Suffolk Drug and Alcohol Health Needs Assessment (May 2022)

SUFFOLK
JSNA

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COVID-19

The data within this report mostly cites 2019/20 data sets from the National Drug Treatment Monitoring System (NDTMS) and therefore does not examine the impact of COVID-19 on service provision and outcomes. Rather, the impact of COVID-19 has been explored through interviews with stakeholders and service users throughout Suffolk.

At the time of publication, 2020/21 data has been published for internal use. Therefore, future work streams related to substance use recovery services will reflect new data sources.

Accompanying documents

Please note that this Health Needs Assessment has been produced in parrel to the Norfolk and Suffolk Constabulary's Suffolk Drug Market Profile. Please refer to the Suffolk Drug Market Profile for information relating to drug markets, commodities and drug seizures, supply, and demand.

Suffolk Public Health and Communities will continue to work in partnership with the Norfolk and Suffolk Constabulary to ensure that the learning from this Drug and Alcohol Health Needs Assessment and the Suffolk Drug Market Profile are unified.

Word accessibility

Please contact the Knowledge, Intelligence and Evidence Team at Suffolk Public Health and Communities if you require a word version of this Suffolk Drug and Alcohol Health Needs Assessment.

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Executive summary

Drug use prevalence estimates

Suffolk is ranked 112th highest out of 151 English local authorities for opiate and/or crack cocaine use (OCU) (6.86 OCU per 1,000 population).

Suffolk had the 7th highest rate of opiate users per 1,000 (5.1 per 1,000) out of the 11 Lower tier local authorities (LTLAs) in the East of England. In 2016/17 there were 2,314 opiate users compared to 2,391 (-77) in 2014/15. This is statistically similar.

Suffolk had the 9th highest rate of crack cocaine users per 1,000 (3.9 per 1,000) out of the 11 LTLAs in the East of England. In 2016/17 there were 1,751 crack cocaine users compared to 1,097 (+654) in 2014/15. Suffolk was the only county in the East of England to see a significant increase in the number of crack cocaine users from 2014/15 to 2016/17.

These prevalence estimates for local areas were last updated in March 2019 for the period between 2016 and 2017. They are published by Liverpool John Moores University (LJMU) and contains comparisons with prevalence estimates of previous periods between 2010/11 and 2014/15[1]. There is no available data for 2015/16. At present, there is not more timely data available.

Alcohol prevalence estimates

The national estimates of alcohol dependence were updated in November 2018 by the University of Sheffield, for the financial year 2016/17. It estimates the number of adults (aged 18+) within each local authority with an alcohol dependency, potentially in need of specialist treatment.

There is no statistically significant difference between Suffolk and England in relation to alcohol dependence.

The estimated number of alcohol dependant adults has increased since 2010 to 2018, from 6,468 to 6,609. However, for the period between 2010 and 2014 confidence intervals were not calculated due to a change in the data collection process, therefore it is not possible to comment whether this increase is statistically significant.

Unmet need

Unmet need for opiate and/or crack cocaine treatment

In 2019/20, an estimated 58% of OCUs users in Suffolk were not accessing treatment services.

Estimated numbers (prevalence) of OCUs, aged 15-64, later than 2016/17 are not yet available. Thus, for each year between 2017/18 - 2019/20, the rate of unmet need has been estimated using the respective 2016/17 OCU prevalence estimate.

Unmet need for alcohol treatment

In 2018/19, there was an estimated 6,811 alcohol-dependant residents in Suffolk that were not accessing rehabilitation services. This represents an unmet need of 89% in 2018/19, with only an estimated 11% of alcohol-dependant residents in Suffolk accessing treatment.

Adults in treatment

In 2019/20,the National Drug Treatment Monitoring System (NDTMS) reported a total of 2,345 adults receiving structured treatment in Suffolk. Nearly half of adults in treatment (48%) were in treatment for opiate use, while nearly 1 in 3 (31%) were in treatment for alcohol.

Alcohol is used by almost half of all service users (49%, n=1,135). In 2019/20, 1 in 4 (25%, n=595) of service users in treatment were taking opiates. This is statistically significantly lower than in 2015/16, when 47% of service users (n=730) reported using opiates. Cannabis use among service users has been relatively static over the last decade with 20% reporting its use during treatment.

There are very few service users who report using club drugs and new psychoactive substances (NPSs) (n=30). This represents only 2% of drug and alcohol service users in Suffolk in 2019/20.

Age of clients (all in treatment)

The largest proportion of service users are in the 30-49 age banding across all drug and alcohol groups, apart from 'non-opiate only' where most service users (57%) are 18-29 years old.

Although the proportion of people 30 – 49 years of age entering treatment has remained stable over the last decade, the 50+ age group has seen an increase from 14% in 2009/10 to 22% in 2019/20. The 18 -29 age group has seen a reduction from 27% in 2009/10 to 16% in 2019/20.

Gender of clients (all in treatment)

From a total of 2,340 clients in 2019/20, there are 780 females (33.3%) and 1,560 males (66.7%).

Ethnicity of clients (all in treatment)

The majority of service users in treatment are white (96.3%).

Religion of clients (new presentations)

1,050 service users provided their religion in 2019/20. The majority (76.7%) said that they did not follow a religion. Almost 1 in 5 (17.6%) reported being Christian, while the third largest proportion 0.5% were Muslim or Buddhist.

Sexuality of clients (new presentations)

The majority of new clients in 2019/20 were heterosexual (95.2%) followed by bisexual (2.4%). Only 1.0% of service users accessing treatment in 2019/20 were gay or lesbian.

