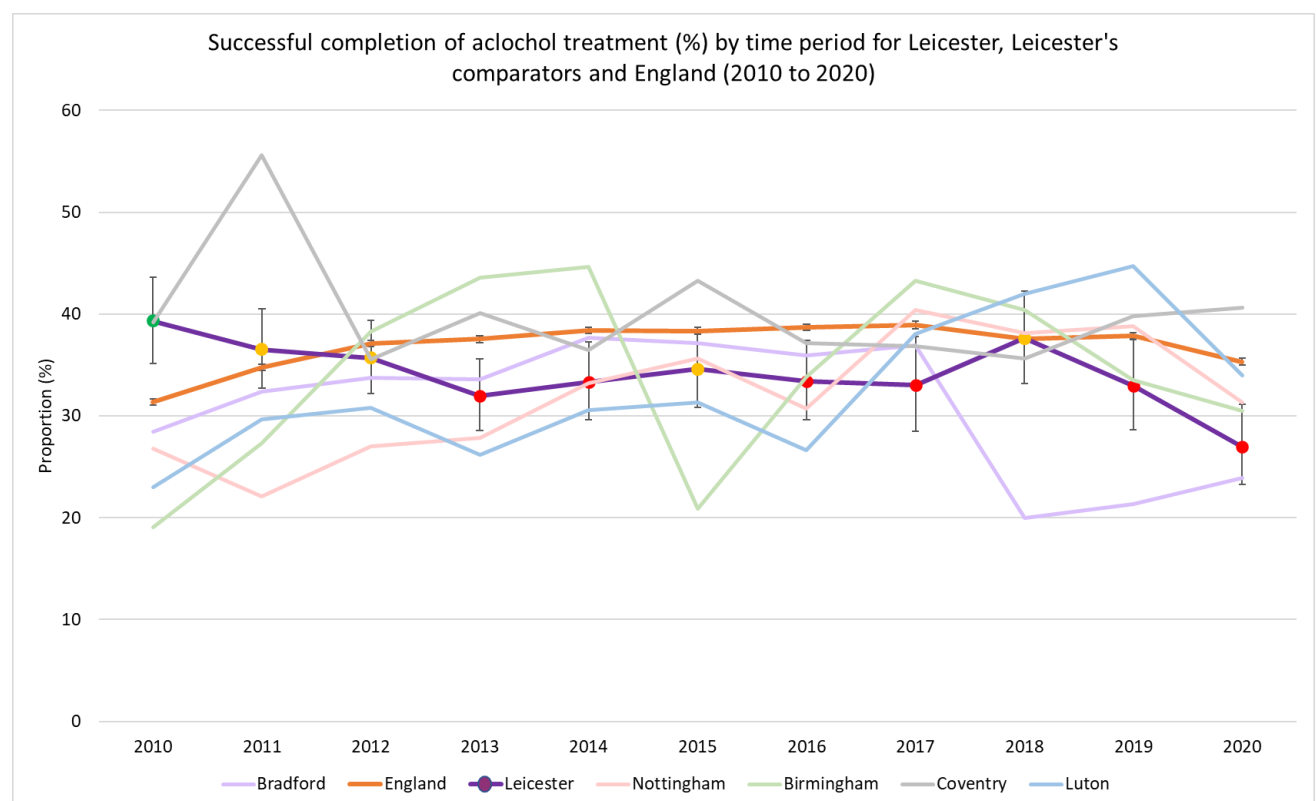
### 13.2.14. Successful Completions

Successful completion of treatment and unplanned exists are regular Key Performance Indicators for individuals who have accessed treatment. Discharge after short-term treatment is currently used as a measure of success, however we must be aware that relapsing and remitting are part of the

condition. The data below relates to adults completing their period of treatment in 2020-21 and shows whether they completed successfully and did not return within 6 months. The following data gives an indication of how well the current system is working in treating those who are receiving structured treatment. A high proportion of successful completions and a low number of re-presentations to treatment indicate that treatment services are responding well to the needs of those in treatment.

As shown in Figure 95, since 2013 the proportion of individuals who successfully completed alcohol treatment in Leicester has been significantly lower (worse) than the proportion in England, with the exception of 2015 and 2018 where the proportion in Leicester was not significantly different to that in England overall. In 2020 Leicester had the second lowest rate of successful completion of alcohol treatment when compared to its five comparators and England. The rate of successful completion of alcohol treatment in Leicester (27.0%) was significantly lower than that of Coventry (40.6%) and England (35.3%). Over the last five time periods there has been no significant change in the proportion of individuals who successfully completed alcohol treatment in Leicester.

Figure 97: Successful completion of alcohol treatment (%) by time period for Leicester, Leicester's comparators and England (2010 to 2020)<sup>125</sup>



A smaller proportion of adults left alcohol only treatment in 2020-21 in Leicester (57%) than in England overall (60%), although this difference was not statistically significant. Of the 507 adults in

alcohol only treatment in 2020-21 in Leicester, 31% left successfully which is significantly lower than the proportion that left successfully in England overall (37%). In Leicester in 2020-21, 54% of adults leaving treatment were leaving treatment successfully, although lower than the proportion leaving treatment successfully as a proportion of all exits in England (62%) this difference was not significant.

Table 15: Number and proportion of adults completing their period of alcohol only treatment in 2020-21 by completion category for Leicester and England

	Total in treatment	Total leaving treatment	% of treatment population leaving treatment	Total leaving treatment successfully	% leaving treatment successfully, as a proportion of those in treatment	% leaving treatment successfully, as a proportion of all exits
Leicester	507	288	57%	156	31%	54%
England	76,740	45,879	60%	28,349	37%	62%

Significantly lower than national  
 Significantly higher than national  
 No significant difference to national

### 13.2.15. Deaths in Treatment

The number of adults who were recorded as having died while in alcohol only treatment within 2020-21 in Leicester cannot be reported due to small counts. In 2021-22 in Leicester, of all clients in alcohol only treatment 1.3% had a treatment exit reason of death, this is not significantly different to the proportion for England (1.2%).

### 13.2.16. Wider health behaviours

#### 13.2.16.1. Drinking Levels

This section shows an estimate of the number of units consumed by people in alcohol only treatment in the 28 days prior to commencing treatment. Most people who require structured treatment for alcohol dependence will be drinking at higher risk levels. Drinking levels can be used as a rough proxy for level of dependence and levels of alcohol health risk.

There is a strong association between levels of consumption and severity of dependence but they are not equivalent. For example, women are likely to become dependent at lower levels of consumption than men.

Consumption is based on all clients in treatment within 2021-22 and the number of units they cited drinking on a typical drinking day in the 28 days before triage multiplied by the number of days






drinking within the 28-day period. There will be some moderately or severely dependent adults who have stopped or reduced consumption prior to treatment (for example in hospital or prison) so they will appear in the lowest category even though they are alcohol dependent and will require treatment.

In 2021-22 in Leicester, 17.0% of adults in alcohol only treatment consumed 1-199 units of alcohol in the 28 days prior to commencing treatment, this is significantly larger than the proportion for England overall (13.6%). A significantly smaller proportion of adults in alcohol treatment consumed 0 units of alcohol in the 28 days prior to commencing treatment in Leicester than in England overall (3.3%), the value for Leicester has been suppressed due to small counts. Over a sixth (17.0%) of adults in alcohol only treatment in 2021-22 in Leicester consumed more than 1000 units in the 28 days prior to entering treatment, this was smaller than the proportion for England (18.3%) although the difference was not significant. There were no significant differences between Leicester and England in the proportion of adults consuming any of the other unit groups in the 28 days prior to commencing treatment.

Table 16: Number of units consumed in the 28 days prior to commencing treatment for those in treatment in 2021-22 in Leicester and England

	Leicester		England	
	Count	%	Count	%
1-199	105	17.0%	11340	13.6%
200-399	119	19.3%	14372	17.3%
400-599	118	19.1%	16875	20.3%
600-799	81	13.1%	9900	11.9%
800-999	73	11.8%	8483	10.2%
1000+	105	17.0%	15180	18.3%

\* The values for 0 units and missing information have been suppressed due to small counts

	Significantly lower than national
	Significantly higher than national
	No significant difference to national

### 13.2.16.2. Tobacco Use

There is a high prevalence of smoking in those who use drugs and alcohol and this is a major cause of illness and death. Smokers who access support to stop smoking are three times as likely to quit as those who try to quit unaided.

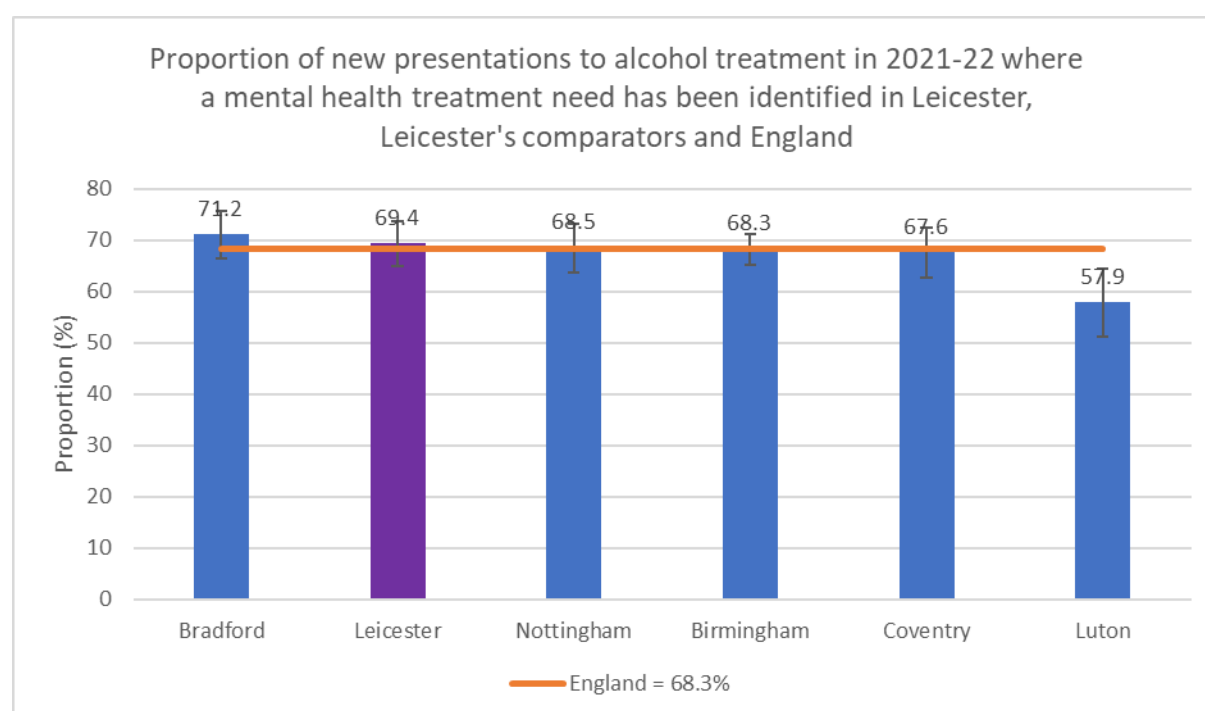
In Leicester in 2020/21, the proportion of adults smoking tobacco at the start of alcohol only treatment was 37%, this was not significantly different to the proportion for England overall (43%). Of those identified as smoking at the start of treatment, a significantly larger proportion in Leicester (51%) than in England (30%) were identified as abstinent from tobacco at review. In 2021-22 1.6% of

clients in alcohol only treatment in Leicester had received a smoking cessation intervention, this was not significantly different to the 1.1% for England overall.

### 13.2.17. Co-occurring Mental Health

Of the adults starting alcohol only treatment in Leicester in 2021-22, 69.4% were identified as having a mental health treatment need, this is not significantly different to the proportion in England overall (63.8%). The proportion of adults starting alcohol only treatment in 2021-22 with a mental health treatment need in Leicester (69.4%) was significantly larger than the proportion in Luton (57.9%). The proportion in Leicester was the 2<sup>nd</sup> highest of it's comparators, although Leicester's value was only significantly different to that of Luton. Of those who were identified as having a mental health treatment need in Leicester, a third (33.8%) were not receiving any treatment - this is a significantly larger (worse) proportion than the fifth (21.2%) of those identified as having a mental health need not receiving any treatment in England overall.

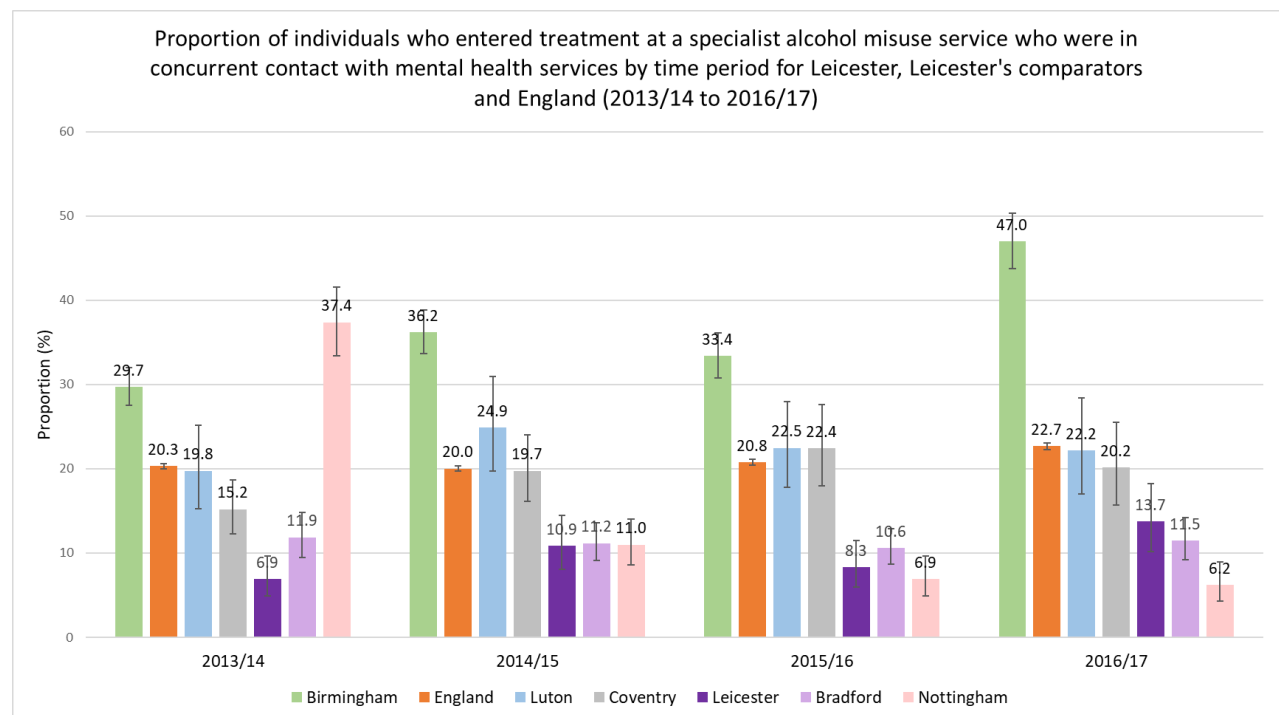
*Figure 98: Proportion of adults presenting to alcohol only treatment in 2021-22 where a mental health treatment need has been identified in Leicester, Leicester's comparators and England*



As shown in Figure 113, the proportion of individuals who entered treatment at a specialist alcohol misuse service who were in concurrent contact with mental health services in Leicester remained significantly below the proportion in England since recording of this indicator began in 2013/14. The proportion of individuals in concurrent contact with mental health services and substance use services for alcohol misuse in Leicester in 2016/17 was significantly above the proportion in Leicester in 2013/14. In 2016/17, Leicester had the third lowest proportion of individuals in concurrent

contact with mental health services and substance use services for alcohol misuse when compared to its comparators. The proportion in Leicester in 2016/17 (13.7%) was significantly above that of Nottingham (6.2%) and significantly below the proportion in Birmingham (47.0%).

Figure 99: Concurrent contact with mental health services and substance use services for alcohol misuse by time period for Leicester, Leicester's comparators and England (2013/14 to 2016/17)<sup>126</sup>



### 13.3. Adults in Drug Treatment

The data below examines information about adults (aged 18+) who are receiving structured drug treatment in Leicester City alongside national and similar area comparisons. The data below covers only those who cite alcohol and non-opiate, non-opiate only or opiate only as their substance use problem. This NDTMS data has been taken either directly from NDTMS or through the Office for Health Improvement & Disparities Fingertips site.

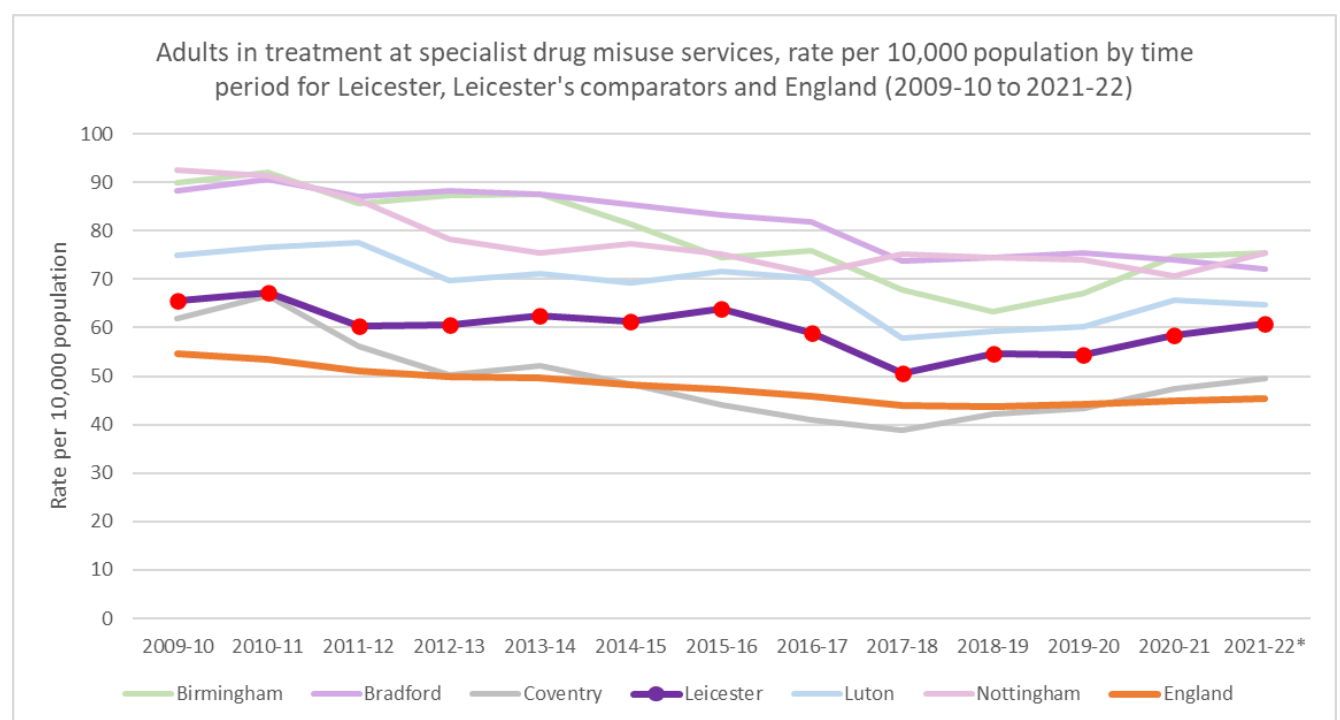
#### 13.3.1. Numbers in Drug Treatment

##### 13.3.1.1. All Drugs

In Leicester in 2020-21 there were 1,580 (58.5 per 10,000 population) adults in community structured drug misuse treatment services. Of those in treatment, 71% were opiate users, 18% alcohol and non-opiate users and 12% were non-opiate users. The proportion of alcohol and non-opiate users was significantly higher than the national percentage (15%) whereas the proportion of non-opiate users was significantly lower than national (14%).

Provisional data suggests that the number of adults using drug misuse treatment services in Leicester has increased to 1,696 (60.8 per 10,000 population) in 2021-22. Between 2009-10 and 2020-21, the rate of adults using specialist drug misuse treatment services has declined by 10.8% in Leicester and 17.9% in England. When including the provisional figures for 2021-22, the rate in Leicester has decreased by 7.3% since 2009-10 and the rate in England has decreased by 16.8%. Figure 97 shows that the rate in Leicester remained relatively stable until 2015-16, following which the rate showed a decreasing trend until 2017-18. Since then, a gradual increasing trend in the rate of adults in treatment at specialist drug misuse treatment services has been witnessed in Leicester over the previous five time periods. A similar pattern has been witnessed in the rate of adults in specialist drug misuse services between 2009-10 and 2021-22 across many of Leicester's comparators. Between 2009-10 and 2021-22 Leicester has consistently had the 2<sup>nd</sup> lowest rate of adults in specialist drug misuse services when compared to its six comparators, with only Coventry having a lower rate than that of Leicester. The rate of adults in treatment at specialist drug misuse services in Leicester has been significantly higher (worse) than the rate in England each year between 2009-10 and 2021-22. This is a reflection of the higher level of need in the population.

*Figure 100: Rate of adults in treatment at specialist drug misuse treatment services in Leicester, Leicester's comparators and England by time period (2009-10 to 2021-22)*

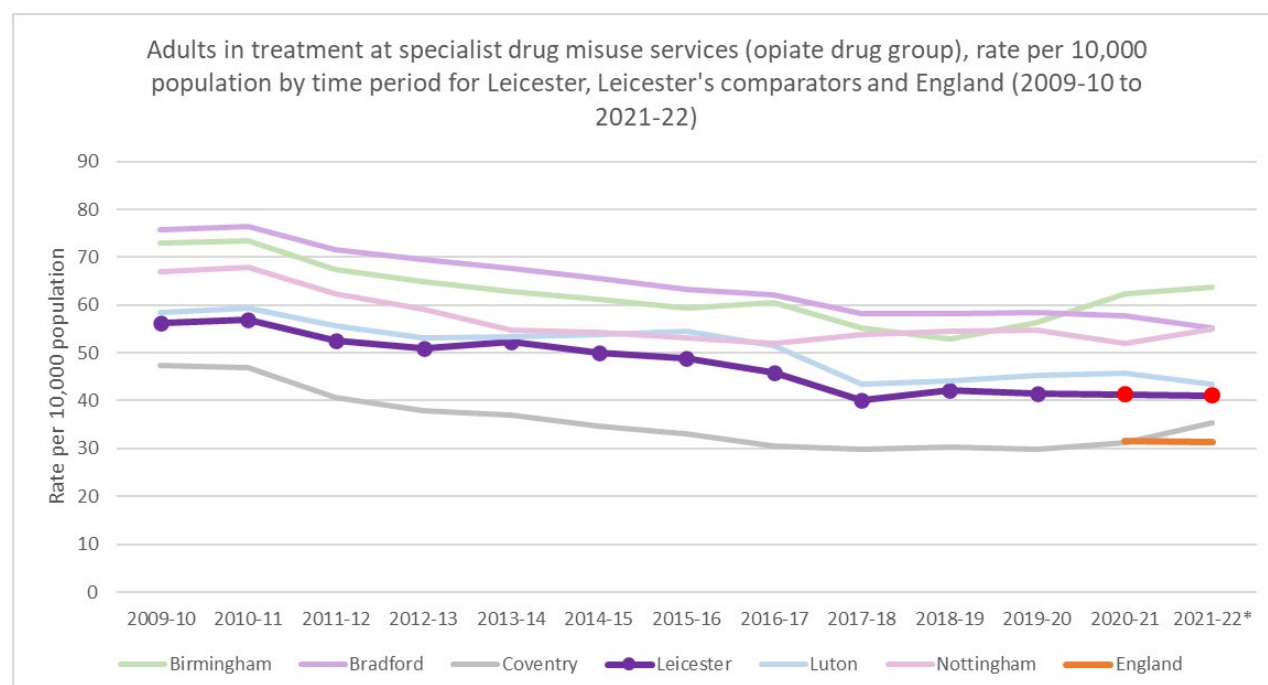


### 13.3.1.2. Opiate Users

The opiate drug user category includes those who are opiate only, opiate and non-opiate, opiate and alcohol and opiate alcohol and non-opiate users. In Leicester in 2020-21 there were 1,114 (41.3 per

10,000 population) adults in community structured drug misuse treatment services due to the use of opiates. Provisional data suggests that the number of adults using drug misuse services due to the use of opiates in Leicester has increased to 1,146 (41.1 per 10,000 population) in 2021-22. Between 2009-10 and 2020-21 the rate of adults using specialist drug misuse treatment services due to opiate use has declined by 26.6% in Leicester, giving Leicester the second largest decline of its comparators. When including the provisional figures for 2021-22 the rate in Leicester has decreased by 26.9%, with Leicester witnessing the second largest decline of its comparators. Figure 98 shows that the rate in Leicester has shown a decreasing trend since 2009-10, with the rate in Leicester decreasing year on year over the most recent four time periods. A similar pattern has been witnessed in the rate of adults in specialist drug misuse treatment services due to opiate use between 2009-10 and 2021-22 across many of Leicester's comparators. Between 2009-10 and 2021-22 Leicester has consistently had the 5<sup>th</sup> highest rate when compared to its six comparators, with only Coventry having a lower rate than that of Leicester. The rate of adults in treatment at specialist drug misuse treatment services due to opiate use in Leicester has been significantly higher (worse) than the rate in England for both 2020-21 and 2021-22, as these are the only years for which data is available for England it remains unknown whether this was the case before 2020-21.

*Figure 101: Rate of adults in treatment at specialist drug misuse treatment services (opiate users) in Leicester, Leicester's comparators and England (2009-10 to 2021-22)*

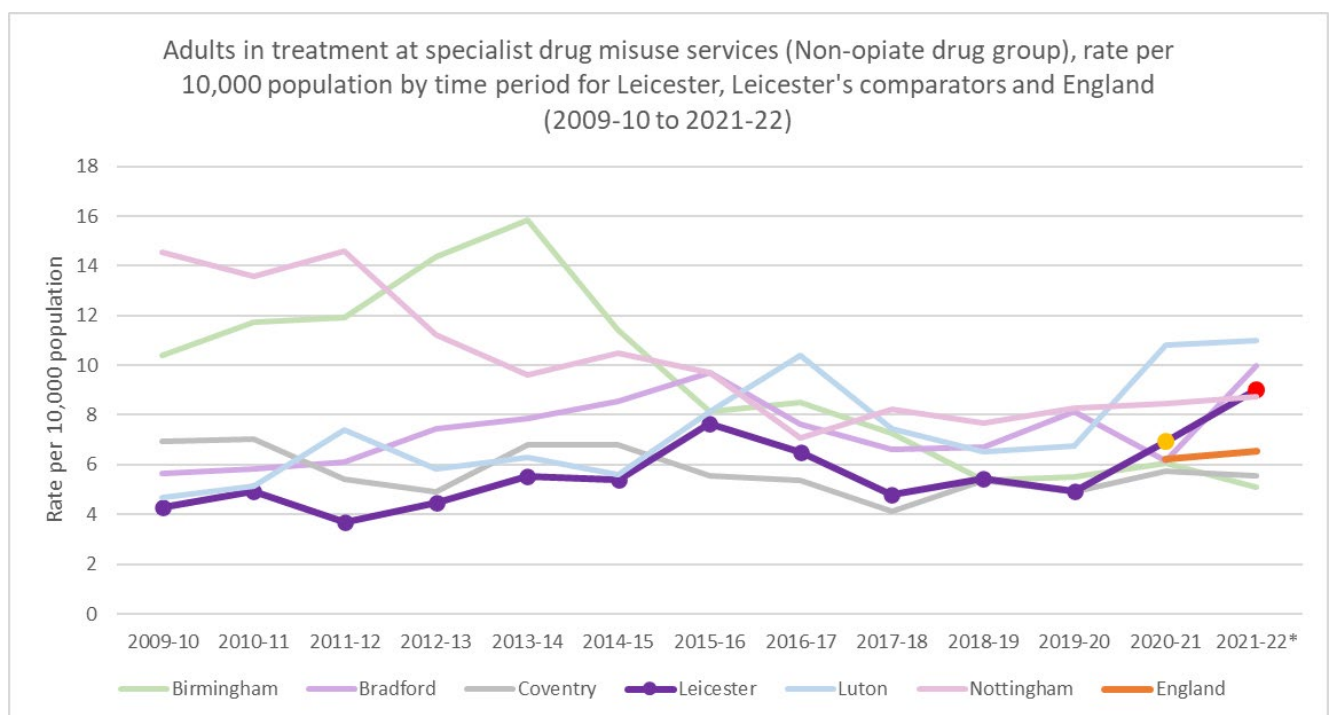


### 13.3.1.3. Non-Opiate Users

In Leicester in 2020-21 there were 187 (6.9 per 10,000 population) adults in community structured drug misuse treatment services for non-opiate use. Provisional data suggests that the number of

adults using drug misuse treatment services due to non-opiate use in Leicester has increased to 252 (9.0 per 10,000 population) in 2021-22. Between 2009-10 and 2020-21, the rate of adults using specialist drug misuse treatment services has increased by 62.4% in Leicester, which is the 2<sup>nd</sup> largest increase when compared to it's comparators. When including the provisional figures for 2021-22, the rate in Leicester has increased by 111.8% since 2009-10 which is also the 2<sup>nd</sup> largest increase of it's comparator group. Between 2019-20 and 2021-22, the rate of adults in community structured drug misuse treatment services for non-opiates increased significantly. In 2009-10 Leicester had the lowest rate of adults in drug misuse treatment services for non-opiate use of it's comparators, in 2020-21 and 2021-22 Leicester had the 2<sup>nd</sup> highest rate. In 2020-21 the rate in Leicester (6.9 per 10,000 population) was not significantly different to the rate in England (6.2 per 10,000 population). As a result of the sharp increase in the rate in Leicester in 2021-22, the rate of adults in community structured drug misuse services for non-opiate use (9.0 per 10,000 population) was significantly higher (worse) than the rate in England overall (6.5 per 10,000 population).

*Figure 102: Rate of adults in treatment at specialist drug misuse treatment services (non-opiate users) in Leicester, Leicester's comparators and England (2009-10 and 2021-22)*

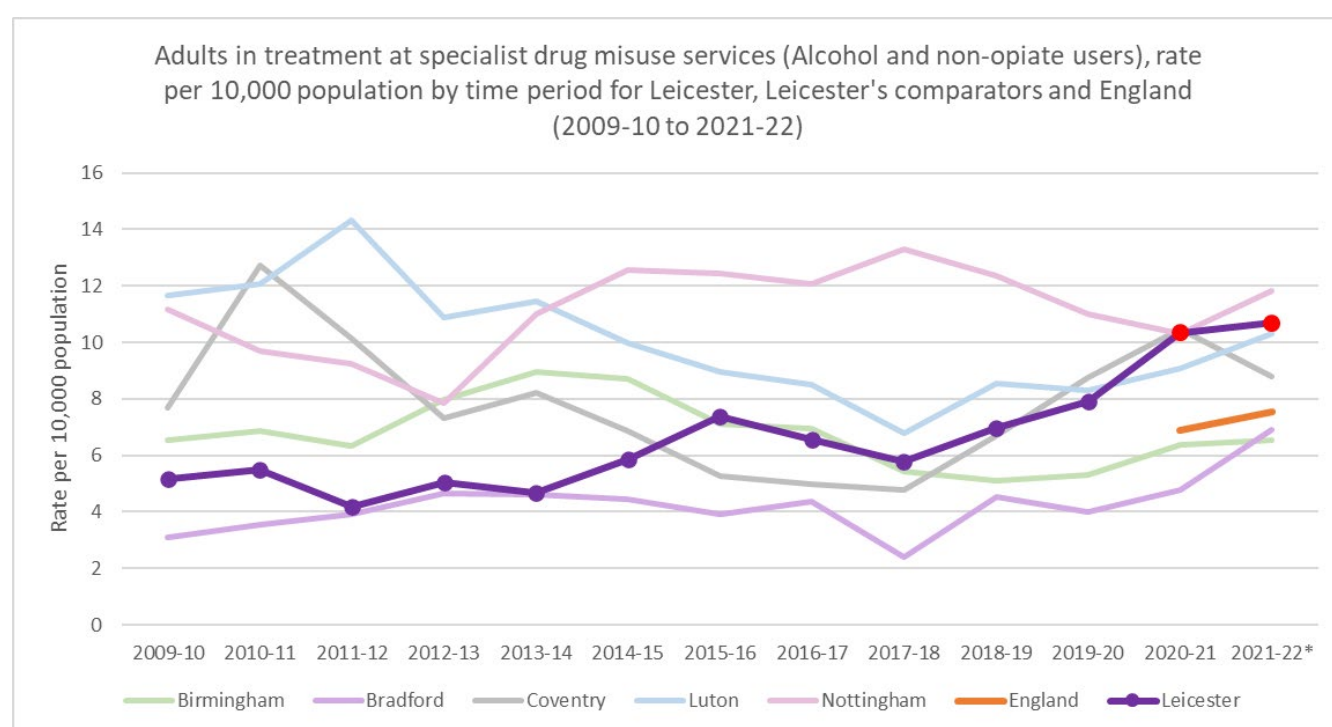


#### 13.3.1.4. Alcohol and Non-Opiate Users

In Leicester in 2020-21 there were 279 (10.3 per 10,000 population) adults in community structured drug misuse treatment services for alcohol and non-opiate use. Provisional data suggests that the number of adults using drug misuse services due to alcohol and non-opiate use in Leicester has increased to 298 (10.7 per 10,000 population) adults in 2021-22. Between 2009-10 and 2020-21, the

rate of adults using specialist drug misuse services has increased by 100.0% in Leicester, which is the largest increase of it's comparators. When including the provisional figures for 2021-22, the rate in Leicester has increased by 106.8% since 2009-10 which is the 2<sup>nd</sup> largest increase of it's comparators following the increase of 123.6% witnessed in Bradford. Between 2009-10 and 2021-22, the rate of adults in specialist drug misuse treatment services due to alcohol and non-opiate use has shown an increasing trend in Leicester. In 2009-10 Leicester had the 2<sup>nd</sup> lowest rate (5.2 per 10,000 population), with only Bradford having a lower rate (3.1 per 10,000 population). By 2021-22, Leicester had the 2<sup>nd</sup> highest rate of adults in drug misuse treatment for alcohol and non-opiate use when compared to it's comparators, with a rate of 10.7 per 10,000 population, only Nottingham (11.8 per 10,000 population) had a higher rate. In 2020-21 and 2021-22, the rate of adults in community structured drug misuse treatment services for alcohol and non-opiate use (10.3 and 10.7 per 10,000 population respectively) was significantly higher (worse) than the rate for England (6.9 and 7.5 per 10,000 population respectively).

*Figure 103: Rate of adults in treatment at specialist drug misuse treatment services due to alcohol and non-opiate use by time period in Leicester, Leicester's comparators and England (2009-10 to 2021-22)*



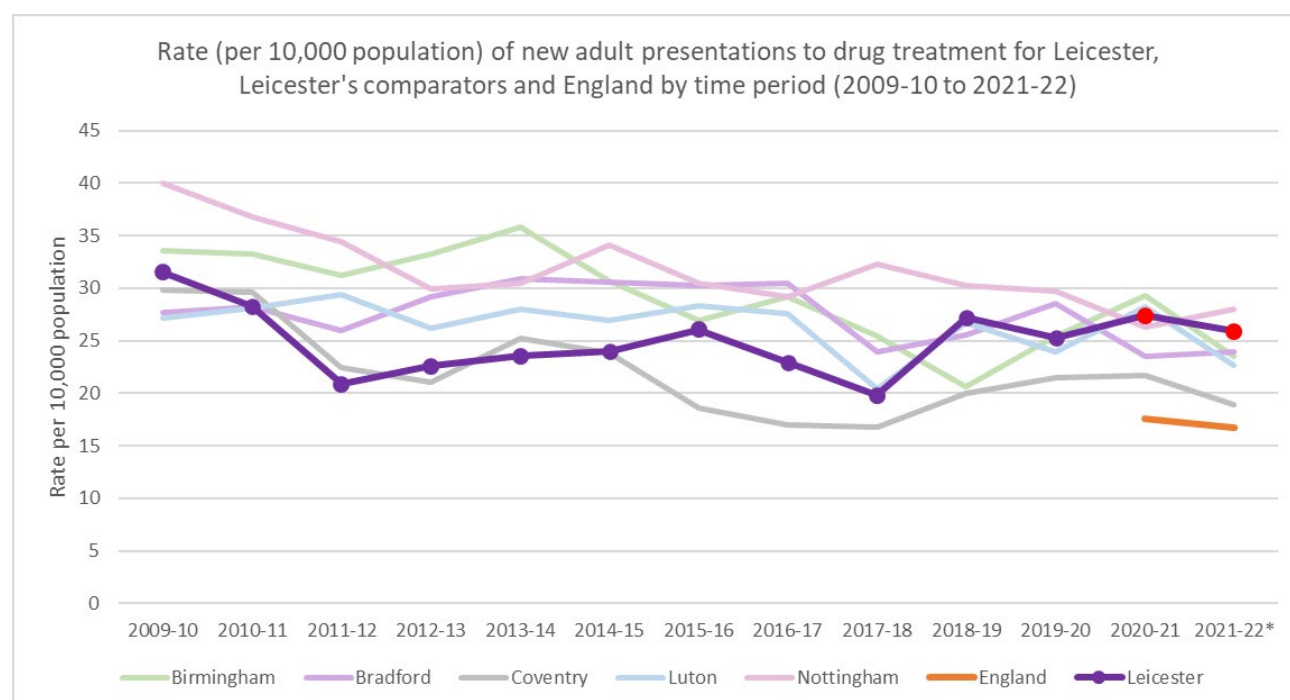
### 13.3.2. Adults Starting Drug Treatment

In 2020-21 in Leicester 739 (27.4 per 10,000 population) adults newly presented to specialist drug misuse treatment services. Provisional data for 2021-22 suggests that a slightly smaller number of 723 (25.9 per 10,000 population) adults newly presented to treatment during this year compared to 2020-21. Between 2009-10 and 2020-21, the rate of adults newly presenting to drug treatment



declined by 13.1% in Leicester. Including the provisional figures for 2021-22 increased the decline to 17.7%. As shown in Figure 101, the rate of adults newly presenting to specialist drug misuse treatment services in Leicester has fluctuated since 2009-10. The rate in Leicester increased significantly from 19.8 per 10,000 population in 2017-18 to 27.2 per 10,000 population in 2018-19, before fluctuating slightly in the following years. In 2017-18, before the significant increase in the rate in Leicester, Leicester had the second lowest rate of adults newly presenting to drug misuse treatment services of it's comparators, in 2021-22 Leicester had the second highest rate of it's comparators. In both 2020-21 and 2021-22 the rate in Leicester (27.4 and 25.9 per 10,000 population respectively) was significantly higher (worse) than the rate in England (17.6 and 16.8 per 10,000 population respectively), as these are the only years for which data is available for England it remains unknown whether this was the case before 2020-21.

Figure 104: Rate of adults newly presenting to specialist drug misuse treatment services in Leicester, Leicester's comparators and England by time period (2009-10 to 2021-22)



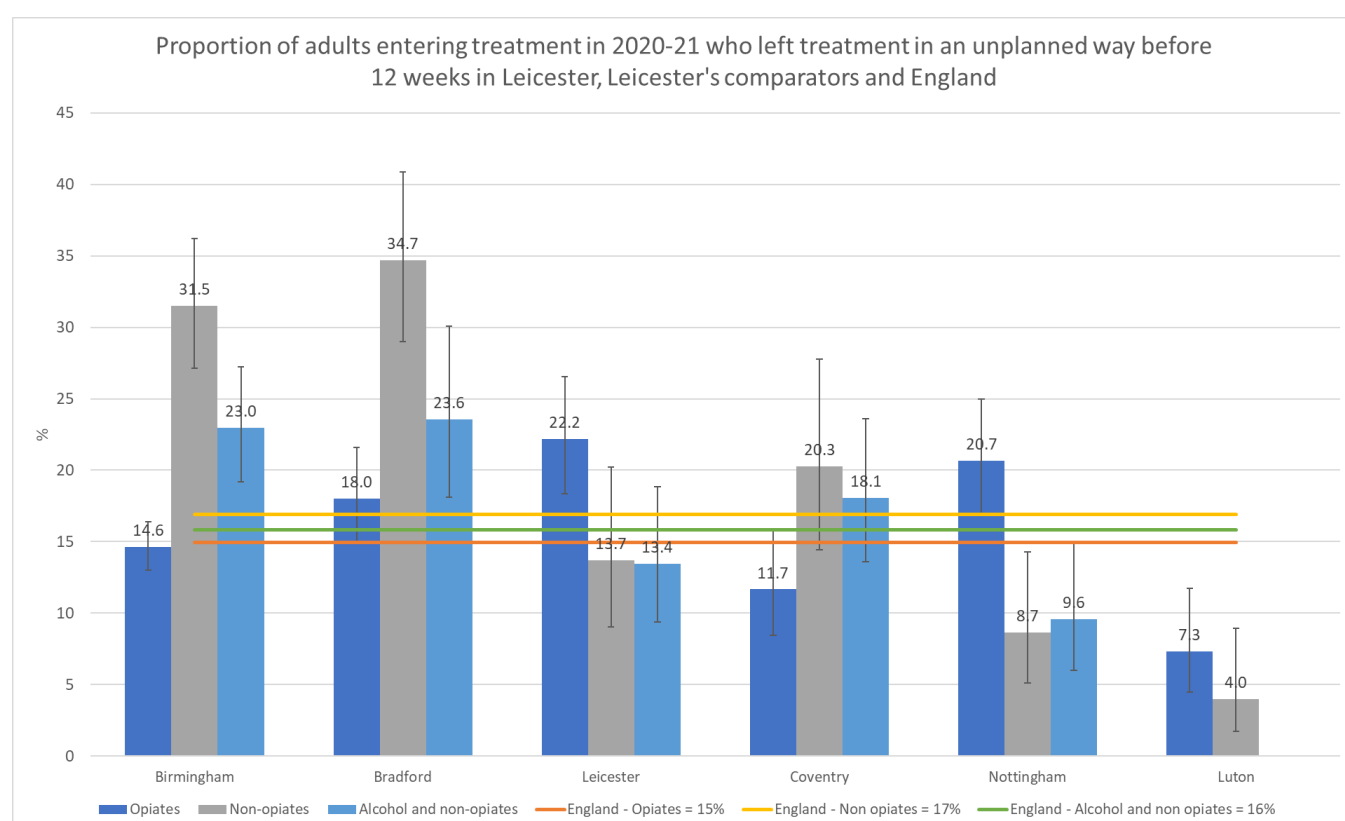
### 13.3.3.Unplanned Exits

When engaged in treatment, people use less illegal drugs, commit less crime, improve their health and manage their lives better – which also benefits the community. Preventing unplanned drop out and keeping people in treatment long enough to benefit contributes to these improved outcomes. The data below shows the proportion of adults entering drug treatment in Leicester, Leicester's comparators and England in 2020-21 who left treatment in an unplanned way before 12 weeks, commonly referred to as early drop outs. In 2020-21 in Leicester, 22.2% of new presentations to drug treatment due to opiate use made an unplanned exit from treatment within 12 weeks of



starting treatment, this is a significantly higher (worse) proportion than the proportion of unplanned exits before 12 weeks in this group in England (15.0%). Leicester had the highest proportion of adults entering treatment due to opiate use in 2020-21 who left treatment in an unplanned way before 12 weeks when compared to its comparators. Leicester had a significantly higher (worse) proportion of new presentations to drug treatment due to opiate use that made an unplanned exit from treatment within 12 weeks of starting treatment (22.2%) than Birmingham (14.6%), Coventry (11.7%) and Luton (7.3%). The proportion of adults entering drug treatment due to non-opiate use or alcohol and non-opiate use in 2020-21 who left treatment in an unplanned way before 12 weeks in Leicester (13.7% and 13.4% respectively) was not significantly different to the proportion for England overall (16.9% and 15.8% respectively).