Disability of clients (new presentations)

From a total of 1,050 new presentations in 2019/20, over 8 out of 10 clients (83.8%) stated they did not have a disability, while 16.2% (n=170) reported one or more disabilities. 1 in 20 (5.2%) service users reported behavioural and emotional disabilities, while a similar proportion (4.3%) reported mobility-related disabilities.

Source of referral into treatment

A considerable increase can be seen in the proportion of referrals from self, family & friends (54% in 2009/10 to 69% in 2019/20), while at the same time, there is a reduction in referrals from health and social care services (21% in 2009/10 to 9% in 2019/20).

Referrals for 'opiates only' show a reduction from health and social care services (10% in 2009/10 to 4% in 2019/20), while other sources of referrals remain relatively static. For 'alcohol only' referrals, however, there has been a considerable increase in the proportion of referrals from self, family & friends (53% in 2009/10 to 74% in 2019/20).

Housing situation

Housing situation data presents the self-reported housing status of the individuals at the time they access treatment. Less than 1 in 10 (8%, n=95) of new presentations for all substances had an urgent housing problem – a similar proportion compared to England (7.4%). However, a higher proportion of opiate users had an urgent housing problem, ranging from 10% in 2009/10 to 22% in 2014/15. In 2019/20, 17% of opiate users in Suffolk had an urgent housing problem – this is similar to England (16%).

Employment status

The proportion of unemployed clients has reduced by 23 percentage points since 2009/10, from 63% to 40%.

Since the category of long-term sick and/or disabled was introduced in 2010, service users reporting 'long term sick and/or disabled' has increased from 17% in 2010/11 to 29% in 2019/20. This peaked in 2016/17 and 2017/18 when 44% of service users were long-term sick and/or disabled.

Parental status and safeguarding

Drug clients

In 2019/20, there were 179 children recorded as living with drug users entering treatment in Suffolk.

Regarding parental status of new service user presentations, 16% (n=113) were living with their own or other children, which was similar to England (18%). A higher proportion (40%, n=287) were parents who were not living with their children. This is a higher proportion compared to England (34%).

Alcohol clients

In 2019/20, there were 200 children recorded as living with alcohol clients entering treatment in Suffolk.

Regarding parental status of new service user presentations, 22% (n=97) were living with their own or other children, which was similar to England (25%). A slightly higher proportion (26%, n=115) were parents who were not living with their children. This is similar to England (25%).

Mental health

Drugs clients

Almost three quarters (72%, n=518) drug users who entered treatment in Suffolk during 2019/20 were identified as having a mental health treatment need. This is significantly higher than England (58%).

Of the 518 drug users who entered treatment in Suffolk during 2019/20 identified as having a mental health treatment need, the majority (66%, n=341) were receiving mental health treatment from their GP, while 1 in 5 (19%, n=97) were already engaged with the Community Mental Health Team[i].

Alcohol clients

Almost three quarters (73%, n=319) alcohol users who entered treatment in Suffolk during 2019/20 were identified as having a mental health treatment need. This is statistically significantly higher than England (60%).

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[i] Community mental health teams (CMHTs) are an important part of our non-urgent care pathway for specialist mental health care.

Of the 319 alcohol users who entered treatment in Suffolk during 2019/20 were identified as having a mental health treatment need, the majority (77%, n=245) were receiving mental health treatment from their GP, while over 1 in 10 (13%, n=40) were already engaged with the Community Mental Health Team.

Access to services: waiting times

Suffolk has reached 100% of all clients being seen within a 3-week period for the last 2 years (2018-2020). Please note that this data does not present the time taken from external referral (i.e., first contact with the drug and alcohol service provider) to assessment.

Treatment and recovery outcomes

Treatment exits

Successful treatment completions for all substances in Suffolk has increased from 35% in 2009/10 to 50% in 2020/21. A similar trend can be seen across the East of England (48% to 54%) and England (43% to 50%).

Successful completions and not re-presenting

Suffolk has had a significantly higher proportion of opiate users completed drug treatment compared to England in 2019 (7.0% compared to 5.6%, respectively) and 2020 (6.1% compared to 4.7%, respectively).

Suffolk has presented a statistically significant lower proportion of successful treatment completions among alcohol clients compared to England since 2012, apart from 2019 when Suffolk was statistically similar to England. In 2020, 29.0% of Suffolk alcohol clients successfully completed treatments compared to 35.3% for England.

Health protection & harm reduction

Injecting behaviour

The injecting behaviour at time of presentation represents whether the client has injected in the last 30 days (categorised as current), previously or never. In 2019/20, 43% of opiate users in treatment had previously injected, while a quarter (24%) were still injecting. A third of opiate users in treatments (33%) had never previously injected.

Needle exchange

Pharmacy data shows that 123,081 1ml syringes and syringe barrels were collected through the Needle Exchange Scheme in 2020/21. This ranged from 95 to 44,789 depending on the pharmacy.

Hepatitis B vaccination (HBV)

In 2019/20, 42% (n=532) clients in treatment who were eligible for an HBV vaccination accepted one. Of those, only 1 in 5 (21%, n=113) completed the course of the vaccination.

Hepatitis C virus (HCV)

In 2019/20, 61% of Suffolk clients in treatment who were eligible for a HCV test received one, compared to 69% nationally.

Drug related deaths

Suffolk currently has a rate of 3.7 deaths per 100,000 compared to England's 5.0. While England has seen an increase in the rate of deaths per 100,000 from 2013-15 to 2018-20 (3.9 per 100,000 to 5.0 per 100,000, respectively), Suffolk has been statistically lower than England since 2017-19.