Figure 105: Proportion of adults entering drug treatment in 2020-21 who left treatment in an unplanned way before 12 weeks in Leicester, Leicester's comparators and England



\*Alcohol and non opiates user value has not been presented for Luton due to low counts

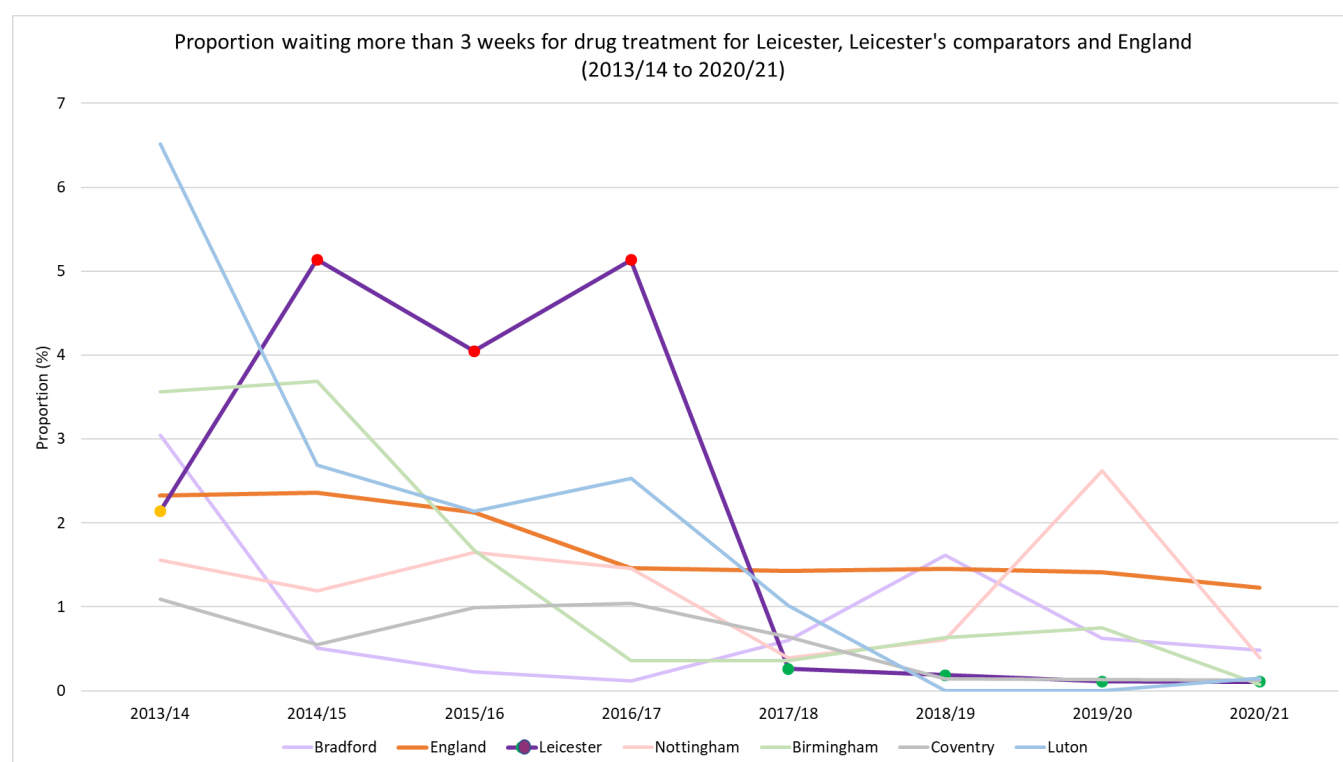
### 13.3.4.Waiting Times

As shown in Figure 103, in 2013/14 the proportion of first drug treatment interventions where the person (aged 18+) waited over three weeks to commence treatment in Leicester (2.1%) was not significantly different to the proportion for England (2.3%). In 2014/15 the proportion in Leicester increased significantly (from 2.1% in 2013/14 to 5.1% in 2014/15) and between 2014/15 and 2016/17 the proportion in Leicester was significantly higher (worse) than the value for England. In

2017/18 the proportion in Leicester decreased significantly (from 5.1% in 2016/17 to 0.3% in 2017/18) and since then the proportion in Leicester has been significantly lower (better) than the proportion for England overall. Leicester had the 2<sup>nd</sup> lowest proportion of adults waiting more than three weeks for drug treatment in 2020/21 when compared to its five comparators. In 2020/21 there were no significant differences between the proportion of adults waiting more than three weeks for drug treatment in Leicester compared to the proportion for its comparators.

In 2021-22 in Leicester, 100% of first interventions for non-opiate only and alcohol and non-opiate only use were received within three weeks or less of referral compared to 98.1% and 97.4% respectively in England. Of first interventions for opiate use in Leicester in 2021-22, 98.5% were received within three weeks or less of the referral compared to 98.8% in England overall.

Figure 106: Proportion of first drug treatment interventions where the person waited over three weeks to commence treatment for Leicester, Leicester's comparators and England (2013/14 to 2020/21)<sup>127</sup>



### 13.3.5. Demographics of Adults in Drug Treatment

The demographic data of those in drug misuse treatment below has not been standardised against the demographic profile of the general population. The proportions of different demographic groups within the treatment population may differ to that of comparator areas whilst being in line with the proportions witnessed in the general population structure of the particular area. Care should be taken when interpreting proportions where comparisons against the general population structure of the area have not been considered.

In Leicester, Leicester's comparators and England, a significantly larger proportion of the adults in drug misuse treatment services in 2021-22 were male than were female. In 2021-22 in Leicester, a significantly larger proportion of the adults in drug misuse treatment were male (73.6%) and a significantly smaller proportion were female (26.4%) than in England (71.3% and 28.7% respectively). There were no significant differences between the proportions in Leicester and its comparators. Below the Leicester adult drug misuse treatment population sex breakdown has been compared to the Census 2021 Leicester 18+ general population estimate. A significantly larger proportion of the Leicester 2021-22 adult drug misuse treatment population was male (73.6%) than in the Census 2021 Leicester 18+ general population estimate (48.8%) and a significantly smaller proportion of the Leicester 2021-22 adult drug only treatment population was female (26.4%) than in the Census 2021 Leicester 18+ general population estimate (51.2%).

Figure 107: Proportion of adults in drug treatment in 2021-22 by sex in Leicester, Leicester's comparators and England

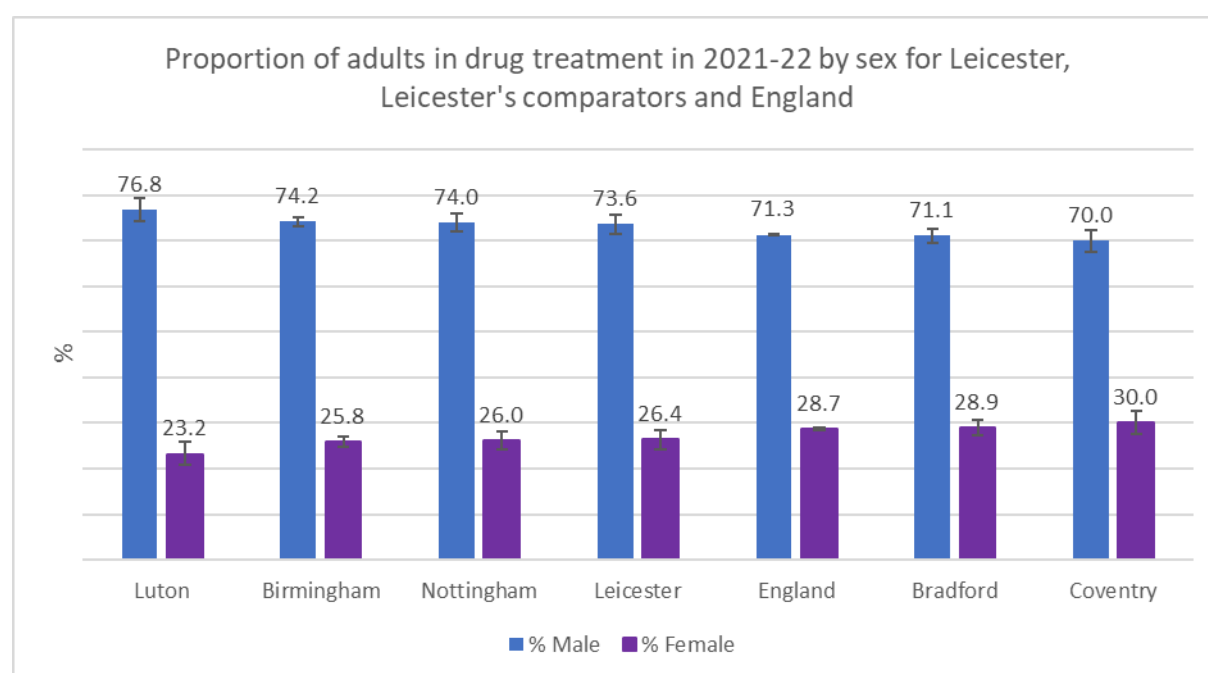


Table 13 shows the count and proportion of adults in drug misuse treatment services by age group in Leicester and England in 2021-22. Leicester has a significantly higher proportion of 35-39 year olds in drug misuse treatment (19.5%) compared to England overall (17.1%). The proportion of adults in drug misuse treatment in Leicester aged between 50-54 years old (9.1%) was significantly lower than the proportion in England (10.9%). Below the Leicester adult drug misuse treatment population age breakdown has been compared to the census 2021 Leicester 18+ general population estimate, more details of which can be found in Appendix 2. The drug misuse treatment population in Leicester in 2021-22 had a significantly larger proportion of its population aged between 30-34, 35-39, 40-44 and 45-49 than the Census 2021 Leicester 18+ general population estimate. The proportion of adults

aged under 25, 55-59 60-64 and 65 and above in Leicester's drug misuse treatment population in 2021-22 was significantly smaller than the proportion of the population in these age bands in the Census 2021 Leicester 18+ general population estimate.

Table 17: Adults in drug misuse treatment in Leicester and England, 2021-22

Age group	Leicester		England	
	Count	%	Count	%
Under 25	124	7.3%	14036	6.9%
25-29	150	8.8%	16982	8.4%
30-34	237	14.0%	27327	13.5%
35-39	331	19.5%	34760	17.1%
40-44	325	19.2%	38311	18.9%
45-49	246	14.5%	31092	15.3%
50-54	154	9.1%	22029	10.9%
55-59	79	4.7%	11697	5.8%
60-64	29	1.7%	4490	2.2%
65 and above	21	1.2%	2289	1.1%
Total	1696	100.0%	203013	100.0%

	Significantly lower than national
	Significantly higher than national
	No significant difference to national

As shown in Table 14, a significantly larger proportion of Leicester's adult drug misuse treatment population in 2021-22 were of an Asian (11.4%) or Mixed (7.1%) ethnic group than in England's treatment population (3.9% and 2.9% respectively). The proportion of adults in drug misuse treatment services in Leicester from a white ethnic background (75.7%) was significantly lower than the proportion in England (87.1%). The ethnic breakdown of the adult (18+ years) treatment population is compared to the Census 2021 all ages Leicester population estimates below as 2021 population estimate data by ethnicity is not available by age. When compared to the Census 2021 population estimates, a significantly larger proportion of Leicester's adult drug misuse treatment population in 2021-22 were White (75.7%) than in the general Leicester population (40.9%). A significantly smaller proportion of Leicester's adult drug misuse treatment population in 2021-22 were Asian (11.4%) or Black (3.6%) than were Asian or Black in the general population in Leicester (43.4% and 7.8% respectively). The pattern of differences witnessed between the proportion of the drug misuse treatment population in 2021-22 and the general population which are of a White, Asian or Black ethnic background in Leicester was similar to that in England. The proportion of those in Leicester's adult drug misuse treatment population in 2021-22 that were of a Mixed ethnic background (7.1%) was significantly higher than the proportion of the general population in

Leicester that were of a Mixed ethnic background (3.8%), in England there was no significant difference between the proportion of those in adult drug misuse treatment in 2021-22 that were of a Mixed ethnic background (2.9%) and the proportion of the general population that were of a Mixed ethnic background (3.0%). A table of the Census 2021 Leicester population estimate by ethnic breakdown is provided in Appendix 3 at the end of this document.

*Table 18: Adults in drug misuse treatment in 2021-22 in Leicester and England by ethnic group*

Ethnic Group	Leicester		England	
	Count	%	Count	%
White	1284	75.7%	176887	87.1%
Asian	194	11.4%	7848	3.9%
Mixed	121	7.1%	5987	2.9%
Black	61	3.6%	5723	2.8%
Not stated	10	0.6%	3006	1.5%
Other	23	1.4%	1917	0.9%
Missing / inconsistent	*	*	1566	0.8%
Chinese	*	*	79	0.0%
Total	1696	100.0%	203013	100.0%

	Significantly lower than national
	Significantly higher than national
	No significant difference to national

The majority (63.8%) of adults new to drug misuse treatment in Leicester in 2021-22 did not follow a religion. The most commonly recorded religion amongst those starting a new drug misuse treatment journey in 2021-22 was Christian (18.0%), followed by Muslim (7.1%) and Sikh (3.6%). All other religions recorded were represented by less than 3% of those who started a new treatment journey in 2021-22.

A large proportion (93.4%) of the adults starting a new drug misuse treatment journey in 2021-22 in Leicester had their sexuality recorded as heterosexual at the start of their treatment journey, whilst 2.6% were bisexual and 2.4% were gay/lesbian.

Around three quarters (73.9%) of adults entering drug misuse treatment in Leicester in 2021-22 cited no disability, so it can be inferred that around one quarter (26.1%) cited at least one disability. A range of disabilities were cited by adults starting a new drug misuse treatment journey in Leicester in 2021-22. Behaviour and emotional disability was cited by one in ten (10.1%) of adults starting treatment, whilst 5.7% cited a mobility and gross motor disability, 4.6% cited a learning disability, 2.9% cited progressive conditions and physical health and 1.1% cited a hearing disability. Other

disabilities cited included manual dexterity, personal, self-care and continence, sight and speech disability.

### 13.3.6. Drugs

In Leicester in 2021-22, other than alcohol, the most commonly cited substance for substance use in adults in treatment for alcohol and non-opiate only use was cannabis (60.4%), followed by cocaine (44.6%) and crack (12.4%). This replicates the pattern found nationally, however the national proportions were significantly lower for cannabis (51.1%) and significantly higher for cocaine (50.9%), the proportion was also lower for crack (10.0%) although this difference was not significant.

In non-opiate only users in drug misuse treatment in Leicester in 2021-22, the most commonly cited substance for substance use was cannabis (75.8%), followed by cocaine (23.0%) and crack (15.9%). This pattern is replicated nationally, however national proportions were significantly lower for cannabis (59.6%), significantly higher for cocaine (33.4%) and lower, although not significantly different, for crack (12.9%).

The most commonly cited substance for substance use in opiate users in drug misuse treatment services in Leicester in 2021-22 was opiates and crack which was cited by 51.9% of opiate users, followed by opiates (48.1%), alcohol (19.7%) and cannabis (11.5%). National proportions replicate this pattern, however national proportions were lower for opiates and crack (50.1%), higher for opiates (49.9%), lower for alcohol (16.9%) and higher for cannabis (15.6%) – the differences for alcohol and cannabis were significant.




### 13.3.7. Employment

Table 15 below shows the number and proportion of adults starting a new drug misuse treatment journey in Leicester and England in 2021-22 by their employment status at the start of their treatment journey. Just over one third (35.5%) of clients in Leicester were unemployed and not seeking work at the start of their drug misuse treatment journey in 2021-22, this is significantly higher than the proportion in England (25.8%). In Leicester, 2.2% of those starting a new drug misuse treatment journey in 2021-22 were pupils/students, this is a significantly higher proportion than those starting treatment across England (1.0%). Around one in five adults (20.7%) starting drug misuse treatment in Leicester in 2021-22 were in regular employment and around one in five were long term sick or disabled (22.1%). A smaller proportion of adults starting drug misuse treatment in Leicester in 2021-22 were unemployed and seeking employment (14.5%) than in England overall (17.3%), although this difference was not significant.

Table 19: Adults starting a new drug misuse treatment journey by employment status in Leicester and England, 2021-22

	Leicester		England	
	Count	%	Count	%
Unemployed and not seeking work	257	35.5%	19332	25.8%
Regular Employment	150	20.7%	18349	24.5%
Long term sick or disabled	160	22.1%	15117	20.2%
Unemployed and seeking work	105	14.5%	12982	17.3%
Missing / inconsistent	*	*	2089	2.8%
Unemployed	*	*	1400	1.9%
Unknown	*	*	1308	1.7%
Not receiving benefits	9	1.2%	972	1.3%
Homemaker	6	0.8%	789	1.1%
Pupil / student	16	2.2%	729	1.0%
Other	8	1.1%	693	0.9%
Not stated	5	0.7%	627	0.8%
Retired from paid work	5	0.7%	368	0.5%
Unpaid voluntary work	*	*	152	0.2%
Economically Inactive	*	*	100	0.1%
NEET	*	*	*	*
Pupil Referral Unit	*	*	*	*
Total	723	100.0%	75015	100.0%

\*counts below 5 have been suppressed

	Significantly lower than national
	Significantly higher than national
	No significant difference to national




### 13.3.8.Housing

A safe and stable home environment enables people to sustain their recovery. Table 16 below shows that the majority of adults starting drug misuse treatment in 2021-22 in both Leicester and England had no housing problem or had a record of other/not answered at the start of their journey (67.1% and 79.0% respectively), the proportion in Leicester was significantly lower than the proportion in England overall. A significantly larger proportion of adults starting drug misuse treatment in Leicester in 2021-22 had a housing problem (18.1%) than in England overall (13.5%). Leicester also had a significantly larger proportion of adults starting drug misuse treatment in 2021-22 with an urgent housing problem (14.8%) than England (7.5%). The proportions suggested in 2021-22 are similar to those of 2020-21 where 64% of adults starting drug misuse treatment had no housing problem, 21% had a housing problem and 15% had an urgent housing problem.

Table 20: Accommodation need at the start of treatment journey for adults starting drug misuse treatment in 2021-22 in Leicester and England

	Leicester		England	
	Count	%	Count	%
NFA - urgent housing problem	107	14.8%	5616	7.5%
Housing problem	131	18.1%	10123	13.5%
No housing problem or other/not answered	485	67.1%	59276	79.0%
Total	723	100.0%	75015	100.0%

	Significantly lower than national
	Significantly higher than national
	No significant difference to national

### 13.3.9. Adults who are parents/carers and their children

The following data can help to identify the need to engage local antenatal and family support services to ensure appropriate support for families at risk. In Leicester in 2021-22, 18.2% of adults in drug treatment had children living with them.

A significantly larger proportion of those in treatment in 2021-22 with valid responses in their latest treatment journey records were recorded as parents in Leicester (31.6%) than in England (27.3%) and all of Leicester's comparators. In Leicester in 2021-22, of those with valid responses in the parental status section of their latest treatment journey records 21.5% had all of the children living with them, 5.3% had some of the children living with them and 50.1% had none of the children living with them. Of the adults new to drug treatment in 2021-22 in Leicester, the majority were not a parent or had no child contact (64.3%), around one in five were parents not living with children (19.9%), 13.1% were parents living with their own children and 2.1% were living with other children.

Of all the female clients starting treatment within 2021-22 in Leicester, 4.4% were recorded as pregnant at the start of their treatment journey.

### 13.3.10. Criminal Justice Pathway

Of the adults in opiate only, alcohol and non-opiate and non-opiate only drug treatment in Leicester in 2020-21, 30%, 21% and 16% respectively were in contact with both a Criminal Justice Integrated Team and the community-based treatment system. The proportion of adults in opiate only, alcohol and non-opiate and non-opiate only treatment in Leicester in 2020-21 that were in contact with both a Criminal Justice Integrated Team and the community-based treatment system was significantly larger than the proportion for England (14%, 6% and 5% respectively).



Table 21: Criminal Justice Integrated Teams adults in contact with the treatment system for Leicester and England, 2020-21

Drug group	Local (n)	Proportion	England (n)	Proportion
Alcohol and non-opiates	58	21%	1,723	6%
Non-opiates	29	16%	1,296	5%
Opiates	335	30%	19,207	14%
<b>Total*</b>	<b>422</b>	<b>27%</b>	<b>22,226</b>	<b>11%</b>

Note:

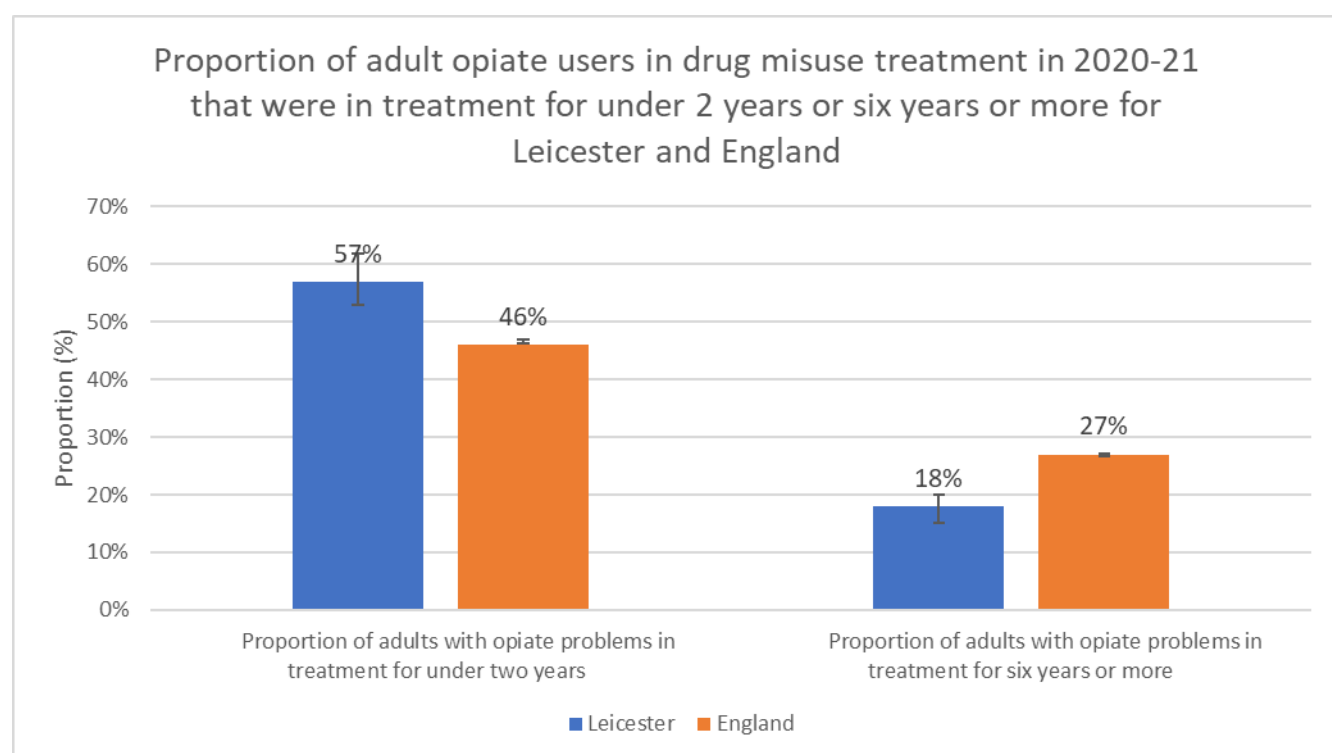
\*Please note the total is comprised of all drug groups: Opiate, Non-opiate only, and Alcohol and non-opiate

### 13.3.11. Length of Time in Treatment

The data below shows the proportion of opiate users in treatment in 2020-21 with a treatment duration of under two years or six years or over. Adults that have been in treatment for long periods of time (six years or over for adults with opiate problems) will usually find it harder to successfully complete treatment. Current data shows that adults with opiate problems who successfully complete within two years of first starting treatment have a higher likelihood of achieving sustained recovery.

In Leicester in 2020-21 the majority (57%) of those in drug misuse treatment with opiate problems had been in treatment for under two years, this was significantly higher than the proportion in England (46%). The proportion of adults in drug misuse treatment with opiate problems which had been in treatment for six years or more in Leicester in 2020-21 (18%) was significantly lower than the proportion in England overall (27%). In both Leicester and England, a significantly larger proportion of adults in drug misuse treatment with opiate problems in 2020-21 had been in treatment for under two years than had been in treatment for six years or more.

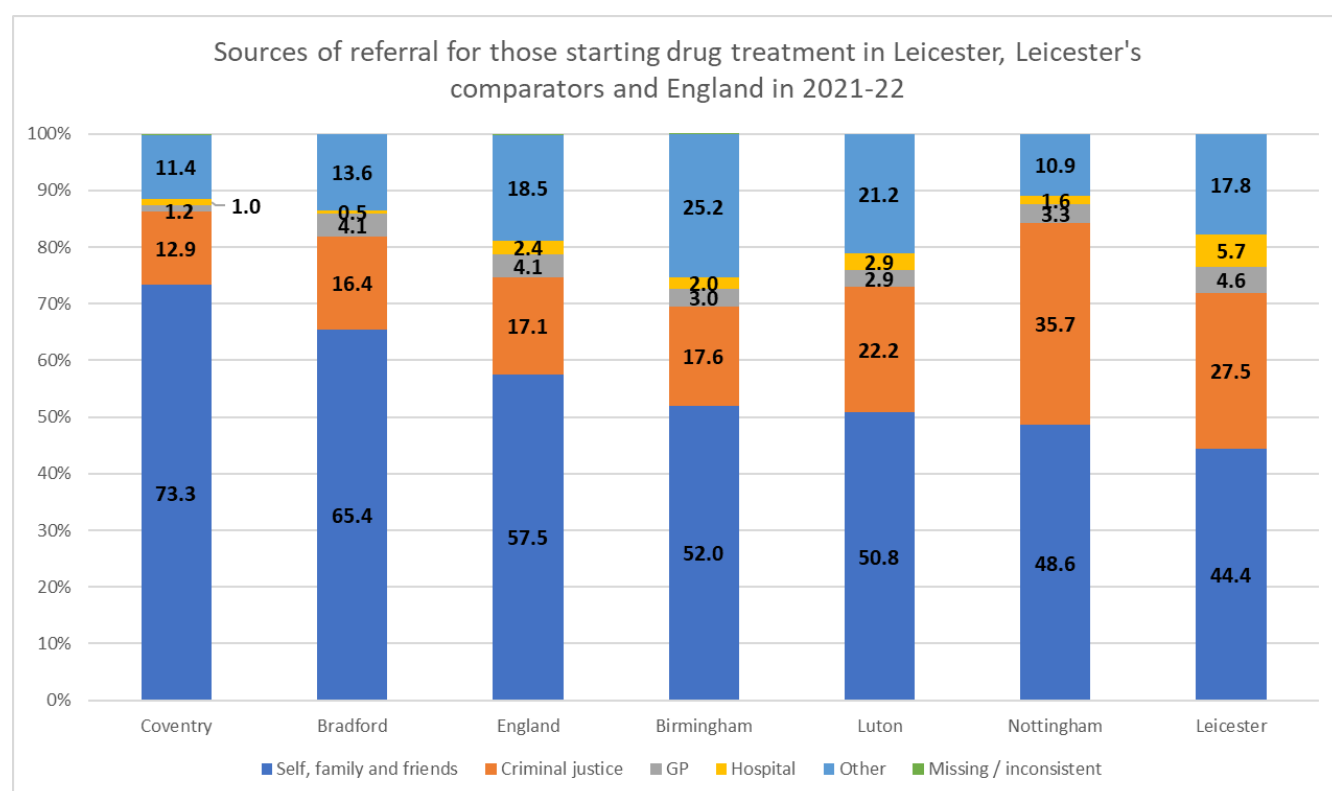
Figure 108: Length of time in treatment for adults in drug misuse treatment in 2020-21 due to opiate use for Leicester and England



### 13.3.12. Referral Source

In 2021-22, Leicester had 44.4% of its referrals for new drug treatment journeys through the client themselves, their family and their friend which was the smallest proportion of referrals through this source when compared to its comparators. The proportion of referrals through this source in Leicester (44.4%) was significantly lower than the proportion from this source in England (57.5%), Birmingham (52.0%), Bradford (65.4%) and Coventry (73.3%). In 2021-22, Leicester had the largest proportion of referrals to new drug treatment journeys through hospitals than any of its comparators, the proportion of referrals through this source in Leicester (5.7%) was significantly larger than the proportion in England (2.4%), Bradford (0.5%), Coventry (1.0%), Nottingham (1.6%) and Birmingham (2.0%). Following Nottingham, in 2021-22 Leicester had the second largest proportion of referrals through criminal justice sources of its comparators. The proportion of referrals to new drug treatment journeys in Leicester in 2021-22 through criminal justice sources (27.5%) was significantly larger than the proportion of referrals through this source in England (17.1%), Coventry (12.9%), Bradford (16.4%) and Birmingham (17.6%) and significantly smaller than the proportion of referrals through this source in Nottingham (35.7%). Leicester had the largest proportion of referrals for new drug treatment journeys in 2021-22 through GP sources of its comparators, although this difference was only significant between Leicester and Coventry with the proportion in Leicester (4.6%) significantly larger than in Coventry (1.2%).

Figure 109: Proportion of referrals by source for new drug treatment journeys started in Leicester, Leicester's comparators and England in 2021-22



### 13.3.13. Interventions Delivered

There were 785 psychosocial interventions started with those in drug treatment in 2021-22, with 93.9% of these taking place in community settings, 4.7% in inpatient units and 1.4% in residential settings. In 2021-22 in Leicester, 728 recovery support interventions (during treatment) were started with those in drug treatment, of which 93.7% were delivered in community settings with the remaining delivered in either inpatient units (5.1%) or residential settings (1.2%). In 2021-22 in Leicester, 337 adults in drug treatment started a pharmacological intervention, the majority of these interventions (88.1%) took place in a community setting with just over one in ten (11.0%) taking place in inpatient unit settings. Recovery support interventions (post treatment) were also delivered to the drug treatment population in Leicester in 2021-22, however, there were only 8 instances of this treatment intervention being delivered with the majority of this intervention being delivered in the community. Further work is required to understand if post treatment recovery interventions would provide additional benefits to clients.

Overall, the majority of interventions started in the drug treatment population in 2021-22 in both Leicester and England were delivered in community settings (95.3% and 96.1% respectively), the remaining interventions were delivered in inpatient units, residential settings and primary care in Leicester with some interventions also being delivered in recovery houses in England.

#### 13.3.14. Naloxone at Triage

In 2021-22, of all opiate clients in treatment in Leicester 43.4% (not significantly different to 45.6% in England) had been issued with naloxone at triage across their latest treatment journey. In comparison 46.9% (significantly higher than the 24.2% in England) had not been issued with naloxone at triage across their latest treatment journey as the client was already in possession of adequate naloxone. One in ten (9.8%) had not been issued with naloxone at triage across their latest treatment journey (significantly lower than the 30.1% in England) as it had been assessed as not appropriate or the service did not provide naloxone.

Out of all valid responses of all of the opiate clients in treatment in Leicester in 2021-22, 45.2% had been administered with naloxone to reverse the effects of an overdose/had been administered with naloxone to reverse the effects of an overdose in the last 6 months, this was a significantly higher proportion than that in England (21.1%).

#### 13.3.15. Successful Completions

As shown in Figure 107, the proportion of adult opiate users in treatment that have successfully completed drug treatment in Leicester has not been significantly different to the value for England since 2010, with the exception of 2013 where the proportion for Leicester was significantly lower (worse) than that of England overall. In 2020 Leicester had the 2<sup>nd</sup> highest proportion of successful completion of drug treatment in opiate users when compared to its five comparators. In the same year, the proportion of adult opiate users that had successfully completed drug treatment in Leicester (5.3%) was significantly higher than the proportion for Birmingham (3.2%). Over the last five time periods, there has been no significant change in the successful completion of drug treatment in opiate users in Leicester.

Figure 110: Successful completion of drug treatment (opiate users) for Leicester, Leicester's comparators and England (2010-2020)<sup>128</sup>

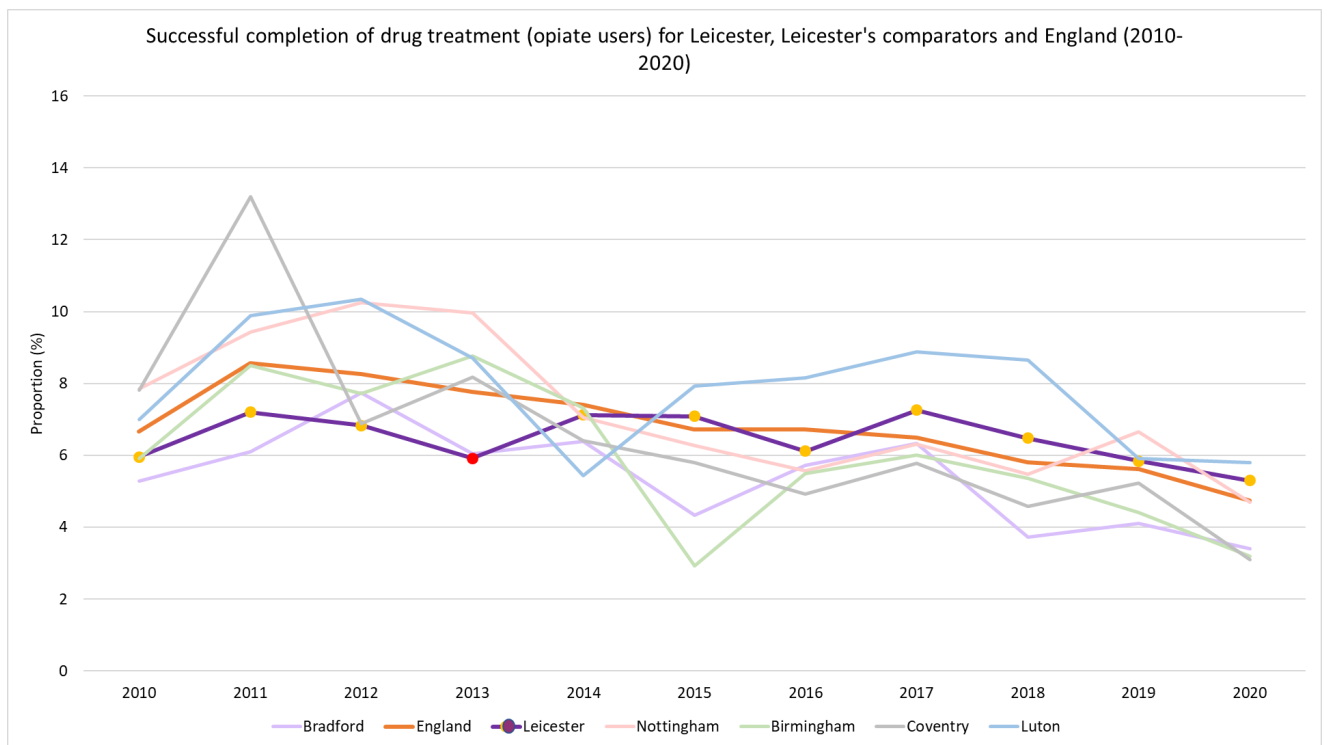
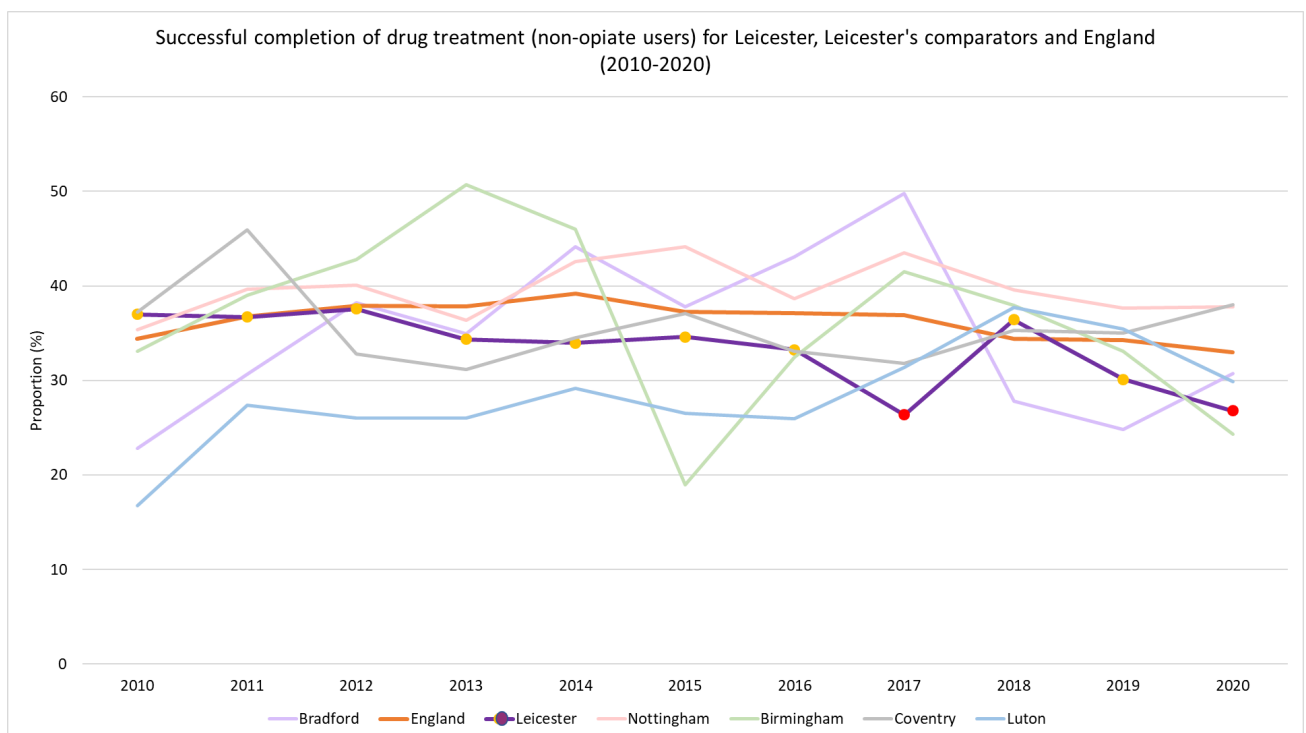


Figure 111: Successful completion of drug treatment (non-opiate users) for Leicester, Leicester's comparators and England (2010-2020)<sup>129</sup>



After two years of consecutive decrease in the proportion of successful completion of drug treatment in non-opiate users in Leicester, in 2020 the proportion of adult non-opiate users that had successfully completed drug treatment in Leicester (26.8%) was significantly lower (worse) than the proportion for England overall (33.0%). Further, as shown in Figure 108, Leicester had the 2<sup>nd</sup> lowest proportion of successful completion of drug treatment in non-opiate users in 2020 when compared to its five comparators. In 2020, the proportion in Leicester (26.8%) was significantly lower than the proportion in Nottingham (37.8%) and Coventry (38.0%).

In 2021-22 in Leicester, the proportion of adults in opiate, non-opiate and alcohol and non-opiate drug treatment that successfully completed treatment was 4.5%, 38.5% and 33.6% respectively.

#### 13.3.16. Deaths in treatment

All deaths in treatment are reported from NDTM. In 2020-21, there was an 18% increase at a national level in the number of people recorded as having died while in treatment for drug misuse, with wide local variation. It is likely that changes to drug treatment, reduced access to broader healthcare services, changes to lifestyle and social circumstances during lockdowns, as well as COVID-19 itself, will have contributed to this increase.

The proportion of adults in drug treatment due to opiate use who were recorded as having died while in treatment within 2020-21 was 1.4%, this is not significantly different to the proportion for England (1.7%). In the non-opiate drug group, no adults were recorded as having died while in treatment within 2020-21 in Leicester and the value for those in the alcohol and non-opiate drug group has been suppressed due to low counts.

In 2021-22 in Leicester, of all clients in treatment in the opiate drug group 1.2% had a treatment exit reason of death, this is not significantly different to the proportion for England overall (1.7%). In the non-opiate drug group, no adults were recorded as having died while in treatment within 2021-22 in Leicester and the value for those in the alcohol and non-opiate drug group has been suppressed due to low counts.

Serious incident reporting from specialist treatment provider gives further information on these drug-specific deaths (e.g. overdose), such as the use of substance, how these deaths vary by treatment setting and the type of intervention. Serious incident reporting is not required for drug-related deaths which may represent a gap in local knowledge. The role of the newly reinstated Drug Related Death Panel for Leicester, Leicestershire and Rutland may help to fill this potential void and should be investigated further.

### 13.3.17. Wider health behaviours

#### 13.3.17.1. Tobacco Use

In Leicester in 2020-21, the proportion of adults smoking tobacco at the start of drug treatment was 49%, which is significantly smaller than the proportion for England overall (65%). Of those identified as smoking tobacco at the start of treatment 54% in Leicester were identified as abstinent from tobacco at review, this is significantly larger than the proportion in England (23%). In 2021-22, 0.4% of clients in drug treatment in Leicester had received a smoking cessation intervention which was significantly lower than the proportion for England overall (1.9%). These indicators represent an unclear picture and further work is needed to understand the operational priorities.

### 13.3.18. Co-occurring Mental Health

Of the adults starting drug misuse treatment in Leicester in 2021-22, 71.1% were identified as having a mental health treatment need, this is not significantly different to the proportion for England (68.1%). The proportion of adults starting drug misuse treatment in 2021-22 with a mental health treatment need in Leicester was the highest of its comparators. The proportion in Leicester (71.1%) was significantly larger than the proportion in Luton (61.9%) and Nottingham (60.2%). Of those who were identified as having a mental health treatment need in Leicester over a third (35.4%) were not receiving any treatment, this is a significantly larger proportion than the proportion of those identified as having a mental health treatment need not receiving any treatment in England (30.9%).

Figure 112: Proportion of adults presenting to drug misuse treatment in 2021-22 where a mental health treatment need has been identified in Leicester, Leicester's comparators and England

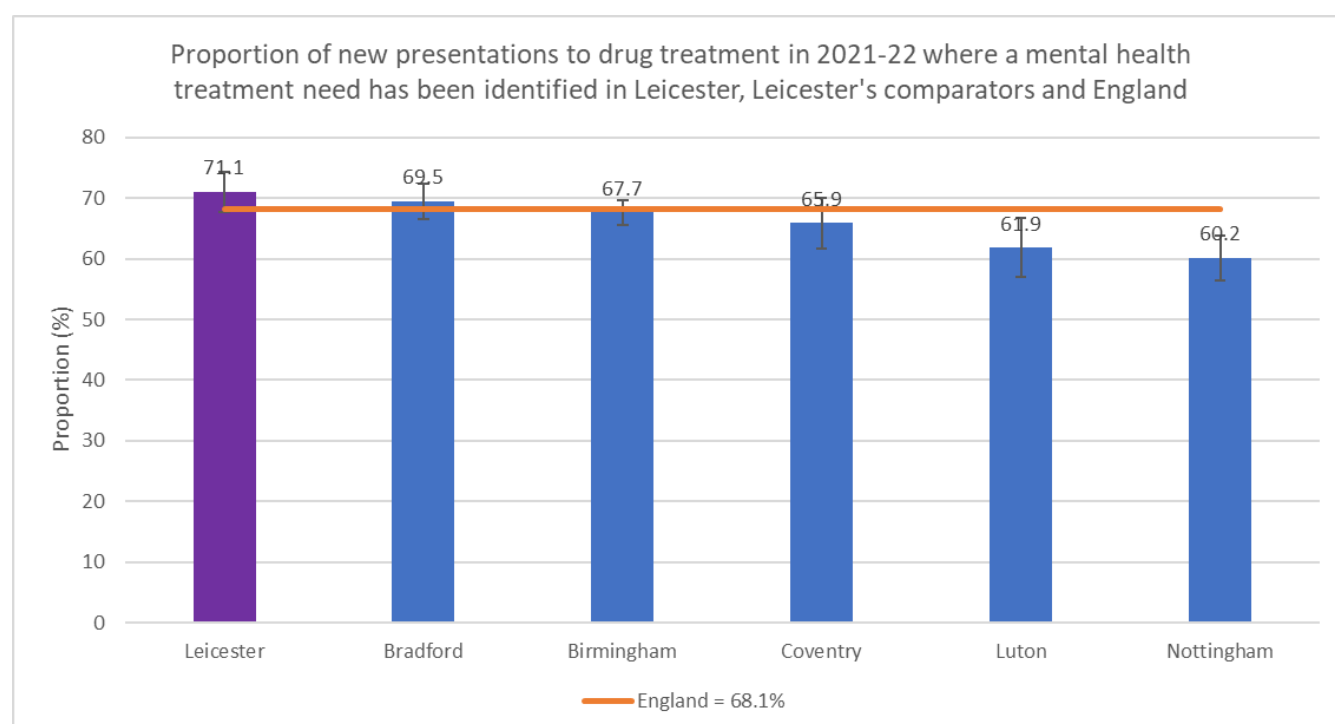
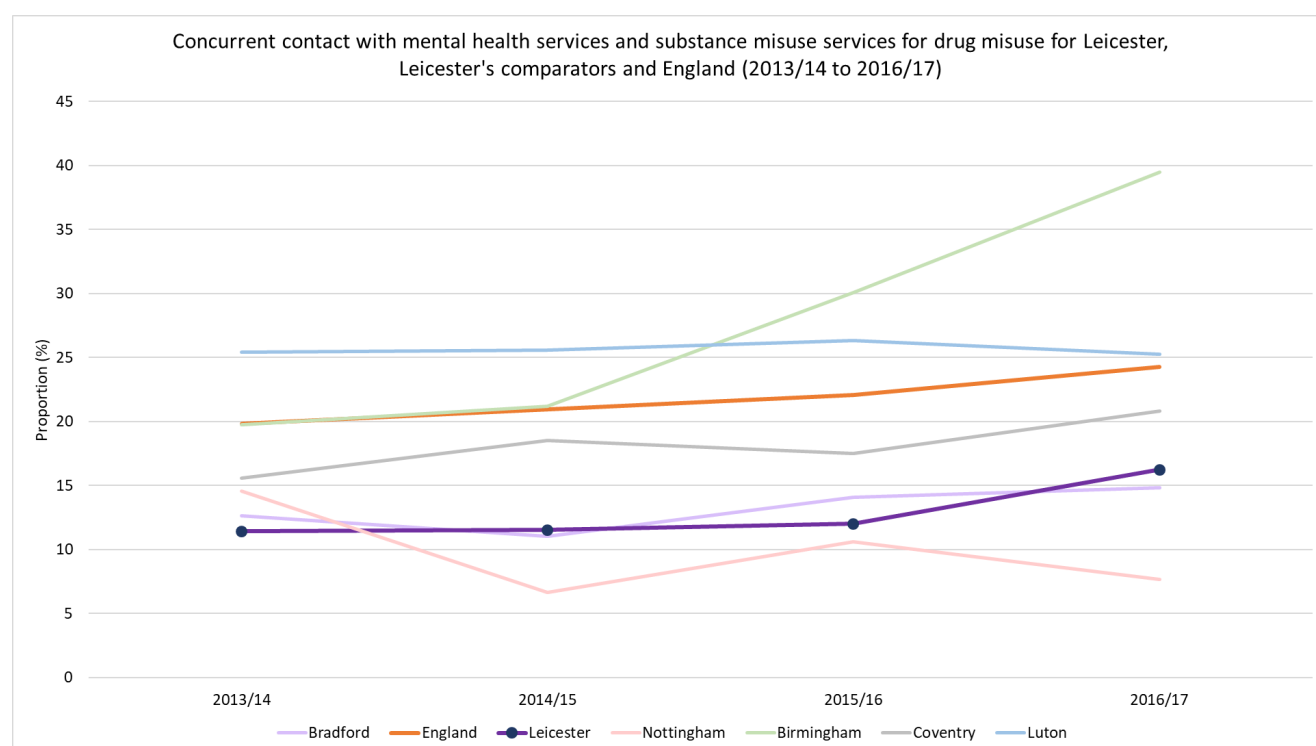


Figure 114 below shows the number of individuals who entered treatment at a specialist drug misuse service and were in concurrent contact with mental health services as a proportion of all individuals entering specialist drug misuse services in Leicester, Leicester's comparators and England overall. Between 2013/14 and 2016/17 the proportion of adults who entered treatment at a specialist drug misuse service and were in concurrent contact with mental health services in Leicester was significantly below the proportion for England overall. In 2016/17 Leicester had the 4<sup>th</sup> highest proportion when compared to its comparators, with Leicester's proportion (16.2%) significantly above that of Nottingham (7.7%) and significantly below that of Birmingham (39.5%) and Luton (25.3%). The proportion of adults who entered treatment at a specialist drug misuse service and were in concurrent contact with mental health services in Leicester increased with each time period since the recording of this indicator began in 2013/14 to the most recent time period in 2016/17.