Deaths from drug misuse

Deaths from drug misuse is a subset of deaths from drug poisoning, involving controlled drugs only. There were 76 deaths related to drug misuse in Suffolk in 2018-20. This is 58.5% of all deaths from drug poisoning.

Deaths from drug poisoning

There were 130 deaths of Suffolk residents related to drug poisoning (involving controlled and/or uncontrolled substances) in 2018-20. Almost two-thirds (63.8%) were of males (n=83) and just over a third (36.2%) were females (n=47).

Deaths while in treatment

There were an increased number of deaths for those receiving structured treatment in Suffolk, from 15 in 2017/18 to 40 in 2020/21. Proportionally, those who died in treatment went from 1.7% in 2017/18 to 3.8% in 2020/21. Please note although these deaths were registered in the same year, from the data it is not possible to ascertain whether these clients actually died in that year.

The composition of the deaths while in treatment since 2017/18 have predominantly been opiate users. Out of the 40 deaths in 2020/21, 25 (62.5%) were opiate users and 15 (37.5%) were alcohol only users.

Children and young people

Number in treatment

There were 130 children and young people in treatment during 2019/20. 2017/18 presented the lowest number in treatment (n=85) in the last decade, while the last 3 years of data show an increasing number of children and young people in treatment (+45 from 2017/18 to 2019/20).

Referral sources (routes into treatment)

In 2019/20, the highest proportion of referrals for children and young people came from 'youth / criminal justice' (35%). This trend has been constant for over a decade. In recent years, referrals from 'friends and family' have increased, from 5% in 2016/17 to 20% in 2019/20.

Age of children and young people receiving specialist treatment

Half (50%) of children and young people in treatment service across Suffolk were 16-17 years of age in 2019/20. 2 out of 5 (42%) were 14-15 years of age, while just under 1 in 10 (8%) were under 14. Please note that the percentages for those under 14 fluctuate from year to year due to the small numbers of under 14s in treatment.

Gender of children and young people receiving specialist treatment

The majority of children and young people in treatment services in Suffolk over the last decade are male. In 2019/20, two-thirds (69%) of children and young people in treatment were male.

Education, employment, and training

In 2019/20, the majority (56%) of children and young people accessing structured treatment services were in mainstream education. Just over 1 in 5 (22%) were in alternative education, while just under 1 in 5 (17%) were not in employment, education, or training (NEET).

Accommodation status of children and young people receiving specialist treatment

Nearly three quarters (74%) of children and young people accessing specialist treatment services in Suffolk lived with their parents or relatives. 1 in 10 (11%) lived independently in settled accommodation. Approximately 1 in 20 (5%) lived in care, in supported housing, or in unsettled accommodation.

Substances cited

Cannabis continues to be the most prevalent substance used, with 92% of those in treatment citing its usage in 2019/20. Thereafter, alcohol was used by nearly half (46%) of children and young people in treatment in 2019/20. Just over 1 in 10 (12%) cited cocaine or 'other'. The category 'Other substance' includes amthamines, ecstasy, solvents, opiates, NPS, nicotine and other. These have been grouped together due to the small number of citations.

Length of time in treatment and interventions

In 2019/20, over two thirds (68%) of children and young people spent under 12 weeks in treatment services. This continues the trend since 2016/17 where the majority of children and young people in treatment service in Suffolk have spent under 12 weeks in treatment.

In 2019/20, just over a quarter (28%) of children and young people spent 13 – 26 weeks in treatment, while only 4% spent 27 to 52 weeks in treatment.

Exiting services

In 2019/20, 81% of children and young people in treatment services successfully completed their course of treatment. However, 1 in 5 (19%) dropped out or left the service. Although this is a higher drop out proportion than England (12%) and the East of England (19%), the higher percentage is due to the relatively low number of children and young people accessing Suffolk services. This can lead to fluctuation in percentages over time.

Recommendations

Reducing harm from substance use		
Recommendation		Rationale
1.	The creation of a multiagency, targeted prevention strategy.	Many stakeholders work with individuals that have low levels of problematic substance use and do not meet the threshold for level 2 or 3 specialist substance use treatment. Public Health and Communities Suffolk should look to create a prevention strategy that reduces harm associated with substance use that targets groups with additional complex needs (i.e., unemployed, those with mental health issues, poor housing or homeless).
2.	Continued emphasis on a holistic approach to treatment	There was consensus that the system should maintain the aim of abstinence but acknowledge that many clients require multiple courses of treatment to achieve recovery and may never achieve abstinence. Therefore, there is a need to adopt a model of long-term, active care management for problematic substance use that is holistic. A long-term, holistic model of care would require both strengthened recovery services and an increase in harm reduction approaches. Existing schemes such as supervised consumption and needle exchange schemes would require further development and expansion. New commissioning approaches are required to engage more community pharmacists and GPs to undertake holistic care. Greater GP involvement would assist in the management also of any physical/mental health co-morbidities.
3.	Continue to develop dedicated recovery support and communities that support long term recovery.	Develop and expand recovery services, including 12 Steps and Smart Recovery, which strengthen support from the community and address the complex socio-economic issues with the aim of securing a sustained recovery. This could include expanding the length of time that a person receives recovery support to reflect client need with the objective of reducing the high number of re-presentations within six months. Many stakeholders and service users mentioned that community-based assets for aftercare had diminished during the pandemic and there was a need for these to be reinstated.
4.	Undertake review of drug related deaths in East Suffolk.	The highest number and rate for deaths from drug misuse are in East Suffolk. In previous years, the highest incidence was in Waveney which has now been incorporated into the East Suffolk area. Understanding the profile and contributing factors of these deaths will inform harm reduction interventions