Figure 113: Concurrent contact with mental health services and substance use services for drug misuse in Leicester, Leicester's comparators and England (2013/14 to 2016/17)<sup>130</sup>



### 13.4. Prescription Only Medicines and Over the Counter Medicines Use

Of those in drug misuse treatment in Leicester in 2020-21 (1,580 individuals), a significantly higher proportion cited prescription only medicines or over the counter medicines use as well as illicit drug use (4%) than cited prescription only medicines or over the counter medicines use and no illicit drug use (2%). The proportion of those in treatment in Leicester in 2020-21 citing prescription only medicines or over the counter medicines use as well as illicit drug use (4%) or prescription only medicines or over the counter medicines use and no illicit drug use (2%) was significantly lower than the proportions in England (10% and 4% respectively).

### 13.5. Club Drug Use

A significantly larger proportion of adults new to drug treatment in Leicester in 2020-21 citing opiate use cited club drug use (10%) than in England (2%). Of adults new to drug treatment in Leicester in 2020-21 that did not cite additional opiate use, 8% cited club drug use which is not significantly different to the proportion in England (8%).

### 13.6. Substance Use Treatment Following Release from Prison

In 2015/16 in Leicester, 56.0% of adults with substance use treatment need successfully engaged in community-based structured treatment following release from prison, this was significantly higher

(better) than the proportion for England (30.3%) and all of Leicester's comparators. Between 2015/16 and 2017/18, the proportion in Leicester decreased significantly year on year and by 2016/17 the proportion of adults with substance use treatment need successfully engaged in community-based structured treatment (12.7%) was significantly lower (worse) than the proportion in England overall (30.3%). Between 2017/18 and 2020/21 the proportion in Leicester was 0.0%, which represented a data issue whereby City counts were attributed to the County figures. Currently national indicators have not published rectified figures, however the latest local data from July 2021 to June 2022 shows 33.1% of adults with substance use treatment need successfully engage in community-based structured treatment within 21 days of release from prison<sup>131</sup>. This is similar to the national percentage of 37.4%. The system has set an emphasis to improve this performance locally, with a stretch targets of 50% for 2022/23 and 65% for 2023/24 agreed.

### 13.7. Numbers in Treatment by Substance Use Group

Between 2009-10 and 2018-19 the rate of adults in substance use treatment services in Leicester due to opiate use was significantly higher than for all of the other substance use groups, whilst the rate for alcohol users was significantly higher than those in treatment due to alcohol and non-opiate and non-opiate only use. Between 2009-10 and 2018-19 there was no significant difference between the rate of those in drug treatment due to non-opiate only and alcohol and non-opiate use. In 2019-20 and 2020-21, the rate of those in treatment due to alcohol and non-opiate use was significantly higher than the rate in treatment for non-opiate use only.

It is important to note increases in numbers in treatment is not just demand led but linked to accessibility of services too. Local data reveals despite the number of referrals declining between 2019/20 and 2020/21 for alcohol only and alcohol and opiate treatment, the numbers in treatment increased due to the increasing conversion rates (see Table 22). This is likely to be related to the increase in number of phone assessments during the COVID-19 pandemic where user attendance was much more likely.

Provisional data for 2021-22 shows there was no significant difference between the rate of adults in treatment services in Leicester due to alcohol and non-opiate use and non-opiate only use. Latest conversion rate and referral data for 2021/22 shows the number of referrals are below pre-COVID levels and the conversion rate has dropped to a rate similar to pre-COVID levels. This suggests the total numbers in treatment are likely to decline in 2021/22.

Figure 114: Adults in treatment at specialist drug misuse services (rate per 10,000 population) in Leicester by substance group and time period (2009-10 to 2021-22)

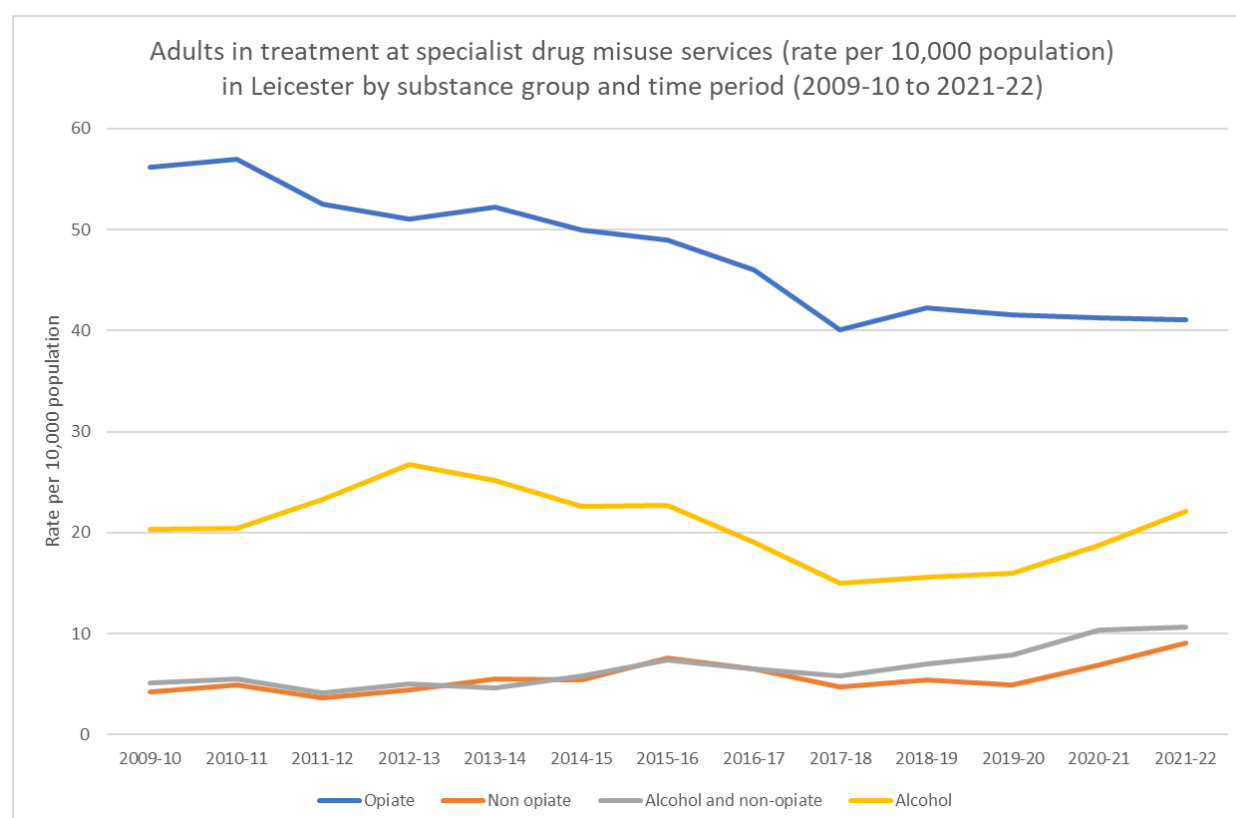


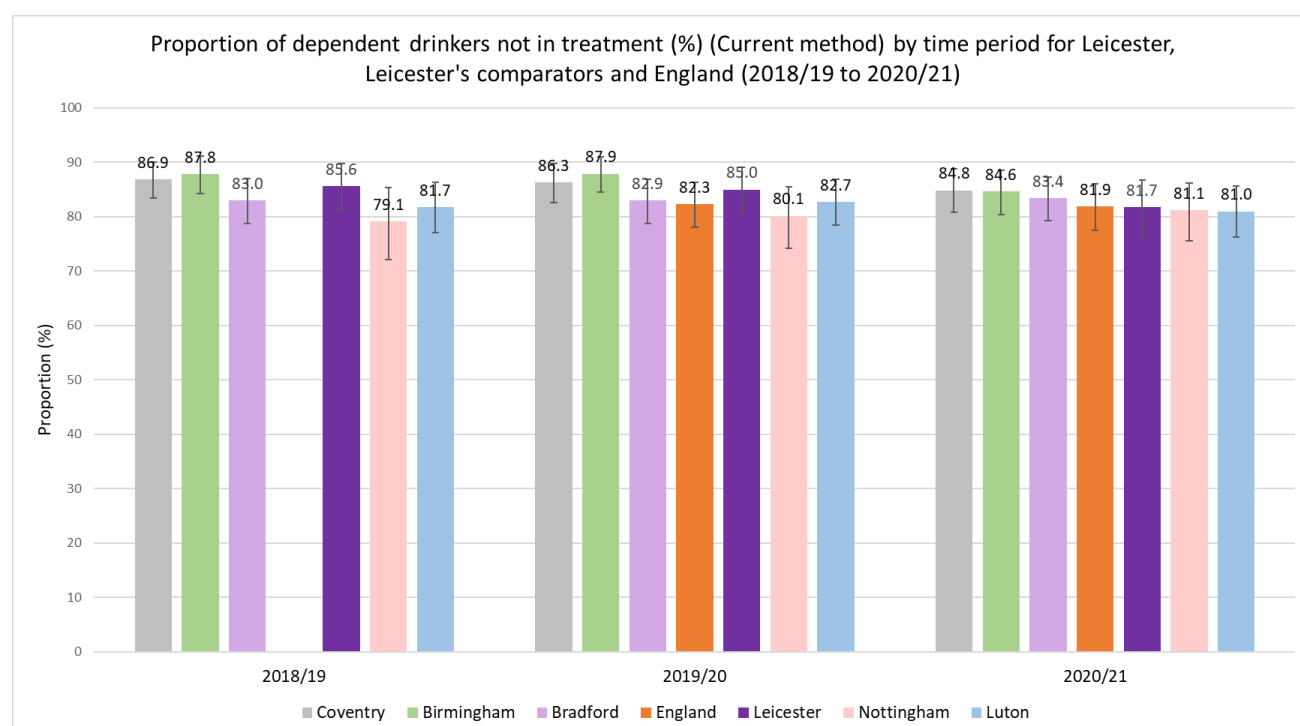
Table 22: The number of referrals and conversion rate by substance group, 2018/19 to 2020/21

Substance Group	Referrals			Conversion Rate (%)		
	2018-19	2019-20	2020-21	2018-19	2019-20	2020-21
Alcohol and non-opiate	439	481	438	42.1%	51.8%	66.2%
Alcohol only	1195	990	913	34.1%	41.6%	53.1%
Non-opiate only	576	490	513	25.0%	38.6%	49.9%
Opiate	969	803	700	63.9%	68.9%	64.3%
No drug group	537	624	151	35.9%	23.9%	15.2%
<b>Total</b>	<b>3716</b>	<b>3388</b>	<b>2715</b>	<b>41.7%</b>	<b>45.8%</b>	<b>55.4%</b>

### 13.8. Unmet Need

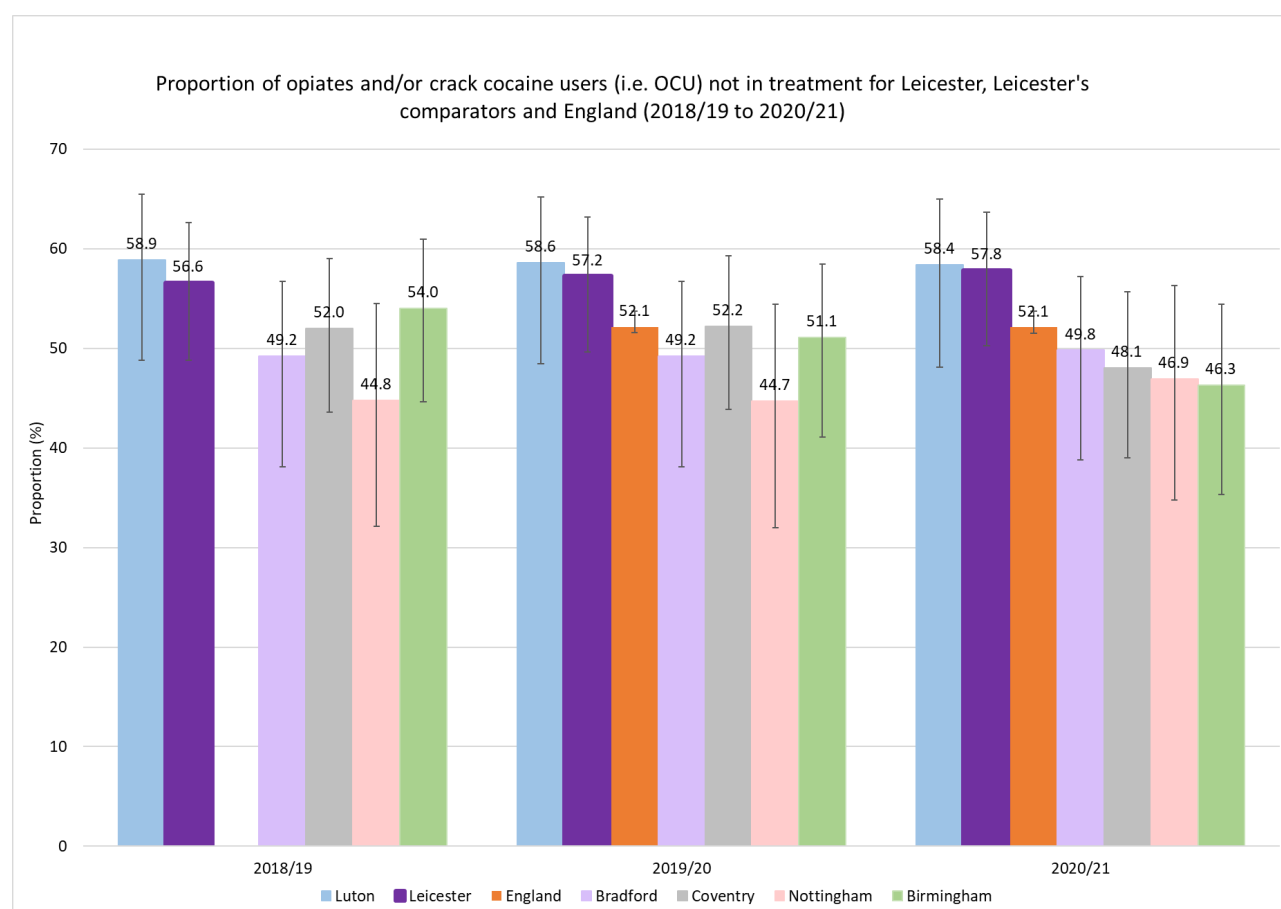
As shown in Figure 111, the proportion of dependent drinkers not in treatment in Leicester in 2019/20 (85.0%, 3,649 individuals) and 2020/21 (81.7%, 3,509 individuals) was not significantly different to the proportion for England (82.3% and 81.9% respectively). In 2018/19, 2019/20 and 2020/21, Leicester had the third lowest proportion of dependent drinkers not in treatment when compared to its five comparators. There were no significant differences between Leicester and its comparators for any of the three time periods.

Figure 115: Proportion of dependent drinkers not in treatment (%) (Current method) by time period for Leicester, Leicester's comparators and England (2018/19 to 2020/21)<sup>132</sup>



As shown in Figure 112 below, in 2019/20 and 2020/21 the proportion of opiates and crack/or cocaine users not in treatment in Leicester (57.2% (1,587 individuals) and 57.8% (1,603 individuals) respectively) was not significantly different to the proportion for England overall (52.1% for both time periods). Leicester had the 2<sup>nd</sup> highest proportion of opiates and/or crack cocaine users not in treatment in 2020/21 when compared to its five comparators, however, there were no significant differences between Leicester and its comparators. There has been no significant change in the proportion of opiates and/or crack cocaine users not in treatment in Leicester across the three time periods.

Figure 116: Proportion of opiates and/or crack cocaine users (i.e. OCU) not in treatment for Leicester, Leicester's comparators and England (2018/19 to 2020/21)<sup>133</sup>



## 14. Services

### 14.1. NICE Guidance

#### 14.1.1. Drugs

The National Institute for Health and Care Excellence provides guidelines and quality standards to support the services for the wider health and social care system. NICE guideline (NC64)<sup>134</sup> covers **targeted interventions** to prevent misuse of drugs, including illegal drugs, 'legal highs' and prescription-only medicines. It aims to prevent or delay harmful use of drugs in children, young people and adults who are most likely to start using drugs or who are already experimenting or using drugs occasionally. Recommendations include delivering drug misuse prevention activities as part of existing services, use routine appointments and opportunistic contacts to assess if someone is vulnerable to drug misuse and offer information and advice following identification of risk.

NICE guidance (PH52)<sup>135</sup> recommends **Needle and Syringe Programmes (NSPs)** are commissioned as an improved harm reduction strategy for people (including those under 16) who inject drugs. NSPs supply needles and syringes for people who inject drugs. In addition, they often supply other

equipment used to prepare and take drugs (for example, filters, mixing containers and sterile water). The main aim of needle and syringe programmes is to reduce the transmission of blood-borne viruses and other infections caused by sharing injecting equipment. NICE guidance is available for further harm reduction strategies including **opioid substitution treatment (OST)**<sup>136</sup> and **maintenance prescribing**.

Various treatment methods for substance use are supported through NICE guidance, such as **reduction prescribing**<sup>137</sup> and **opioid detoxification**. NICE Guideline (CG52)<sup>138</sup> aims to support adults and young people over 16 who are dependent on opioids to stop using drugs by opioid detoxification. It states that detoxification should be a readily available treatment option for people who are opioid dependent and have expressed an informed choice to become abstinent. Community based programmes for detox should be routinely offered to service users in the first instance, unless user's need prevents this.

**Residential rehabilitative treatment** provides a safe environment, a daily structure, multiple interventions and can support recovery in some people with drug use disorders who have not benefitted from other treatment options. NICE quality standard (QS23)<sup>139</sup> identifies that people in drug treatment are given information and advice on the NICE eligibility criteria for residential rehabilitative treatment if they want to stop taking drugs, have other medical or social problems, have completed a detoxification programme and past psychosocial treatment has not been successful.

NICE Guideline (CG51)<sup>140</sup> 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. The key priorities for implementation are:

- **Brief interventions:** Opportunistic brief interventions focus normally consist of two sessions lasting 10-45 minutes and explore ambivalence about drug use and possible treatment, with the aim of increasing motivation to change behaviour and provide non-judgmental feedback.
- **Self-help:** Users should be provided information about self-help groups. These groups should normally be based on 12-step principles e.g. Narcotics Anonymous and Cocaine Anonymous.

**Contingency management:** is a set of techniques that focus on changing specified behaviours. In drug misuse, it involves offering incentives for positive behaviours such as abstinence or a reduction in illicit drug use, and participation in health-promoting interventions.

- **Behavioural couples therapy:** This should be considered for people who are in close contact with a non-drug-misusing partner and who present for treatment of stimulant or opioid misuse. The intervention will focus on the service users drug misuse and consist of at least 12 weekly sessions. This is not currently commissioned by Leicester City.

NICE guidance is available for the individuals with coexisting severe mental illness and substance use. The outcome for people with a mental health disorder and coexisting substance use is worse than for people without coexisting substance use, partly because the substances used may exacerbate their mental health condition and partly because substances often interfere with pharmacological or psychological treatment. Guidance is available in **healthcare**<sup>141</sup> settings and **community health and social care services**.<sup>142</sup>

#### 14.1.2.Alcohol

NICE guideline has been produced on the prevention and early identification of alcohol-use disorders among adults and adolescents (PH24)<sup>143</sup>. It aims to prevent and identify such problems as early as possible using a mix of policy and practice. It recognises that a combination of interventions are needed to reduce alcohol-related harm, to the benefit of society as a whole, at both a population and individual level. Recommendation of practical interventions include: the use of screening, brief interventions, structured brief advice and extended brief interventions. Further clinical guideline sare available on the diagnosis and management of alcohol-use disorders:

- NICE's guideline on alcohol-use disorders: diagnosis and management of physical complications (2010)<sup>144</sup>. A clinical guideline covering acute alcohol withdrawal including delirium tremens, alcohol-related liver damage, alcohol-related pancreatitis and management of Wernicke's encephalopathy.
- NICE's guideline on alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (2011)<sup>145</sup>. A clinical guideline covering identification, assessment, pharmacological and psychological/psychosocial interventions, and the prevention and management of neuropsychiatric complications.

#### 14.1.3.Young People

Many of the NICE guidelines cover young people and adults. NICE guideline (NG135) alcohol interventions in secondary and further education<sup>146</sup> covers interventions in secondary and further education to prevent and reduce alcohol use among children and young people aged 11 up to and including 18. The recommendations encompass planning and delivering alcohol education and

providing targeted interventions to children with risk factors that make them vulnerable to alcohol misuse.

## 14.2. Current Services

### 14.2.1. Young People

- **Healthy Together:** This service offers brief intervention and referral into open access and specialist substance use services via schools and following contact made by young people via CHATHEALTH (young peoples' texting service).
- **REACH service:** The Reach Programme is a six-month, evidence-informed intervention for children and young people who are at risk of suspension or who are persistently absent from school, and where there are concerns about future involvement in anti-social behaviour and crime as both a victim or a perpetrator. Young people who fit this eligibility criteria are identified and referred to the programme by their school. Referrals are triaged to assess eligibility and if eligible, the young person is matched/allocated to a Youth Worker. The programme incorporates intensive and flexible mentoring at school, at home and within the community. It offers opportunities for prosocial activity, and addresses individual, relationship and community risk factors through structured learning components such as social skills training. Although substance abuse is not regarded as a predominant reason for involvement with REACH service, this offers another opportunity to support young people in a structured programme of care.
- **Family Therapies:** Are evidence-based family therapies aimed to reduce looked after placements and keep children safely at home. The therapies are split into three subdomains of Multisystemic Therapy Standard (MST), Multisystemic Therapy – child abuse and neglect (MST-CAN), Functional Family Therapy – Child Welfare (FFT- CW):
  - **MST** standard is designed to reduce harm to children ages 11 to 17 where the child is displaying concerning behaviours. It is a short term (3-5 months) intensive home-based programme with the entire families which uses behavioural, cognitive behavioural and family therapies to address difficulties in parent/child; peer/child; school/child interactions.
  - **MST-CAN** is designed to reduce harm to children ages 6 to 17 and their families who are on a child protection plan due to physical abuse and/or neglect. It works with the entire family in an effort to keep children with their families and help the family resolve clinical and practical concerns so that children can be safe. Teams have Case Support Workers who address financial, housing needs etc. MST CAN is a medium term (6-9 months) intensive home based programme which uses behavioural, cognitive behavioural, family therapies alongside psychiatric support to address negative parent child interactions.



- **FFT-CW** aims to protect children and young people, aged 0-17 from entering out of home care. FFT-CW uses an holistic approach to addressing issues affecting families facing vulnerability. FFT-CW works with families who are reluctant to engage with services targeting mental health concerns, abuse or neglect issues, a history of family violence, substance abuse or engagement with the criminal justice system. FFT-CW is a short term (around 6 months) intensive home based programme which uses strategic family therapy, cognitive behavioural and behavioural therapies to change family interactions and create safe, stable relationships.
- **Turning Point** provide substance use treatment services for children and young people and adults. This includes treatment, advice and guidance, recovery support and harm reduction.
- **Youth and Justice Services** such as Probation, Police, Liaison and Diversion service have developed a strong working relationships with specialist treatment services.

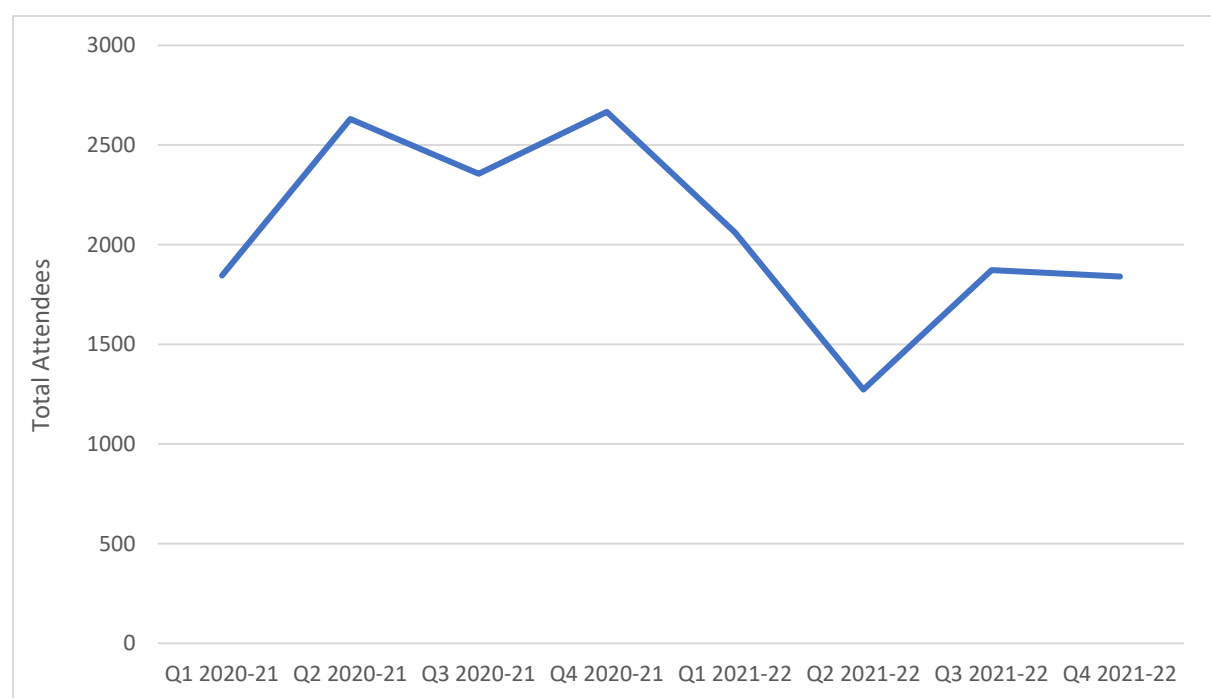
#### 14.2.2.Adults

- **Turning Point** provide substance use treatment services for children, young people and adults. This includes treatment, advice and guidance, recovery support, access to rehab and harm reduction services such as needle exchange and BBV prevention and treatment.
- **Inpatient detox:** The Level is a block contract with Framework Housing Association based in Nottingham. The service provides 10-day detox for drug or alcohol users as part of their recovery journey. Referrals are made by Turning Point and users either go onto residential rehab or receive aftercare in the community. This is a vital step to recovery. Throughout 2020/21 and 2021/22, 63 and 74 service users were admitted to the inpatient detox unit for stabilisation and withdrawal. Although there was an increase in users between 2020/21 and 2021/22, the under-utilisation of bed days is a cause for concern because... The latest annual percentage of utilisation stands at 55.4% in 2020/21 and 57.3% in 2021/22. The percentage of service users admitted for alcohol withdrawal has increased (although not significantly) from 51% in 2020/21 to 55% in 2021/22.<sup>147</sup>
- **No.5 Recovery Hub:** This is provided by Inclusion Healthcare. The service provides recovery support for people who are street drinking or misusing drugs including those with a street lifestyle. The service aims to reduce the harms for those with complex needs and to support them into treatment. The centre has a wet room where those with alcohol dependency issues can drink under supervised conditions to ensure safer drinking and creating an environment to engage them with treatment services. The service also provides health interventions (e.g. flu-jabs), skill-based sessions (e.g. computer skills, nutrition) and on-site access to other services such as DWP. It offers a daily Monday to Friday drop-in service for those on the streets who are

struggling with alcohol and other substance use problems. Food is served from 8am in the morning and there are also washing and laundry facilities available.

Figure 115 shows a decrease in total attendees to No. 5 was witnessed from Q4 2020/21. This was expected as the service was co-located with the Y during COVID-19 pandemic. When examined by service user, the reduction in access in 2021/22 was largely due to a reduction in non-street drinkers, whereas the number of street drinkers has remained static.<sup>147</sup> In 2021/22, a decrease in active street drinking clients no longer street drinking was witnessed, at the same time as an increase of active street drinking clients showing a major reduction in street drinking. Historic data has shown these indicators have tended to show an inverse relationship.<sup>147</sup>

Figure 117: Trend of number of attendees accessing No. 5, 2020/21 – 2021/22<sup>147</sup>



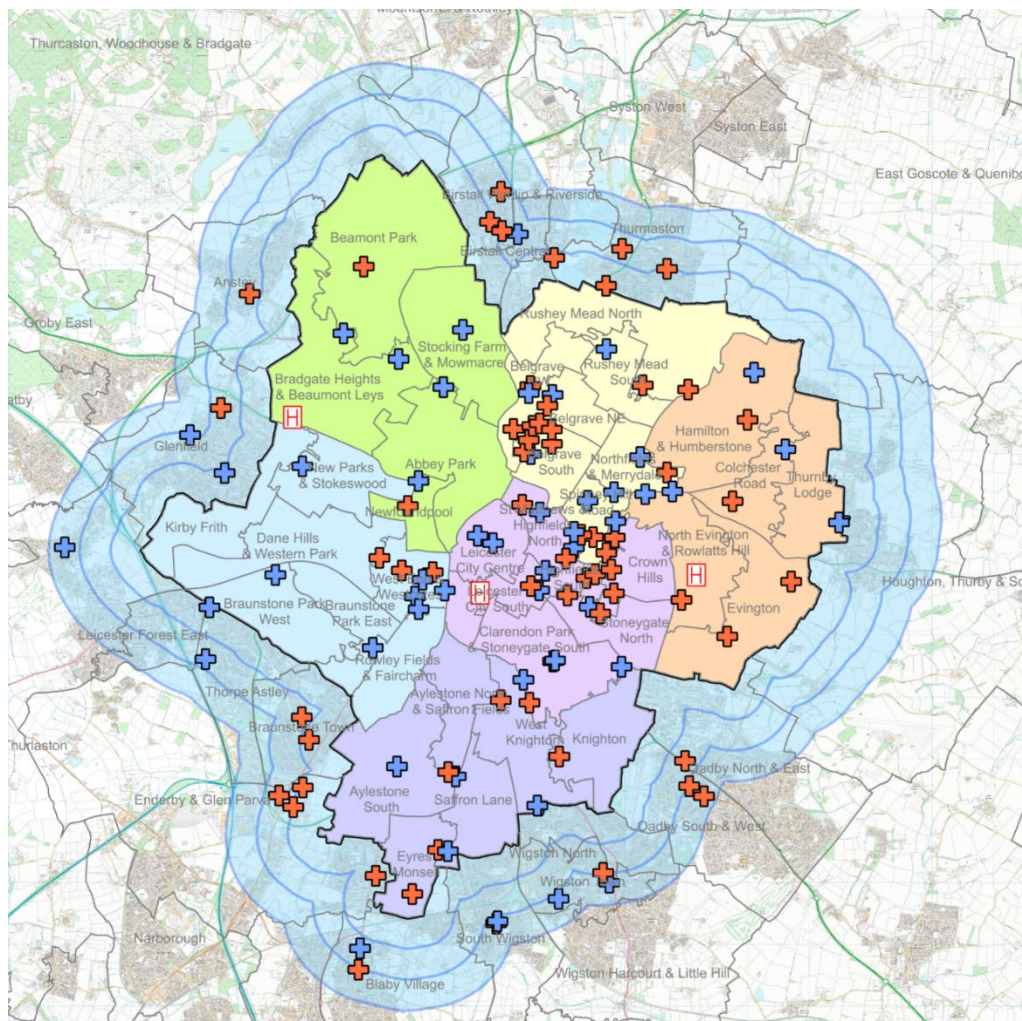
- There is a developing recovery community in Leicester City, in particular through the work of “**Dear Albert**”, which develops mutual aid facilitation through its ‘you do the MAFs’ (Mutual Aid Facilitation) courses, and more recently through ‘SPEAR’ that provide welfare advice. This community is independent of treatment services but is commissioned by Turning Point.
- **Hospital Liaison Team for Alcohol** services: This service is delivered by Turning Point and aims to work with patients attending secondary care for urgent and planned care, who are identified as harmful or dependent drinkers or those who attend as a direct result of alcohol related harm. The team provides specialist assessment and intervention, as well as initiating a supportive treatment plan and a referral into community based alcohol treatment services for post

discharge specialist support when required. Close management of patients who are identified as “frequent attenders” is also examined.

- **Supervised Consumption:** Supervised consumption services are for drug users and aim to ensure compliance with the agreed treatment plan by dispensing prescribed medication in specified instalments. It ensures each supervised dose is correctly administered to the patient it was intended. It also allows close monitoring of the patient’s response to prescribed treatment; for example if there are signs of overdose, if the patient appears intoxicated or when the patient has missed doses. It helps reduce the risk to local communities by the overuse or underuse of medicines and diversion of prescribed medicines onto the illicit drugs market. This service is managed by Turning Point through its contracts with pharmacies.

As of 2021/22 supervised consumption services are offered at 43 pharmacies across the city and 11 within 1.5km of the boundary, as shown in the map below (Figure 116).

Figure 118: Pharmacies accredited for Supervised consumption services in Leicester in 2021/22



### Pharmacies providing a Supervised Consumption Service in Leicester and surrounding area

**Supervised Consumption Service 2022**

- + Supervised Consumption provided (54)
- + Supervised Consumption not provided (64)

**Locality**

- Central
- East
- North
- North West
- South
- West

H University Hospitals of Leicester

0.5km buffer

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### Data: Turning Point

Table 22 below shows the uptake of supervised consumption services during April 2021-March 2022 in Leicester. There were over 73,700 dispenses of the service across pharmacies in the city. The highest uptake of the service is in the centre of the city, with over 29,200 dispenses here during the 12 month period. The lowest uptake is in the south of the city where there were just over 3,700

dispenses within the same time period. All locality areas of the city are represented by at least four pharmacies offering the supervised consumption service.

*Table 23: Supervised consumption service dispenses by locality area (April 2021 –March 2022)*

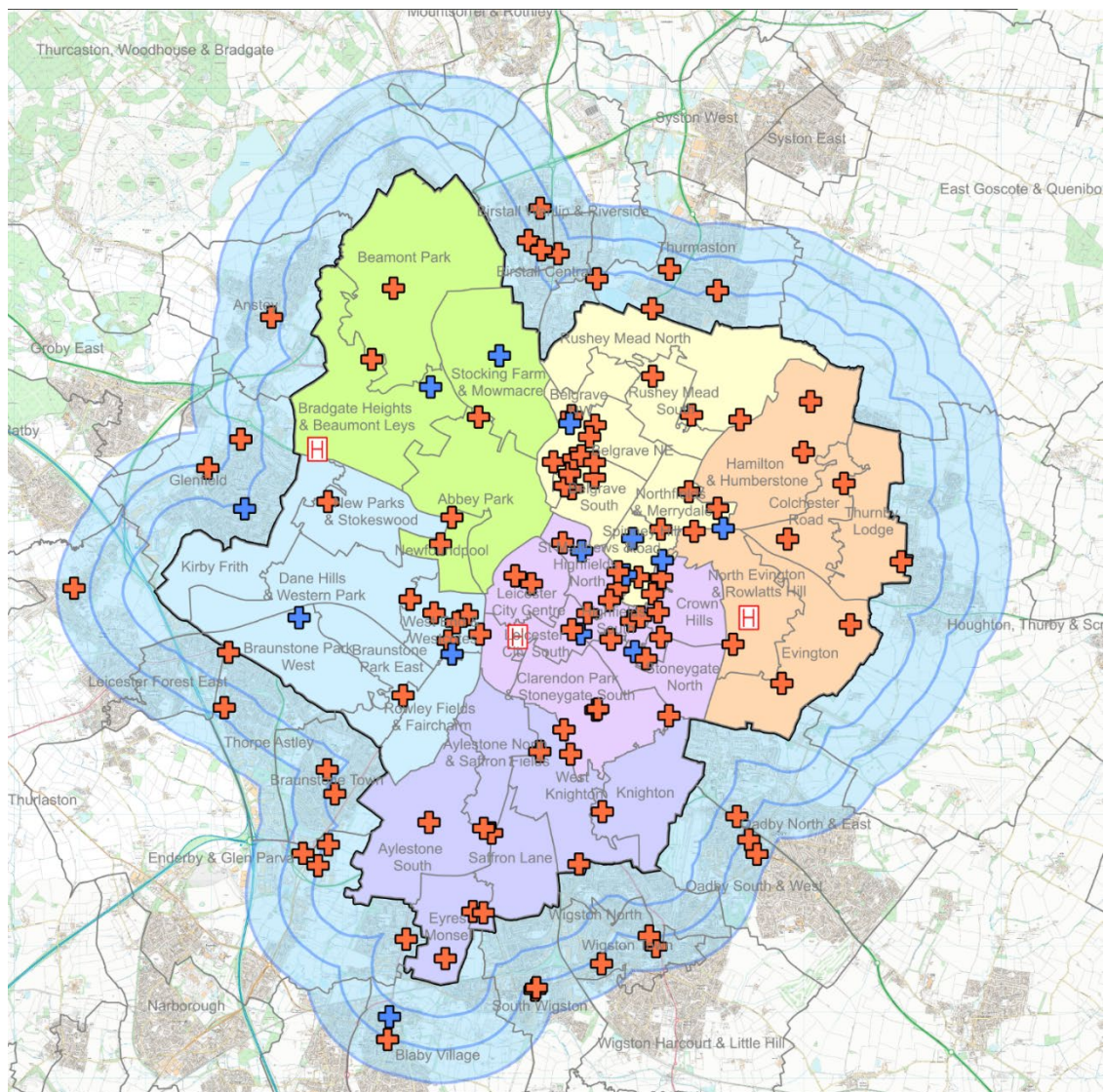
Locality Area	Number of Pharmacies	Number of transactions
Central	11	29209
East	5	4735
North	9	8500
North West	4	12043
South	6	3716
West	8	15520
<b>Leicester Total</b>	<b>43</b>	<b>73723</b>
Distance from Leicester boundary	Number of Pharmacies	Number of transactions
0km to 0.5km	2	3417
0.5km to 1km	4	2171
1km to 1.5km	5	2055
<b>Total within 1.5km of Leicester</b>	<b>11</b>	<b>7643</b>

- **Needle Exchange:** Pharmacy needle exchanges aim to reduce the rate of sharing and other high-risk injecting behaviours by providing sterile injecting equipment and other support, as well as ensuring the safe disposal of used injecting equipment. Pharmacy needle exchange facilities are available to all adult injectors who are using drugs illicitly. This service is managed by Turning Point through its contracts with the pharmacies.

As of 2021/22 needle exchange services are offered at 14 pharmacies across the city and 2 within 1.5km of the boundary, as seen in the map below (Figure 117).



Figure 119: Pharmacies accredited for Needle exchange services in Leicester in 2021/22



## Pharmacies providing a Needle Exchange Service in Leicester and surrounding area

### Needle Exchange Service 2022

- + Needle Exchange service provided (16)
- + Needle Exchange service not provided (102)

### Locality

- Central
- East
- North
- North West
- South
- West

H University Hospitals of Leicester

0.5km buffer

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Data: Turning Point

Needle exchange services are offered at hubs and pharmacies in Leicester, pharmacy needle exchange services account for 87% of transactions in the city. Table 23 below shows the uptake of needle exchange services in pharmacies during April 2021-March 2022.

As shown in Table 23, there were over 16,900 transactions for needle exchange services in pharmacies in Leicester in 2021/22. The highest uptake of the service is in the centre of the city, with over 7,200 transactions during the 12 month period. The lowest uptake is in the east of the city where there were 0 transactions for the same period.

*Table 24: Pharmacy needle exchange service transactions by locality area in Leicester (April 2021 –March 2022)*

Locality Area	Number of Pharmacies	Number of transactions
Central	3	7241
East	0	0
North	5	1378
North West	2	1294
South	1	989
West	3	6022
<b>Leicester Total</b>	<b>14</b>	<b>16924</b>
Distance from Leicester boundary	Number of Pharmacies	Number of transactions
0km to 0.5km	1	868
0.5km to 1km	1	95
1km to 1.5km	0	0
<b>Total within 1.5km of Leicester</b>	<b>2</b>	<b>963</b>

- **Recovery communities** help support recovering from drug and alcohol addiction through a range of activities such as therapy, counselling, peer mentoring, employment training and social activities. Alcoholic Anonymous, Narcotics Anonymous and Spinney Hill Drug Alcohol and Recovery support all provide support in the city. Recovery networks are available for certain population groups, for example the Sikh Recovery Network.

Figure 120: Trend of number of service users receiving accommodation and floating support, 2020/21 – 2021/22<sup>147</sup>

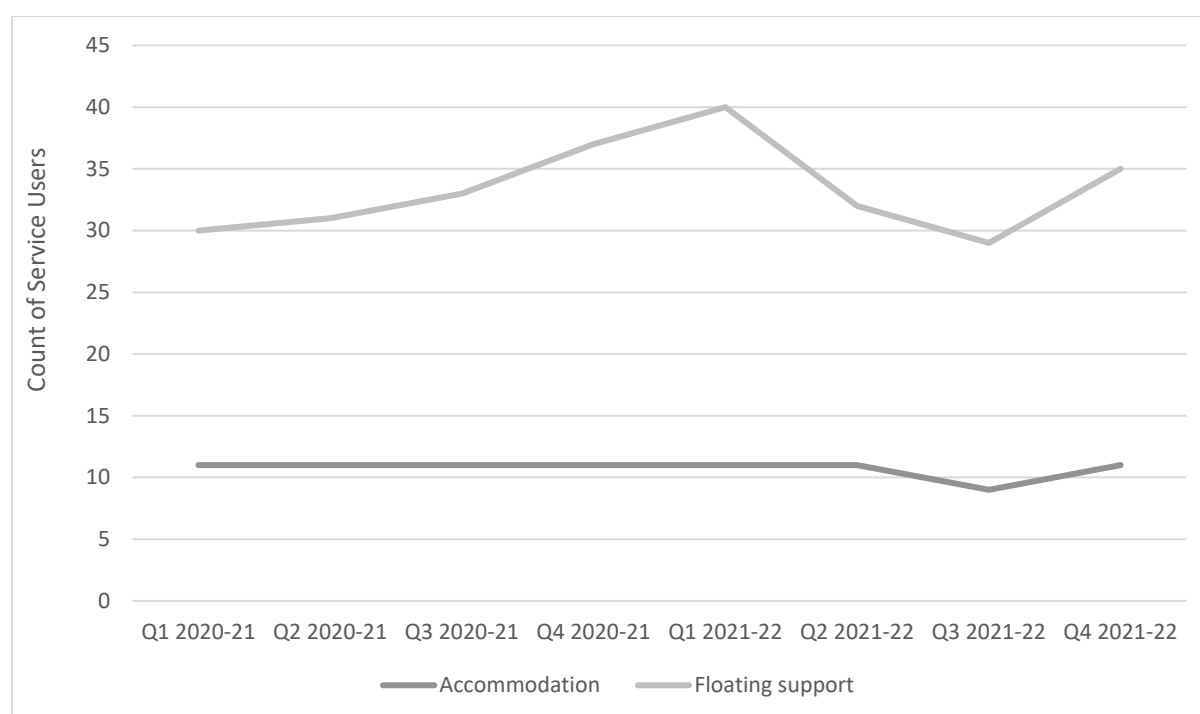


Figure 118 shows the number of people accessing the service has reduced slightly between 2020/21 to 2021/22. For accommodation-based support, the introduction of a live in volunteer role reduced the capacity from 11 service users to 10. The service experienced a reduction of referrals into the service between Q1 to Q3 2021/22; this had a more significant impact on the floating support element (as accommodation-based service has a slower throughput).<sup>147</sup>

Additional indicators show that three accommodation-based service users and three floating support service users reported increased independence and increased health and wellbeing in Q4 2021/22. Furthermore, three accommodation-based service users and two floating support service users were supported to successfully gain secure housing in this same quarter. It is important to recognise the important and lifechanging interventions this service supports.<sup>147</sup>

Latest data from Q1 2022/23 shows the numbers of individuals accessing accommodation-based support (11) and floating support (39) remained largely static, due to maximising the number of commissioned beds. There was a total of 12 planned exits from the service which supports the increased patient flow through the service.<sup>147</sup>

- **Unity House** provide by Home Group is an accommodation service that houses up to eleven people in two shared accommodation properties on two sites. It provides one to one support from a dedicated link worker, structured support and activities are designed to support people



to recover from and drugs and alcohol or who wish to continue their abstinence. In addition, there is also support from Progress House which is based in the community, offering more independence whilst still benefiting from a wider support system.