		and facilitate ongoing partnership collaboration in addressing the issue.
5.	Review admission profile of people admitted to Ipswich Hospital for alcohol-related conditions to inform harm reduction approaches.	Those aged 40 to 64 in Ipswich, both male and female, were the only age banding across all of Suffolk's LTLAs to show a statistically significantly higher rate of admission for alcohol-related conditions compared to England. Suffolk Public Health and Communities and system partners should make a concerted effort to tackle problematic drinking in Ipswich residents aged 40 to 64.
6.	Improved vaccination uptake and screening for Hepatitis B (Hep B) and Hepatitis C (Hep C).	Suffolk's continued low uptake and incomplete vaccination for Hepatitis B and low testing for Hepatitis C requires continued commitment. Although NHSE have commissioned an external partner to boost testing, there needs to be more joined up and co-ordinated action across the Suffolk system to increase vaccination and testing rates for Hep B and Hep C.
7.	Review impact of current system to support people using substances to maintain housing tenancy.	Stakeholders acknowledge the importance of coordinated action across agencies to support this cohort. Acknowledging the need to support housing providers to effectively help clients sustain their tenancies in the light of relapse, difficult circumstances etc.
Meeting the needs of underserved populations		
Recommendation		Rationale
8.	Increase numbers in treatment for problematic alcohol use.	Data indicates unmet need for those with problematic alcohol use. Maximise opportunities across primary and secondary care and community-based services to engage with people requiring support for dependency on alcohol, supporting entry into specialist treatment.
9.	Increasing access and treatment uptake by delivering specialist treatment for substance use at place.	At present, the specialist drug and alcohol treatment service have three main hubs in Suffolk making service provision largely confined to Ipswich, Bury St Edmunds, and Lowestoft. Delivering at a 'place' level, whether co-locating and partnering with Integrated Neighbourhood Teams (INTs) and Primary Care Networks (PCNs), in areas of rurality and/or areas where there are higher prevalence of alcohol and substance use was a priority for stakeholders and service users alike.
10.	Review current access to services methods in order to identify and implement ways to increase accessibility and uptake of specialist	Stakeholders acknowledge that women using substances have different needs and vulnerabilities and may have barriers to accessing services. For example impact of exploitation, child-care responsibilities.

	drug and alcohol treatment services by women.	
11.	Embed consideration of substance use issues into services that support older people.	Many stakeholders raised concerns about problematic substance use in the older population. Suffolk Public Health and Communities should raise awareness /education about substance use amongst older people with statutory and voluntary sector older people's services. Access might be problematic due to co-morbidities Lack of awareness – focus on other issues.
Working together to address complex needs		
Recommendation		Rationale
12.	Review, develop and implement a clear pathway / service offer between substance use services and mental health services.	Currently, individuals experiencing substance use and mental ill-health are too complex for commissioned service that address mild to moderate mental health needs. A statutory service that these individuals can access to address their mental health needs should be explored. The service pathway and options for addressing this gap also need consideration. There is an on-going need to build collaboration and overcome the organisational challenges between services.
13.	Specialist treatment services for homeless individuals, including assertive outreach.	Many stakeholders commented that the structured format for recovery does not work effectively for the most chaotic individuals and communities, such as rough sleepers. The option of an integrated pathway for rough sleepers that is separated from conventional pathways should be explored.
Developing Services		
Recommendation		Rationale
14.	Review options for funding interventions beyond commissioned specialist drug and alcohol treatment providers, optimising opportunities to align resources across the wider Suffolk system.	There was a consensus across all stakeholders that there is a need for brief and extended interventions beyond traditional commissioned services, in areas where they are most effective and have the greatest cost benefits. For example, interventions at a population level through PCNs or GP Practices and preventative programmes through specialist nurses in acute hospitals when service users present with substance use issues.
15.	Increasing community detoxification, exploring supportive role of primary care and community and third sector organisations.	Community detoxification can have good outcomes when delivered alongside a structured psychosocial intervention. It is also cost effective.

16.	Increase accessibility of specialist drug and alcohol services.	Both service users and stakeholders representing service users' voices noted that the current treatment services do not work well for people who are employed. The '9 – 5' nature of the commissioned services limit access for those who are employed. It's understood that telephone consultations are offered to those in employment, but some service users said that this did not work for them. Service provision specifically aimed at those in employment, such as evening sessions, should be explored.
17.	Continued development of hospital liaison services for alcohol detoxification.	Alcohol Specialist Nurses continue to provide great support and treatment, and there is a clear cost benefit provided by the liaison service. Learning from Alcohol Care Teams demonstrates the benefits of acute hospitals proactively focusing on alcohol to identify problematic use and developing pathways of care into the community.
18.	Continued development of hospital liaison services for wider substance use.	At present, Suffolk hospitals do not have any formalised system for supporting those who are using substances (non-alcohol) who present at the hospital. Some preliminary discussions indicates that there is a cohort of people who present on numerous occasions (i.e., 'frequent flyers'). More investigation is required to identify who these are and the most appropriate intervention. Suffolk Public Health and Communities commissioned outreach services, and secondary care should build on current pathways between outreach drug and alcohol services and A&E teams to ensure that substance use patients are not overlooked. Additionally, thought should be given to establishing / re-establishing multiagency meetings concerning frequent flyers using multiple services – many of these were in place prior to the pandemic and have subsequently changed or have been suspended indefinitely.
19.	Develop a Suffolk drug and alcohol workforce development plan.	Stakeholders acknowledged ongoing issues regarding recruitment and retention of staff. Issues regarding continuity of staff, staff turnover, and staff training was also expressed by many stakeholders and service users. Stakeholders acknowledged the key role of non-drug and alcohol services and the need therefore, to increase skills and knowledge amongst the wider workforces.