## 15. Stakeholder Engagement

### 15.1. Young Adults

A focus group was conducted with a total of 14 participants (eight women and six men) attending De Montfort University in Leicester City. Seven participants (two women and five men) actively engaged in the conversation. The participants were recruited from an email invite by the Welfare Executive Officer from the Student Union of De Montfort University. Notes from the focus groups were taken by a scribe and the resulting data was thematically analysed.

#### 15.1.1. Availability of substances

Participants from the focus group reported that drug and alcohol consumption in the student population was associated with partying or clubbing. One participant stated ecstasy was *“going around at the moment and in quite high demand.”* A concern was voiced around the inability to control consumption once under the influence and individuals are not aware how much they consume, with one participant stating they have witnessed an drugs overdose because of this. It was widely agreed the use of these substances was *“as an escape”* from the pressures of education.

The focus group highlighted novel ways were used by sellers to avoid detection when promoting drugs, with Nitrous Oxide disguised as whipped cream canisters. For those who were seeking out drugs, access was regarded as straightforward. Participants were targeted on the street and offers of home deliveries in the middle of the night were available. Multiple participants agreed it was widely known among the student population the location of flats/house selling drugs but fear of persecution prevented individuals from speaking out.

#### 15.1.2. Accessing Professional Support

When students were asked where they would seek support if they needed emotional or health support, all respondents stated they would discuss with friends or family. *“Reaching out”* as the first stage of support was seen as the hardest part of the journey. No participants stated they would go to a General Practitioner for support due to current waiting times in the system and the perception that the GP would not be trained to meet their needs, nor would they understand them.

## 15.2. Service Users

Another focus group was conducted with a total of eight participants (five women and three men) with a history of substance use living in Leicester City. Five participants (four women and one man) actively engaged in the conversation. The participants were recruited from attendance at a drop in session at an addiction rehabilitation centre (Dear Albert) in Leicester. Notes from the focus groups were taken by a scribe and the resulting data was thematically analysed. Barriers and successes were identified.

### 15.2.1. Successes of services

The consensus of opinion for treatment services was very positive. One participant stated *“Turning Point is brilliant”* whereas another described her detox experience as *“such a good service.”* The Stairway Project was seen as of paramount importance for peer support, where individuals share stories and help each other in their recovery journey. One participant shared *“I feel better in myself here than anywhere else.”*

### 15.2.2. Barriers to services

Analysis of the focus group data showed that a barrier to receiving treatment was a perception of a long waiting time and the requirement to undertake a prescribed treatment process (e.g group treatment prior to commencing an individualised plan). The duration of this process was seen as an unrealistic task for individuals with extremely chaotic lives, like rough sleepers. The need of having a mechanism for re-engagement with services if a user drops out mid-treatment was also raised as there was no inclination to engage in treatment if you are required to start at the beginning again. Flexibility of treatment plans and the ability to “fast-track” individuals with the greatest need were suggested as an option to investigate.

The group acknowledged that many individuals with addiction issues have mental health disorders. One participant identified the lack of support for her mental health condition when undertaking a detox. She shared that one nurse supported her *“but the rest just left me, they said that they weren’t there for mental health.”* Fragmentation of services was also discussed as it was felt that mental health services, the community treatment service and the detox treatment organisation were not working together for this individual during and post detox.

The awareness of services supporting substance use disorders was seen as a limitation of access by the group. One participant who was new to substance use support, stated *“I am willing to take advice, but I just don’t know where to get it.”* Another participant described the only way they learnt about substance use treatment services was via a personal internet search. TV or radio advertising was suggested to improve awareness in the population; however it was acknowledged that stigma

may be the reason why universal advertising was not heavily promoted. A participant stressed the importance of raising the profile of treatment services in the public's knowledge for when individuals want to initiate support.

Barriers to receiving housing support were also identified. One participant, a homeless elderly man, attended the Dawn Centre to be told he wasn't a priority and signposted to Dear Albert instead, leaving him with no immediate shelter.

### 15.3. Providers

Semi-structured interviews can be a productive way to collect open-ended data from participants. This method of research was used to inform the Drugs and Alcohol Needs Assessment as semi-structured interviews with professionals and providers of substance use services were undertaken to recognise the facilitators, barriers and gaps in the current substance use system. This gave the opportunity to capture "felt" need from the participants. The ten questions all participants were asked are available in Appendix 4 and the organisations represented in the interviews are available in Appendix 5. Following the interviews, the transcripts were reviewed and descriptive themes applied to the data before further condensing to look for patterns. The findings are discussed below.

#### 15.3.1. Prevention opportunities

Almost all participants identified the populations engrained in substance use were likely to be from a troubled background. Users may have had difficulties in their childhood, such as trauma, abuse or neglect. These individuals were likely to be looked after children, from very deprived backgrounds or have a criminal past.

Furthermore, users may not be living in a safe environment or in extremely poor living standards. Access to food may be limited and some individuals require extensive support to undertake life tasks, such as paying bills, applying for benefits etc. All participants interviewed recognised their role far extended past their job description, whereby to support with any task that was needed on that day. The aim of the professionals is to work towards a long-term outcome of a lifestyle shift for the client and their families.

The multi-faceted approach to primary prevention in substance use disorders requires tackling the wider determinants of health as *"unless you've explored all those avenues, you'll never going to get to the crux of the problem."* Housing support was identified as a key barrier. In Leicester City, the Dawn Centre offers temporary accommodation for individuals in need; however, many participants identified the Dawn Centre as being an unattractive option. One participant stated the *"majority of*

*them will say I'll sleep outside than go to Dawn Centre*" as the reputations of the Dawn Centre shared included *"drug using, violence and even rape."*

As an alternative for the Dawn Centre, one participant stated some users were offered temporary hotels *"that are rubbish and with other rubbish people."* There was concern raised that users were housed together, ensuring it is harder for users to disassociate themselves from the engrained behaviour of the substance use community. Additional needs for housing support were identified for all substance users, but particularly prison leavers and those with alcohol issues (to include a wet room).

The importance of involving the recovery community in identifying the cyclical pattern of users and creating an awareness that prevents relapse and promotes recovery, supports secondary prevention efforts. If services did not engage and utilise this community, it was highlighted a gap in provision would exist. Furthermore, participants identified the importance of understanding the cyclical pattern of users and using their own professional knowledge to recognise what interventions were appropriate given the user's current state of behaviour.

#### 15.3.2. Barriers to engagement

Intrinsic motivation of the service user was reported as the key reason for lack of engagement with substance use services or professionals. There was an understanding from all participants that the behaviour change or motivation must come from the service user: *"It's on them at the end of the day, it's that you can only offer the support. It's whether they take it or not."*

Participants also described service users entrenched behaviour and the unwillingness or want to make a change. An example discussed was a patient entering an acute service for treatment due to an overdose and *"rather than learning from their behaviour, they're kind of say I'll see you next month when I get my next round."* However, due to this cyclical behaviour, a participant described that professionals may stigmatise users and not always refer users into treatment services. This infers the supportive mechanism for change may not being offered to all in need.

Furthermore, the chaotic behaviour of individuals who were using was seen as a barrier of engagement with services. It was identified a large proportion of these individuals were likely to be homeless, with challenging circumstances and may have been excluded from services in the past. The behaviour identified could be as extreme as *"trashing a place or making threats to people"* which would make engagement with professional services unlikely as *"the chances of them complying by the rules are pretty slim."*

Participants identified that due to the chaotic lifestyle of users, flexibility of treatment plans is essential to ensure continued engagement. It was described as “*quite unrealistic*” for individuals to keep multiple appointments with many organisations. Specifically, the process of starting Opioid Substitution Treatment (OST) was seen as long-winded and jumping through hoops, when in comparison, a user “*can just go and raise and then go and score.*” However, the professional perspective wholly understood the safeguarding rationale for this process.

Lack of trust from young people with services and professionals was identified as an additional barrier for lack of engagement by this population. Working closely with the user, to understand their specific barriers, is essential to tailor support and provide a higher likelihood of engagement with services.

### 15.3.3. Improving access and the treatment pathway

Service provision catering to sub-populations, explicitly the Polish population, were identified of needing better access to services. Despite this, strong partnerships were identified with the Somali community and with extended families, such as Mother’s Groups.

Multiple participants identified waiting times to access services as a major barrier for treatment. Due to the chaotic nature of some users lives, being able to access treatment services quickly when they are engaged and ready to change was discussed frequently. Waiting lists for community treatment and for detox or rehab was described as up to four weeks and up to six months respectively. It was deemed very unlikely that users would be able to sustain their level of motivation for change by the time treatment services could see them. The effect of long waiting times was also suggested to place additional demands on the wider health system, such as Accident & Emergency. One mechanism proposed, was having the option to “fast-track” users through a pathway of treatment. It was also raised the need of having a mechanism for engagement for services if a user’s health status declines rapidly to reduce the impact of this decline.

The high threshold for service entry, particularly for detox, was also identified as a barrier. One participant stated “*quite often we wait until they're about to die and then we send them into a detox.*”

It was recognised that users who are on a treatment pathway are likely to be involved with multiple services and with many health professionals, including those outside of substance use services. Two participants identified the importance of all health professionals receiving training to build their confidence about talking about substance use. It was also raised the importance that professionals are aware of NHS, private and the wider community based services that available to service users

e.g. Crisis cafes. These third sector services may help improve access by reducing NHS waiting lists and helping users receive immediate support.

#### 15.3.4. Reducing fragmentation across the system

The need for partnership working was identified between many participants including community services, health services, criminal justice system, and others. The lack of communication across services was seen as a significant limitation in improving access and treatment pathways. The system was described as having *“no collaborative approach. It's everybody doing silo work.”* A rationale for this fractured system was explained by the commissioning arrangements, as services are separate, distinct from the County Council and over a short-time period which leads to inconsistency and instability.

A key issue of this silo working was the inability for an organisation to take a holistic ownership for an individual's care or wellbeing. Two participants identified the lack of desire to *“open the can of worms”* (the reason for their substance use) due to the short duration a patient spends with a service. Furthermore, another participant identified the emphasis placed on *“quick wins”* throughout the system rather than long term behaviour change.

Suggestions to alleviate this silo working centred around ensuring information sharing agreements were set up across organisations and building the bridges of communication. The Covid-19 pandemic has narrowed the barriers between services as online meetings for a multi-disciplinary professionals meeting are a regular event, whereas pre-pandemic these meetings were onerous due to the need to be in *“one room.”* One participant recognised that information sharing was occurring but only for those most at risk or presenting an extreme challenge. As a preventative measure, information sharing should be used for all patients across the system.

A further suggestion centred around joint care planning and joint risk assessing with services together. This would generate positives for all the professionals involved (e.g. reduction in separate risk assessments) but certainly for the service user. Continuing the process of this shared care approach on a regular basis (e.g. annually) was also suggested as a *“business as usual”* process. It was identified that some agencies initiate this multi-disciplinary meeting regularly and others use it for exceptional circumstances, but none were on a consistent basis. A further suggestion to support shared care arrangements was the development of a *“hub”* of services so users can be supported by multiple organisations in one place.

The prison system was explicitly identified as an area in need and requiring partnership support from wider organisations. The level of substance use in prison is high and due to Leicester Prison being a

remand prison, users are in and out regularly. Prison was therefore seen as an opportunity to start discussing behaviour change, whereby you can *“plant those seeds so if they come in again then we can kind of move on from there with it.”* Further discussions centred around building a strong relationship with the community provider, including supporting prison visits and supervised pick-ups on release. Probation and primary care services were also identified as needing a louder active voice in the substance use system, although stretched capacity was suggestion for reduced engagement.

Participants have highlighted the need of effective integration of treatment and recovery services across the wider health and care systems to addressing substance use and its consequences.

#### 15.3.5. Process vs. Personalisation for service delivery

Many participants identified an operational clash of providing a personalised service to users whilst being confined to organisational process and meeting targets. When dealing with such vulnerable individuals, participants recognised it is important to build trust and a strong rapport, to support users to make an impactful change, however long it may take:

*“if you've got somebody who's entrenched and complex, it can take you a year to get them to make even a very small step. But that small step might save their life.”*

However, it was recognised that it was not always possible as capacity is stretched across the system due to the high levels of demand. One participant compared her constant workload to being *“on a conveyor belt”* and that they *“haven't got the capacity to hold the hand”* of users.

Coupled with a high workload, there was a recognition that the roles in treatment services were changing, with time that used to be spent offering face-to-face appointments now replaced by administration and data collection tasks. Some processes were described as *“a tick box exercise.”* This inability to perform this personalised service is also impacted heavily by the high turnover of staff. Multiple participants discussed the instability in the workforce in treatment services. The training and retention of staff was identified as a key risk for now and in the future.

One suggestion was for senior management to indorse spending the time to deliver a personalised service to support behaviour change. This *“needs to come from top down and for them to have permission to, say, hang on, I'm just gonna stay for another half an hour, if you don't mind. And because the end goal will be more successful.”*

A further suggestion was to provide long term sustainability planning to users and continue to offer support *“to give them a more certain future”* and broaden life aspirations. Suggestions included initiating a post-treatment pathway in the community filled with support and activities to replace

substance use behaviour. For those users that do re-present, it is important that professionals critically examine the reasons for this to aid future learning.

#### 15.3.6. Responding to current and future need

In relation to service provision, the profile of users attending treatment services are changing with a higher proportion of alcohol and poly-substance clients than ever before.

Participants recognised that there are more hospital admissions and deaths due to alcohol than drugs but *“no one ever does anything about alcohol.”* There was also the recognition that the majority of substance use funding is spent on drugs, which is disproportionate to the need, as alcohol is *“the worst problem.”* This identifies the want and need from professionals to examine and support the increasing demand from alcohol comprehensively.

From a preventative perspective, participants identified a lack of engagement of the public to acknowledge the dangers and effects of alcohol as a barrier. As drinking is seen as acceptable and many social situations involve alcohol, this creates a huge barrier in delivering education messages to a receptive audience: *“Now when we talk to them (and) say we’re supposed to drink 14 units a week and then they just laugh and (say) that’s probably an evening”*

The importance of professionals in keeping up to date with new and emerging trends in substance use was stressed by one participant, particularly when working with young people. It was recognised that some professionals *“don’t move with the times”* but that this is essential in staying relevant and knowledgeable in this subject area. Intelligence sharing, particularly from the Police, is vital to ensuring partners keep their knowledge up to date.

It is important that commissioners and providers are adaptable to respond to this changing population of need, now and in the future.

##### 15.3.6.1. Mental health and substance use

Furthermore, it was recognised that substance use and mental health should no longer be viewed as separate entities. Mental health disorders were highlighted as a key reason for starting to abuse substances, often as a coping mechanism and for self-medicating purposes. Barriers identified for dual diagnosis individuals (substance abuse and mental health disorders) included an inconsistent understanding of what to treat first, mental health or substance use, and the limited capacity of mental health teams to take on more patients in a timely manner or provide adequate support for both concerns. Waiting lists for mental health treatment was also raised as longer than average. In addition, it was acknowledged on three occasions the importance of all staff to receive mental health training due to the high prevalence of mental health disorders in substance use populations.



### 15.3.7. Wellbeing of professions

The instability of the drug and alcohol workforce has already been discussed above, along with high workloads and the awareness that most roles were stressful and likely to include some upsetting situations. One participant identified the importance of staff morale and staff mental health when working in these demanding roles. It was noted that monthly counselling sessions for staff are available from one organisation, other organisations may wish to support staff in a similar manner.

## 16. Key Findings

### 16.1. Alcohol consumption and alcohol-related harm

It is difficult to ascertain the number of residents drinking at risky or harmful levels as disparity in the prevalence of reported alcohol consumption exists and the local effect of the COVID-19 pandemic is still unknown. National studies report that alcohol consumption has increased during the pandemic and polydrug use (e.g. alcohol and drugs) is becoming more common. The Leicester Health and Wellbeing Survey (LHWS) reported 5% of the population were drinking at higher levels whereas the Health Survey for England found 21% of adults drinking above 14 units a week. This suggests the estimated burden from higher risk drinking affects between 16,500 to 77,000 Leicester residents. Due to the large sample size and methodological reviews, the HSE is likely to be more reliable and therefore the population engaging in higher risk drinking is likely to be at the upper limit.

Furthermore, the LHWS highlighted 45% of the male adult population and 55% of the female adult population are non-drinkers in Leicester. Despite this, the trend for alcohol specific admissions is worsening and rates have performed significantly worse than national average for the last seven years. Additional indicators examining hospital admissions due to alcohol-related conditions (narrow definition), mental and behavioural disorders due to the use of alcohol and alcohol-specific mortality all perform significantly worse than the national average in males and similar to the national average in females. This is especially concerning as these indicators do not take into account the local drinking behaviour when identifying the population at risk (denominator), therefore due to the high levels of absenteeism in the City, the rates presented are likely to be a substantial underestimate. The high levels of hospital admissions supports the priority of the Leicester City Alcohol Harm Reduction Strategy 2022-27 to encourage a culture of responsible drinking and reduce the impact of associated harm.

Examining small area geography analysis for alcohol-related admissions suggests the highest demand is from students (Leicester City South MSOA) and “most deprived” “white” areas of the city such as Braunstone and Saffron Lane. Hospital admissions for alcohol related conditions reveal the

highest rates are from males across all age bands. When examined by age, the 40-64 age group was the most prevalent followed by 65+ and under 40s.

Rate of hospital admissions for alcoholic liver disease and liver disease perform similar to the national average, however premature mortality from alcohol liver disease is significantly worse. When examining mortality by gender, males had a significantly higher rate of alcohol specific mortality and mortality from chronic liver disease compared to the national rate over the last nine time periods. For both these mortality indicators, females performed similar to the national rates throughout this time.

Local alcohol dependency rates from 2018/19 are significantly higher (1.62%) than national (1.37%) and equate to nearly 6,000 dependent drinkers in the city. Extrapolating local data and findings from OHID, suggest only 10.3% to 18.3% of the population with alcohol dependency are utilising treatment locally.

Participants from the qualitative research highlighted the demand in the system was greatest from alcohol, however the majority of drug and alcohol funding is spent on drugs which is disproportionate to the need. One such reason for this is the treatment duration of opiate users is likely to be longer and will include more expensive clinical OST. Professionals also identified a lack of engagement from the public to acknowledge the dangers and effects of alcohol due to the social acceptability of drinking.

## 16.2. Prevalence of drugs and drug-related harm

The prevalence of substance use in Leicester across young people and adults is difficult to establish. Synthetic modelling suggests there are 2,800 opiate and crack cocaine users in the city, of which there is substantial unmet need (57.1%) of adults who would benefit from treatment, but is out of date. Local prevalence information regarding other drug use or polydrug use must be identified as a gap in knowledge.

Examining the primary diagnosis for drug-related mental and behavioural disorders infers the patterns of drug choice and behaviour is changing in the local population. The proportion of admission episodes due to multiple drug use and use of other psychoactive substances has increased (worsened) significantly whereas the use of opioids has decreased (improved) significantly over the last three time periods. Across the specialist treatment service, the rate of clients in treatment for opiates is four times higher than non-opiates locally. Recent numbers in treatment trends show adults using opiates is declining whereas the demand for non-opiate and non-opiates and alcohol combined treatments are increasing.<sup>148</sup> Throughout the COVID-19 pandemic, despite the number of

referrals declining, the number of clients in treatment for alcohol only and alcohol and opiate treatment increased due to an increase in conversion rates (as telephone assessments commenced). Provisional data for November 2021 – October 2022 shows the number of referrals remain below pre-COVID counts and the conversion rate has declined to pre-COVID levels. This suggests the total number of clients in treatment is likely to decline in 2021/22.

The rate of deaths from drug poisoning in Leicester have increased over the last three time periods, with the rate of increase faster in males than females. Local rates have remained similar to the national average throughout this time.

### 16.3. Impact on young people

At a national level, the prevalence of any drug use in the last year was highest amongst 16 to 19 year olds and 20 to 24 year olds (21.1% and 21.0% respectively). The local School Health Education Unit (SHEU) survey reveals around one in ten secondary school aged children reported that they have been offered drugs. Children living in the West of the city, of White British ethnicity, have poor mental wellbeing, a long term illness or special educational needs were significantly more likely to have been offered drugs than the rest of the population.

A significantly high proportion of secondary school children (12-15 years) surveyed in Leicester (59%) last drank alcohol with their parents/carers compared to other routes. Evidence infers parental supply of alcohol is associated with increased risk of drinking. The percentage of pupils suspended from school due to drug and alcohol issues is increasing at a faster rate locally compared to nationally.

The number of young people entering specialist treatment services has witnessed a declining trend at both a national and local level. When examining newly presenting young people to treatment, the counts have declined from 75 to 11 between 2018/19 and 2021/22 and the rate has reduced faster compared to nationally (-81%, -55%). Latest Liaison and Diversion data has highlighted 48 youth cases with suspected substance or alcohol misuse only and 16 youth cases with suspected polydrug use in 2021/22. This disparity in counts identifies a potential population with a treatment need not being served.

Despite this, in Leicester, 2.2% of adults starting a new drug misuse treatment journey in 2021-22 were pupils/students, this is a significantly higher proportion than those starting treatment across England (1.0%). Further investigation is necessary to understand why this percentage is high, while the numbers of young people in treatment is declining.

#### 16.4. Treatment Profile

The populations engrained in substance use were at risk of being from a troubled background, such as difficulties in their childhood, including trauma, abuse or neglect. These individuals may have been a looked after children, from very deprived backgrounds or have a criminal past. National evidence has highlighted gay and bisexual men and lesbian and bisexual women have higher rates of drug use within the last year compared to heterosexual men and women. Women who experience domestic abuse or are sex workers also have an increased risk of using substances.

Clients in treatment for either alcohol only and drug treatment were significantly more likely to be male and aged 35-39 years than compared to the national treatment profile. When ethnicity is examined, a significantly higher proportion of Asian and Mixed ethnicities accessed alcohol only and drug treatment compared to nationally. This is likely to reflect the high ethnic mix in the Leicester population. The percentage of clients accessing alcohol treatment as a proportion of the estimated population drinking at harmful levels were not significantly different across White, Asian and Black ethnic groups. This may reflect that some population groups, may find it harder for individuals to recognise a problem or be comfortable in seeking support. Qualitative research discussed the importance of recognising cultural barriers and associated stigma that may exist with regards to substance use across population groups.

The rate of admission episodes with a primary diagnosis of drug poisoning by illicit drugs was significantly higher in the most deprived quintile. Furthermore, admission episodes for alcohol-specific conditions in Leicester were significantly higher (worse) in the most deprived quintile than in the other quintiles. The population living in the most deprived area represents an opportunity to focus support.

A significantly larger proportion of adults starting a new alcohol only or drug treatment journey in Leicester in 2021-22 were unemployed and not seeking work than in England overall. Despite this, just over one third (34.7%) of alcohol only clients and a fifth (20.7%) of drug treatment clients in Leicester were in regular employment at the start of their treatment journey in 2021-22 which underlines the working population is an area to target. A significantly large proportion of those in both alcohol only and drug treatment in 2021-22 were recorded as parents in Leicester compared to England.