20.	Co-ordinated multi-agency interventions for those people who use substances and are in the criminal justice/community safety arenas.	Stakeholders acknowledged the key role specialist drug and alcohol treatment services had in criminal justice settings, including within the courts
Supporting children and young people		
Recommendation		Rationale
21.	Increased support and embedding of drugs and alcohol universal offer to all educational settings, children's homes, youth services and CYPs teams.	Although Suffolk compares well in terms of substance use in children and young people there are still substantial numbers who use substances. Stakeholders acknowledged the negative impact of funding constraints on prevention and engagement approaches aimed at children and young people and those that work with this cohort. This is reflected in lower numbers of children and young people in drug and alcohol treatment services than in previous years.
22.	Targeted and co-ordinated population-level outreach in high-risk areas and/or with high-risk groups, building on pockets of good practice.	Many of the children and young people in the treatment services have different vulnerabilities. Looked after children, those with mental ill-health or who are self-harming are examples of common vulnerabilities. There is evidence for targeted, early interventions for these groups.
23.	Co-ordinated, multi-agency specialist support to children and young people with complex need, building on pockets of good practice. Include wrap around support by including Voluntary Community and Social Enterprise (VCSE) youth support organisations.	Stakeholders report increasing complexity of need amongst children and young people, exacerbated by the impact of Covid-19.
24.	Embed coproduction and principles of resilience and managing risk into services that work with children and young people.	Stakeholders recognise the impact of wider determinants such as deprivation and exploitation as risk factors for children and young people.
25.	Improved interagency working for children and young people who have parents or carers misusing substances.	Children living with parents who have problematic substance use are at high risk of poorer health and wellbeing outcomes. The Suffolk Safeguarding Partnership continue to positively impact children and young people who have parents or carers with problematic substances. However, stakeholders have said that the lessons learned from these cases should be used more explicitly to improve interagency working across the Suffolk system.

Background

Use of alcohol or drugs at some stage in life is common; it is estimated that approximately 10.4 million adults in England consume alcohol at levels associated with some risk to their health, and that nearly one in three of the adult population have tried illegal drugs[2].

For a proportion of these individuals their alcohol and drug use may reflect dependency or excessive consumption and may be associated with substantial harmful consequences such as health problems or encounters with the criminal justice system. Alcohol is one of the leading modifiable health behaviour related drivers of non-communicable diseases alongside smoking and obesity, and it is estimated to be the behavioural risk factor with the second highest impact on the NHS budget after poor diet[3]. It is also a causal factor in more than 200 medical conditions, including circulatory and digestive diseases, liver disease, several cancers and depression[4].

The impact of alcohol and drug use on wider communities can be far-reaching and include 1) direct economic costs on health and social care services, the criminal justice system and the social welfare system; 2) indirect costs from low productivity, unemployment, absenteeism and premature mortality or morbidity; and 3) intangible costs to the affected individual or their family members from anxiety, pain, financial worries and reduced quality of life[4].

Alcohol and drug treatment services have an important and evidence-based role in mitigating the personal and financial costs of alcohol and drug misuse and have the potential to provide cost-efficiency savings for a range of public services including health and social care, housing and welfare, and the criminal justice system. This Health Needs Assessment will comparatively describe the needs of alcohol and drug users in Suffolk, highlighting areas of potential service improvement or partnership development to better meet these needs.

Aims and objectives

This Health Needs Assessment aims to:

1. use quantitative and qualitative data sources to assess the needs of the population of Suffolk in relation to alcohol and drug use;

2. identify areas of currently unmet need and inequalities; and

3. make recommendations to address the needs of the local community in future service commissioning.

Understanding Suffolk's population

The health and health care needs of a population cannot be measured or met without knowledge of its size and characteristics. The main population influences on health service needs are:

- size
- age structure
- ethnicity
- migration
- inequalities and deprivation

One individual may belong to more than one demographic "group". Not everyone within the same demographic group will experience the same challenges.

Understanding how a population has changed in the past can help project how a population may appear in the future, whether by complex calculations or simple facts. For example, the "baby boomers" born in the 1960s will be in "older age" by 2041. These projections can inform future health and care planning.

Some life stages require higher levels of health care, such as:

- neonatal period (first 4 weeks of life) and infancy
- fertile years for women (support for pregnancy and childbirth)
- old age (when multimorbidity increases, healing may be slower, and treatments may be palliative rather than curative)

Further impacts of longer life include:

- increased need for social care. One in five people aged 75 to 84 have at least some difficulty washing or dressing, and this is even higher for people aged 85 and over
- difficulty accessing services, as older people often live in more rural areas and may find it difficult to travel

In Suffolk (and England as a whole) the population aged 65 and over is growing more rapidly than the working age population, and faster than the retirement age is increasing.

Population data should be used to improve access to services and reduce inequalities. The Equality Act 2010 prohibits unlawful discrimination in the provision of services on the grounds of age, disability (physical or mental, including long-term conditions), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation (these are known collectively as "protected characteristics"). Clinical Commissioning Groups are legally required to reduce inequalities in access to and outcomes of health services. Therefore, organisations need to know about our communities and their needs.

NHS England uses the term "inclusion health" to define groups of people who are socially excluded and often experience poor health outcomes, such as:

- people who are homeless and rough sleepers
- the Traveller community (including Gypsies and Roma)
- vulnerable migrants (refugees and asylum seekers)
- sex workers
- those undergoing or surviving Female Genital Mutilation (FGM)
- those undergoing or surviving human trafficking

- those who define themselves as being part of the recover mental ill health
- the trans / non-binary community

What is the local picture?

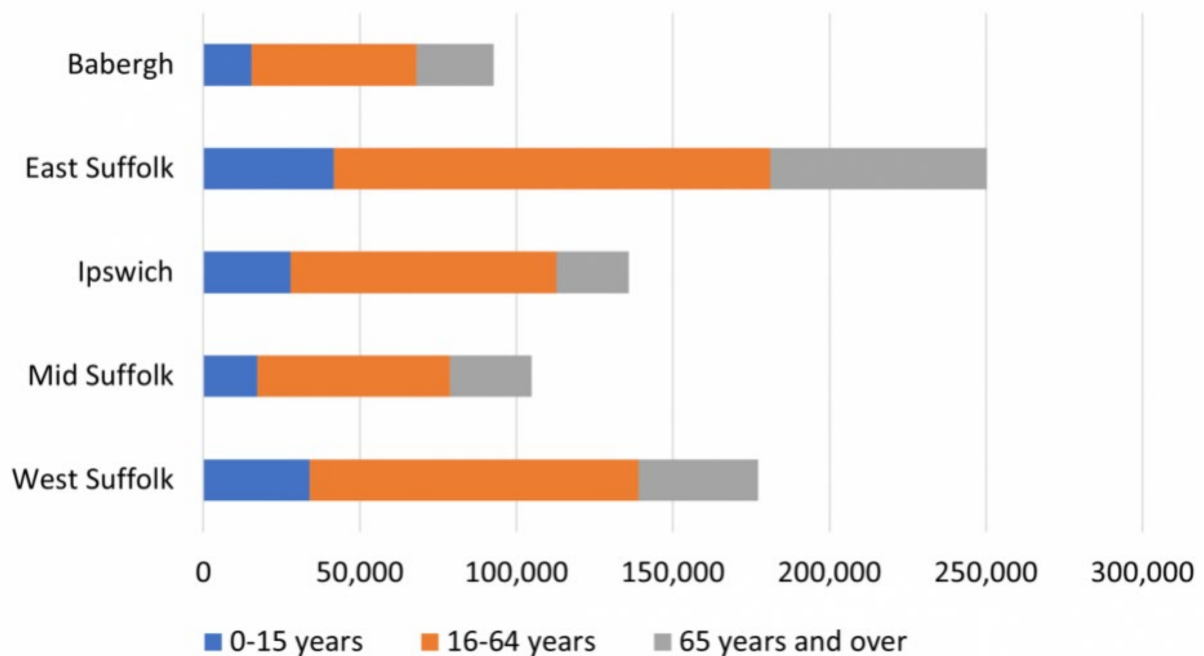
Suffolk has a higher percentage of its population aged 65 and over than England (23.8% compared to 18.5%), and a lower proportion of working age people (58.3% compared to 62.3%).

Ipswich (20.5%) is the only area in Suffolk where the percentage of children (aged under 16) is above the average for England (19.2%). (Figure 1)

East Suffolk (27.7%) and Babergh (26.5%) have the highest proportion of people aged over 65. Other than Ipswich, all areas in Suffolk have a higher proportion of people aged 65 compared to England (18.5%).

Ipswich is the only borough or district to have a higher proportion of working age adults than England (Ipswich 62.5%, England 62.3%).

Figure 1: Suffolk population by broad age band and district/borough, 2020

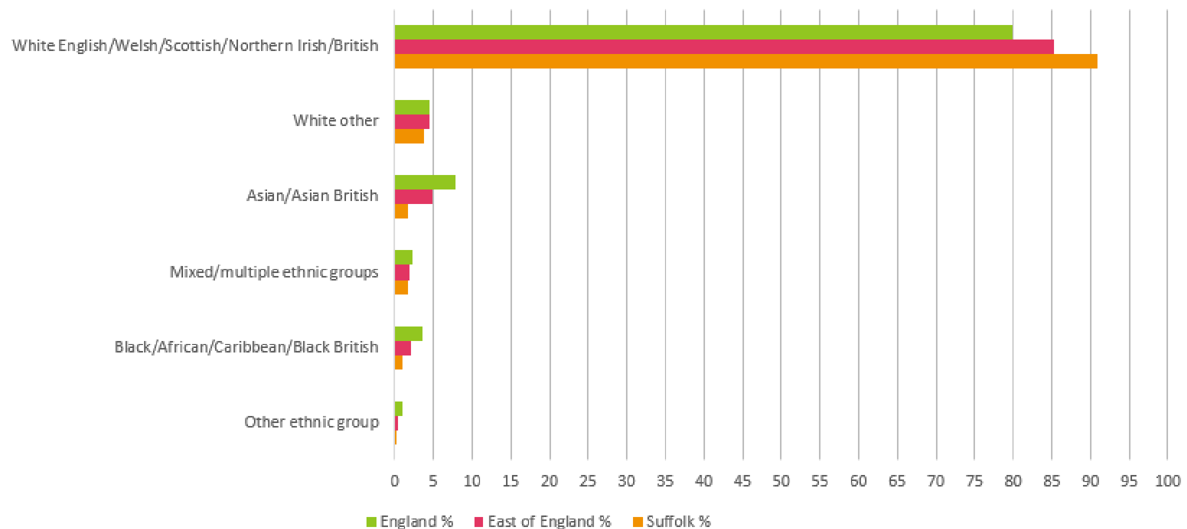


Source: Office for National Statistics. "Mid-Year Population Estimates, UK, June 2020", 2021.