Of the total number of new drug treatment journeys in Leicester in 2021/22, almost half (46.3% and 46.5%) had been offered a hepatitis B and hepatitis C intervention but had refused. Although these percentages are not significantly different to the proportion in England (39.3% and 43.4%), this cohort represents an at-risk population potentially living with an undiagnosed infection.

## 16.5. The drug and alcohol system

Fragmentation of the drug and alcohol system was highlighted as a key concern across the qualitative engagement exercises. The lack of communication across services was seen as a significant limitation in improving access and treatment pathways. The inability for an organisation to take a holistic ownership for an individual's care or wellbeing was felt to have led to an emphasis placed on "quick wins" throughout the system rather than long term behaviour change.

Across the health and care system, individuals with coexisting severe mental illness and substance use should be an area of focus, with professionals reporting these diagnoses should no longer be viewed as separate entities. Mental health disorders were highlighted as a key reason for starting to abuse substances, often as a coping mechanism and for self-medicating purposes. Of all individuals starting alcohol only treatment, two thirds (69.4%) were identified as having a mental health treatment need, but a third (33.8%) were not receiving any treatment. This percentage not receiving treatment is significantly larger (worse) than the national proportion of a fifth (21.2%). Furthermore, admissions for drug-related mental and behavioural disorders are increasing and have doubled over the last three time periods. Latest data shows the local rate is highest (worst) compared to local comparators and the national rate.

The multi-faceted approach to primary prevention in substance use disorders requires tackling the wider determinants of health. A significantly higher proportion of clients in alcohol only and drug treatment programmes reported having a housing problem compared to nationally. This is an area of need that was highlighted extensively in the qualitative research.

Waiting times to access services was identified as a major barrier for treatment by professionals and service users in the engagement work. However, the latest statistics from the community treatment provider shows the proportion of individuals receiving their first interventions within three weeks of referral for alcohol only, non-opiate only and alcohol and non-opiate only treatment was 100%. For opiate only treatment, this proportion was 98.5%. Further investigation is required to understand the local concerns.

Professional engagement recognised that treatment and recovery includes remission and relapse as the norm, however treatment pathways are not conscious to this process. Performance metrics for drug and alcohol services often do not always demonstrate the full positive impact nor take account of the concept of "relapse" throughout the treatment journey. An example of this is the successful completions Key Performance Indicator.

A significantly higher proportion of adults entering alcohol only treatment and drug treatment due to opiate use left treatment in an unplanned way compared to England. Successful completions for alcohol only and non-opiate treatment performs significantly lower than that of England, whereas opiate treatment performs similar to the national average, but the latest data represents a 5.3% success rate only. It must be acknowledged the importance of retention, whereby being in treatment can be seen as a safer option for many clients, but further investigation is needed to understand the local difference compared to national performance for this indicator. Professionals identified reasons for lower successful completions due to the entrenched, chaotic behaviour of users and the unwillingness or want to make a change. Flexibility of treatment plans was regarded as essential to ensure continued engagement with users.

Latest data from 2020-21 reveals the proportion of adults in contact with both a Criminal Justice Integrated Team and the community-based treatment system was significantly larger than the national average for both drug and alcohol treatment. Furthermore, referrals to new drug or alcohol treatment journeys in Leicester in 2021-22 through criminal justice sources was significantly larger than the proportion of referrals through this source in England. This represents an area of good practice and an opportunity for system-wide learning. In contrast, the proportion of referrals from the individual themselves, their family and their friends was significantly lower than the England percentage in 2020-21. Understanding the barriers for this is important to increase the reach of all treatment services.

To ensure the crime reduction benefits of treatment can be realised, there must be robust and integrated pathways between prison and community-based treatment. Feedback from professionals suggest further work is required to strengthen this pathway. Latest data from July 2021 to June 2022 shows 33.1% of adults with substance use treatment need successfully engaged in community-based structured treatment following release from prison, a similar percentage to nationally (37.4%).

The proportion of admission episodes with a primary diagnosis of poisoning by illicit drugs from the adverse effect of and underdosing of other opioids (T402) increased significantly from 31.5% to 45.7% between 2012/13-2014/15 and 2018/19-2020/21. To combat this, work should focus on enhancing harm reduction provision such as increasing the availability of Naloxone. Latest data from 2021-22 shows the proportion of opiate clients in treatment administered with naloxone to reverse the effects of an overdose or had been administered with naloxone to reverse the effects of an overdose in the last 6 months was twice as high as the national proportion (45.2% compared to 21.1%). This represents a level of need in the community. Future work should focus on exploring the extended provision and training of Naloxone with partner organisations.

## 17. Gaps

The prevalence of substance use in Leicester is difficult to establish, with estimates for with higher risk alcohol consumption particularly wide ranging. Synthetic modelling indicates that there is substantial unmet need for individuals who would benefit from a substance use intervention, particularly regarding alcohol. Furthermore, the impact of the COVID-19 pandemic has been difficult to distinguish at local level due to data availability and represents a knowledge gap.

Referrals to new drug or alcohol treatment journeys through criminal justice sources represent a significantly larger proportion than nationally in Leicester. However, little is known who come into contact with other services such as Accident and Emergency Departments, primary care, maternity services, mental health services, and homeless and housing services. This may be due to the lack of current systematic process for sharing existing data between partner agencies to provide an overview and basis for action to tackle substance use strategically.

National surveys highlight that reported drug use is highest among 16-19 and 20-24 year-olds. The number of young adults in treatment is declining and under 25 year olds represents only 7.3% of all clients in adults only drug treatment. Data also indicates that “Asian” and “Black” ethnicity groups are underrepresented in alcohol treatment. Both these sub-populations may represent a potential gap of treatment provision in our local population, however further investigation is needed to understand local behaviour.

Serious incident (SI) reporting from the specialist treatment provider gives further information on drug-specific deaths (e.g. overdose), however SI reporting is not required for drug-related deaths which may represent a gap in local knowledge. The role of the newly reinstate Drug Related Death Panel for Leicester, Leicestershire and Rutland may help to fill this potential void but should be investigated further.

NICE Guideline states that behavioural couples therapy should be considered for people who are in close contact with a non-drug-misusing partner and who present for treatment of stimulant or opioid misuse. This intervention is not currently commissioned by Leicester City. Further work is required to understand why this intervention has not been invested in.

## 18. Recommendations

### 18.1. Prevention

A combination of interventions are needed to reduce alcohol-related and drug-related harm to the benefit of society as a whole.

### 18.1.1. Alcohol

- Greater population gain will be obtained by achieving a small reduction in alcohol misuse within the large group of "risky" drinkers. Across health and social care (primary and secondary care), the system should ensure all frontline staff are embracing Every Contact Count (MECC) principle where by conversations about drug and alcohol use are discussed at every healthcare contact.
- Identify support pathways for individuals drinking at harmful levels but not requiring treatment, including the role of the Council's live well healthy lifestyle service and digital interventions.
- Utilise a population management approach to implement targeted interventions, for example offering Information and Brief Advice (IBA) and specialist treatment to:
  - higher risk drinkers in Leicester City South, Braunstone in the West and Saffron Lane in the South of the city
  - areas where evidence infers abstinence is the lowest (e.g. least deprived areas)
- Alcohol consumption has increased during the pandemic and polydrug use (e.g. alcohol and drugs) is becoming more common. At a population level, public health should explore utilising the community health champions to reduce stigma and challenge social norms of population groups (including religious organisations and young people) relating to self-medicating and experimenting with substances and alcohol. Furthermore, we must ensure services respond effectively to drug users who also misuse alcohol.
- The trend for alcohol specific admissions is worsening and rates have performed significantly worse than national average for the last seven years. Alcohol specific mortality and alcohol related mortality continue to perform significantly worse than the national average. Prevention work should continue to focus on reducing ill health and deaths from alcohol.
- Both nationally and locally the rate of alcohol-specific hospital admissions was highest with no prior admission in the preceding 24 months, followed by three or more prior admissions. Interventions should be considered for those admitted with two prior admissions to reduce the likelihood of becoming regular attenders.

### 18.1.2. Drugs

- The CSEW has highlighted that as drug use decreases, life satisfaction increases. Work should focus on ensuring commissioned services support recovery and help address the wider factors that reinforce dependency, including housing, social care needs and family support.



### 18.1.3. Population Groups

- The populations engrained in substance use were likely to be from a troubled background, such as trauma, abuse or neglect. Commissioners should support trauma-informed approaches and building resilience in young people and families at risk of substance use through skills training designed to increase resilience and reduce risk.
- National evidence has highlighted gay and bisexual men and lesbian and bisexual women have higher rates of drug use within the last year compared to heterosexual men and women. However, in Leicester the majority of individuals in treatment for drug use described themselves as heterosexual (93.4%). Work should be prioritised to understand if unmet need exists with regards to population in gay/lesbian or bisexual sexual orientation locally.
- Women who experience domestic abuse or are sex workers have increased risk of using substances. Tailored support should be in place for these women with clear referral pathways into treatment (e.g. through New Futures).
- A significantly larger proportion of those in alcohol only treatment (36.5%) and drug treatment (31.6%) in 2021-22 were recorded as parents in Leicester (36.5%) than in England (30.5%; 27.3%). We should continue to develop closer working between our early help and social care teams and alcohol treatment services to increase accessibility and visibility of services for parents to get the help they need to address alcohol issues. Furthermore, there is an opportunity to work with children in these families to provide preventative messages and support.
- Just over one third (34.7%) of alcohol only clients and one fifth (20.7%) of drug treatment clients in Leicester were in regular employment at the start of their alcohol only treatment journey in 2021-22. This highlights the need and the importance of workplace health in promoting available health services to staff.
- Furthermore, a significantly larger proportion of adults starting a new alcohol only or drug treatment journey in Leicester in 2021-22 were unemployed and not seeking work than in England overall. For these individuals in treatment, Individual Placement and Support (IPS) should be promoted for those seeking work.

### 18.1.4. Wider Determinants and Environment

- It is clear that substance use has complex biological and social determinants. It is important that prevention programmes are evidence based and target these determinants, as well as adverse experiences.

- Housing has been noted as a rising concern, particularly for individuals in drug and alcohol treatment. Work should be prioritised with housing colleagues to examine the barriers in accessing support for those with an urgent housing problem.
- In Leicester, where there is high level of deprivation, alcohol outlet density is likely to be a particular pertinent issue and further understanding of our population's environment is required.

## 18.2. Young People

- A significantly high proportion of secondary school children (12-15 years) surveyed in Leicester (59%) last drank alcohol with their parents/carers compared to other routes. Evidence infers parental supply of alcohol is associated with increased risk of drinking. A communication plan to ensure parents and guardians are aware of the health harms of alcohol to children should be instigated.
- Around one in ten secondary aged children reported that they have been offered drugs, with a significantly larger proportion in the 14-15 year age group than the 12-13 year age group. The number of 15 year olds and 16 years olds in treatment is low. The secondary school population should be targeted with health promotion messages, support pathways (e.g. REACH) or referrals into treatment if required.
- The national prevalence of any drug use in the last year was highest amongst young people (16- to 24-year-olds). This does not align with the declining number of young people new to treatment. To combat this, work is needed to optimise screening and referrals in children and young people's services to ensure all those at risk are identified. This work should strengthen the connection between treatment services, schools and other CYP services so that direct referrals can be made.
- The community treatment service should trial using behavioural insight methodology to support individuals to recognise they may have a substance problem and engage with treatment services.
- It is important for service planning that emerging substances, such as cannabis edibles, LEAN, Nitrous Oxide should be discussed when educating young people about dangers of drug use, and planning for some young people requiring prescribing as part of their treatment. Continuous liaison with the Police is needed to keep this information up to date.
- The percentage of pupils suspended from school due to drug and alcohol issues is increasing at a faster rate locally compared to nationally. Schools are an important part of any young people's drug strategy, for building resilience, for early prevention, to identify substance use and refer into specialist treatment services. Ensuring that schools are adequately trained to

assess children and young people vulnerable to drug misuse and staff should be aware of what services and treatment options are available for pupils that may be struggling. This includes empowering school staff to deliver alcohol IBA where appropriate with young people, such as through the school nurse workforce.

- In Leicester, 2.2% of adults starting a new drug misuse treatment journey in 2021-22 were pupils/students, this is a significantly higher proportion than those starting treatment across England (1.0%). Further investigation is necessary to understand why this percentage is high, while the numbers of young people in treatment is declining.
- The stakeholder engagement exercises with students and professionals highlighted the lack of trust from young people with healthcare workers, due to the perception that professionals will not understand and relate to their needs. To combat this, young people should have a consistent support worker, who has the time to build a relationship where the young person feels believed and understood. The co-location of specialist young people treatment workers with other services (in a hub) is likely to naturally increase contact time with young people and build relationships.

### 18.3. Commissioning and Service Delivery

- Mental health and substance use needs should be addressed in both drug and alcohol and mental health services. Commissioners, providers and partners of mental health should build upon the pilot mental health/drug and alcohol pathway in the community treatment provider, including an evaluation of its delivery. Further funding should be sought to expand this pilot if the evaluation reports favourable outcomes.
- Work should be prioritised across the system to reduce the high rates of admissions from mental and behaviour disorders due to alcohol in Leicester. This should include working with commissioned treatment services to meet the needs of Leicester's population, including those with dual diagnosis.
- Work with our treatment providers and partners to increase referrals into treatment and to increase numbers accessing and successfully completing treatment:
  - Multiple participants identified waiting times to access services as a major barrier for treatment. Public health should investigate the waiting time for each specialist service and the support given to clients while waiting to move to their next stage of treatment.
  - For both drug and alcohol treatment, the proportion of referrals from the individual themselves, their family and their friends was significantly lower than the England percentage in 2020-21. Understanding the barriers for this is important. Future work

should focus on improving the awareness of available services in the general public (and workplaces) and hard to reach populations.

- A significantly higher proportion of adults entering alcohol only treatment and drug treatment due to opiate use left treatment in an unplanned way compared to England. Further work is needed to understand why this is happening and what the triggers are.
- The pathway from leaving prison and entering community treatment is essential to breaking the cyclical pattern of behaviour. Currently uptake is low. Investigation of pre-release protocols and the subsequent pathway should be formally reviewed to identify the facilitators and barriers of engagement.
- Throughout the COVID-19 pandemic, despite the number of referrals declining, the number of clients in treatment for alcohol only and alcohol and opiate treatment increased due to an increase in conversion rates (as telephone assessments commenced). Provisional data suggests the total number of clients in treatment is likely to decline in 2021/22. The specialist treatment provider should look at alternative and innovative ways to increase referrals and conversion into treatment.
- Professional engagement recognised that treatment and recovery includes remission and relapse as the norm, however treatment pathways are not conscious to this process. This may be reflected in the significantly lower successful completion percentages for alcohol only and non-opiate treatment compared to England. Public Health should work with the treatment providers to better understand how we can incorporate flexible treatment plans into reporting mechanisms to ensure continued engagement with users. The option of a “Fast Track” system should be explored, where a service user has short wait/ready to make a change.
- Individuals are treated in a fragmented health and social care system, despite progress being made in specific areas (for example, rough sleepers, Early Help). Partners should take a holistic approach to treating individuals through an integrated, multi-agency partnership such as a “Shared Care Plan” which comes together on a regular basis (e.g. bi-annually). This should include joint care planning and joint risk assessments to reduce the burden of repetition across organisations and have one vision of care. To achieve this, the following areas must be prioritised:
  - Shared data systems
  - Agreed referral pathways
  - Co-location of staff

- Lead organisations
- Almost half of all individuals in treatment offered a hepatitis B and hepatitis C intervention refused. Furthermore, additional indicators highlight concerns relating to offering HBV intervention and referrals to HCV treatment. This represents an at-risk population potentially living with an undiagnosed life-threatening infection and not receiving treatment. Further work is needed to understand the barriers for uptake, including from the client and delivery perspective, and an analysis of the referral pathway.
- Over a third of adults (37%) and almost half of adults (49%) were smoking tobacco at the start of alcohol only treatment and drug treatment in 2021-22. Only 1.6% and 0.4% of clients received a smoking cessation intervention. Future work should focus on increasing access to smoking cessation service and ensure this referral (where relevant) is included in the package of support to clients in treatment. Of those identified as smoking at the start of treatment, a significantly larger proportion in Leicester were identified as abstinent from tobacco at review in both drug and alcohol treatment. This outcome represents an area of good practice and should be investigated to identify learning for other areas.
- Public Health should utilise the resource of neighbouring providers and Local Authorities to examine their services and interventions which have an evidence base and have evaluated positively to generate shared learning.
- NICE Guideline states that behavioural couples therapy should be considered for people who are in close contact with a non-drug-misusing partner and who present for treatment of stimulant or opioid misuse. This intervention is not currently commissioned by Leicester City. Further work is required to understand why this intervention has not been invested in.

#### 18.3.1. Alcohol

- Local analysis suggests alcohol treatment clients are over-represented by individuals from a white ethnicity and under-represented from individuals from Asian or Black backgrounds. It is important that work is undertaken with the specialist treatment providers to ensure treatment services are meeting the needs of Leicester's diverse population and increasing uptake from ethnic minority groups.
- Rate of hospital admissions for alcoholic liver disease and liver disease perform similar to the national average, however premature mortality from alcohol liver disease is significantly worse. The local pilot of fibro scanning should be evaluated to look at its effectiveness to identify problem drinking and provide an opportunity for individuals to reverse early damage and seek treatment. If deemed successful, it should be rolled out to a wider audience.

- NICE Clinical Guideline CG115 recommends varying lengths of alcohol treatment from three months onwards depending on need. In Leicester, the majority of adults exiting alcohol only treatment in 2020-21 had been in treatment for between 1 to 6 months, and on average adults exiting alcohol only treatment in Leicester spent one month less in treatment than those in England overall. In the same year, the rate of successful completion of alcohol treatment in Leicester (27.0%) was significantly lower than that of England (35.3%). Further investigation is needed to understand the causes and barriers to shorter treatment lengths and lower successful treatment rates locally.

### 18.3.2. Drugs

- The rate of admission episodes with a primary diagnosis of drug poisoning by illicit drugs was significantly higher in the most deprived quintile. The population living in the most deprived area represents an opportunity to focus support.
- The proportion of admission episodes with a primary diagnosis of poisoning by illicit drugs from the adverse effect of and underdosing of other opioids (T402) increased significantly from 31.5% to 45.7% between 2012/13-2014/15 and 2018/19-2020/21. To combat this, work should focus on enhancing harm reduction provision such as increasing the availability of Naloxone.
- The proportion of opiate clients in treatment in Leicester in 2021-22 administered with naloxone to reverse the effects of an overdose or had been administered with naloxone to reverse the effects of an overdose in the last 6 months was twice as high as the national proportion (45.2% compared to 21.1%). This represents a level of need in the community. Future work should focus on exploring the extended provision and training of Naloxone with partner organisations.
- The rate of deaths from drug poisoning in Leicester have increased over the last three time periods, with the rate of increase faster in males than females. Public Health should investigate the reasons for this increase, including reviewing any changes in associated service provision, such as supervised consumption in pharmacies.
- Qualitative engagement interviews have highlighted the thresholds for detox are high. Public Health should review the current threshold alongside the evidence base for treatment.

### 18.4. Data

- There is no reliable data examining the prevalence of drugs misuse at a local level. The recommended work with community health champions should be used to explore this gap in knowledge.

- Provide low level geography (MSOA) findings to the community health champions to ensure their work is supported and targets individuals using the most up to date evidence base.
- Challenges exist in collecting and sharing information across the health system regarding substance users that come into contact with multiple services. The opportunities and barriers should be investigated to support effective information sharing and governance arrangements.
- The impact of the COVID-19 pandemic has been difficult to distinguish due to data availability. It is recommended to undertake a system mapping exercise of post-pandemic need of both drugs and alcohol services to inform knowledge on current behaviour and future commissioning.
- Performance metrics for drug and alcohol services often do not always demonstrate the full positive impact nor take account of the concept of “relapse” throughout the treatment journey. An example of this is the successful completions Key Performance Indicators (KPIs). Public Health will work with the specialist treatment providers to consider how this important information is better reflected in future KPIs.
- Serious incident (SI) reporting from the specialist treatment provider gives further information on drug-specific deaths (e.g. overdose), however SI reporting is not required for drug-related deaths which may represent a gap in local knowledge. The role of the newly reinstated Drug Related Death Panel for Leicester, Leicestershire and Rutland may help to fill this potential void but should be investigated further.

### 18.5. Training and Development

- Lack of knowledge, limited training opportunities and pre-conceived stigma of professionals who work across the health and social care system was a key theme in the professional engagement work. Staff working in all services who care for people who potentially misuse substances should receive training in awareness and knowledge of substances and contributing factors, IBA and be confident in referring to treatment organisations.

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## Appendix

### Appendix 1: Alcohol Specific ICD-10 Codes and Description

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

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## Appendix 2: Leicester adults aged 18+ Census 2021 Rounded Population Estimate by Age

Age group	Leicester	
	Count	%
Under 25	47320	17.0%
25-29	27300	9.8%
30-34	27600	9.9%
35-39	27200	9.8%
40-44	24700	8.9%
45-49	22600	8.1%
50-54	21900	7.9%
55-59	19500	7.0%
60-64	17300	6.2%
65 and above	43500	15.6%
Total	278920	100.0%

\*Note: 18 and 19 year old population estimated based on 15-19 year age band divided by 5 and multiplied by 2

## Appendix 3: Leicester Census 2021 Population Estimate by Broad Ethnic Group

Ethnic group	Leicester	
	Count	%
Asian/Asian British	159977	43.4%
White	150657	40.9%
Black/Black British	28766	7.8%
Other ethnic group	15272	4.1%
Mixed	13899	3.8%
Total	368571	100.0%

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## Appendix 4: Semi-Structure Interview Guide

### Part 1 - Contextual Information

1. Can you tell me about your role?

### Part 2 - Roles and Responsibilities

2. What kind of strategies or interventions do you deliver?
3. Which policies, protocols and procedures guides your work?
4. Do you collaborate with others? How is this done? E.g. Intra-agency referrals

### Part 3 - Professional Perspective

5. How do you build relationships with service users?
6. What works well?
7. What works not so well?
8. What are the current gaps? How do you deal with them?
9. If you were in charge, what would you do? (Specify the most important)
10. Is there anything else you would like to add?

## Appendix 5: Sampling and recruitment framework

Participant Group	Sample Size
Turning Point	4
Children's Social Care and Early Help, LCC	2
Adult Social Care and Safeguarding, LCC	1
Framework Housing Association	1
Home Group	1
Housing, LCC	1
Leicester Partnership Trust	1
Leicestershire Police	1
Nottinghamshire Healthcare NHS Foundation Trust	1



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University Hospitals of Leicester	1
Voluntary Community Sector	1
<b>Total</b>	<b>15</b>

<sup>148</sup> National Drug Treatment Monitoring System (2022) Numbers in Treatment.