Population by ethnicity

At the time of the *2011 Census*, 90.8% of Suffolk's population was White British, compared to 79.8% for England. After White British, the most common ethnicities were Other White (4.4%), Asian (1.8%) and Mixed heritage (1.7%) (Figure 2). The results of the 2021 Census should be available in 2022.

Figure 2: Ethnic groups in Suffolk, region and country, 2011



Source: Office for National Statistics. Census 2011 Ethnic group - NOMIS table KS201EW. (2011)

In 2011, the proportion of residents who did not identify as White British was higher in urban areas compared to rural areas. Proportions were higher in the north west of the county, where United States military forces and support staff are stationed with their families (Figure 3).

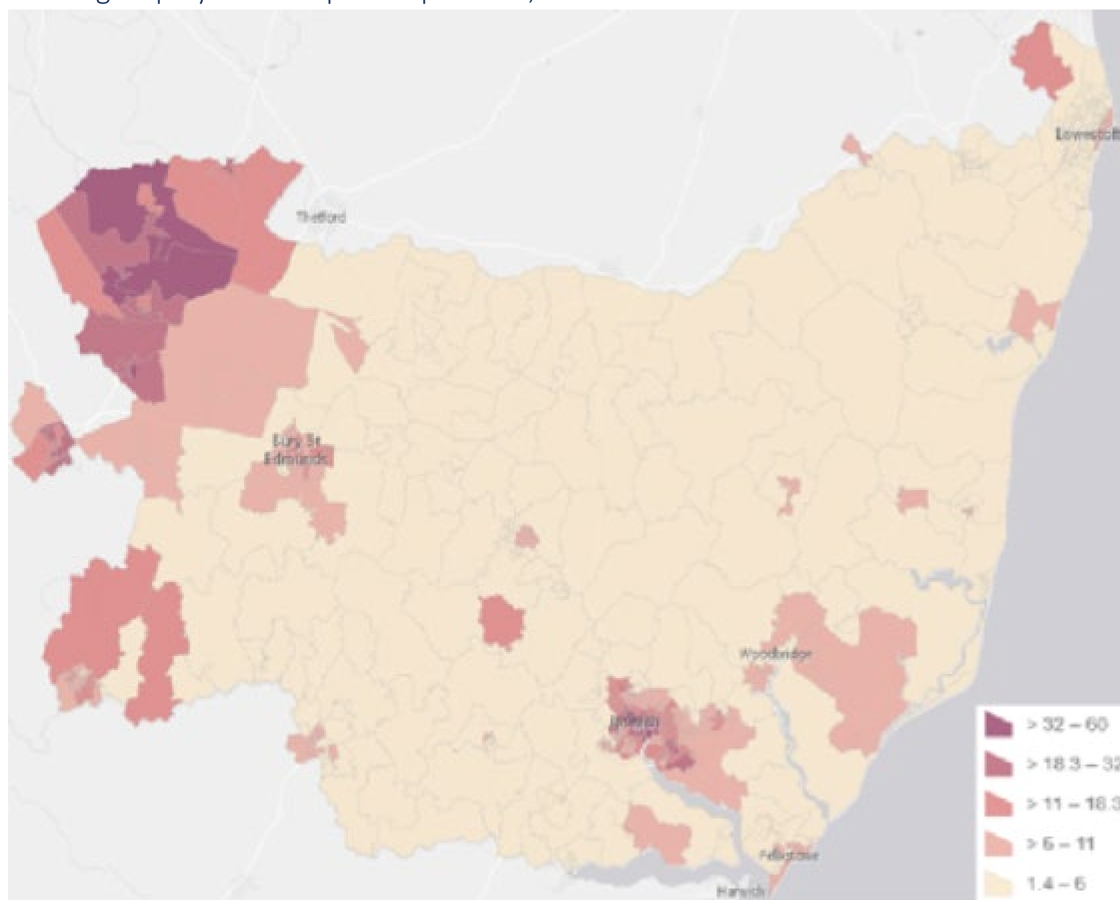
In 2020, 92.4% of the Suffolk population were UK nationals, which is higher than for England (90.3%). People who were not UK nationals were most likely to be nationals of:

1. European Union 5.2% (England 5.5%)
2. Rest of the World 1.6% (England 1.9%)
3. Sub-Saharan African 0.7% (England 0.8%)
4. North American 0.7% (England 0.4%)

In 2020, 90.3% of Suffolk residents were born in the UK, compared to 84.4% in England. People living in Suffolk who weren't born in the UK were most likely to have been born in:

1. European Union 6.1% (England 5.6%)
2. Rest of the World 2.3% (England 4.6%)
3. Sub-Saharan Africa 1.1% (England 2.4%)
4. North American 0.9% (England 0.6%)

Figure 3: Map of Suffolk showing the proportion of residents from a Black, Asian or minority ethnic group by lower super output area, 2011



Source: Office for National Statistics. Census 2011 Ethnic group - NOMIS table KS201EW. (2011)

Population by sex

A higher proportion of the population are female in England, and in Suffolk. ONS estimates and projections by sex and broad age band show there are more males than females among children (0-15), a difference that is less pronounced among the working age population (16 to 64). Better life expectancy rates for women mean there are more older women (65 and over) than men.

The gap between the number of males and females aged 65 and over is reducing. By 2041, 47.0% of people aged 65 and over in Suffolk will be male, compared to 44.8% in 2008 (46.6% in 2041 and 43.7% in 2008 for England).

There are estimated to be 2,630-7,610 transgender people in Suffolk, that is people whose gender identity is different from the sex assigned at birth. This estimate is based on a population prevalence of 0.35%-1.0% as used by the Government Equalities Office. This Figure does not include people who identify as non-binary[5].

Population by sexual identity

Estimates of sexual identity can be calculated using results from the Annual Population Survey. By applying estimates for the East of England region to the Suffolk population, there may be between

10,600 and 23,100 Suffolk residents aged 16 and over who identify as lesbian, gay, bisexual or other (Table 1). Estimates at a lower geography are unreliable and not available for Suffolk.

Older people (65 and older) are more likely to identify as heterosexual or straight (UK 95.8%, CI +/- 0.2%) than younger people (16 - 24) (UK 88.5%, CI +/- 1.1%). As Suffolk has a higher percentage of older people, the estimate is likely to be slightly lower than shown.

Table 1: Sexual identity in England, and estimated Suffolk Figures, 16 years old and over, 2019

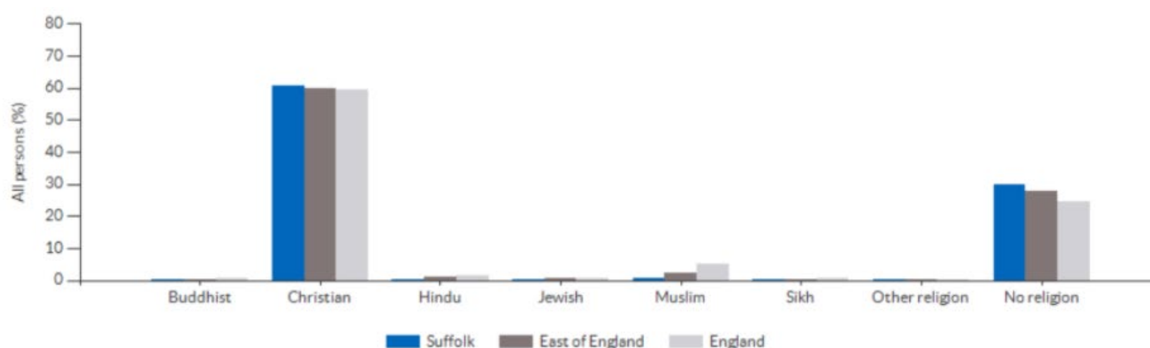
Sexual identity	East of England		Suffolk	
	%	*Confidence interval (CI) +/-*	*Low est.*	*High est.*
Heterosexual or straight	95.5%	0.7	592,100	600,800
Gay or lesbian	1.2%	0.4	5,000	10,000
Bisexual	1.0%	0.3	4,400	8,100
Other	0.5%	0.3	1,200	5,000
Don't know or refuse	1.8%	0.4	8,700	13,700

Source: Office for National Statistics. Sexual orientation, UK: 2019

Population by religion

3 in 5 (443,632) Suffolk residents identified as Christian in the *2011 Census* (60.9%, 59.4% England). The next largest group was people who had “no religion” (29.7%, 24.7% England). The next largest religious group was Muslim, at 0.8% (5.0% England), or fewer than 6,000 people (Figure 5).

Figure 5: Population by religion, Suffolk 2011



Source: Suffolk Observatory / Census

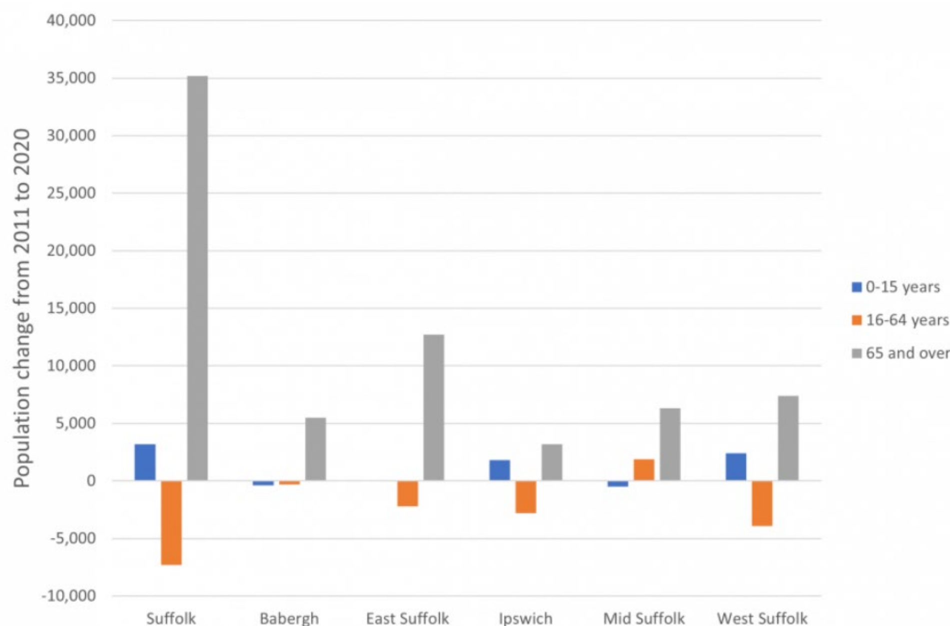
How is the population changing?

The population of Suffolk grew by 4.3% from 2011 to 2020, which is lower than the growth rate for England (6.5%). This overall growth rate conceals larger changes within age groups. Suffolk’s over 65 population has seen dramatic growth compared to those aged 0 – 15. Those aged 16 – 64 decreased from 2011 to 2020.

The number of people aged 65 and over in Suffolk is projected to grow by 20.8% between mid-2020 and mid-2030 (20.9% England). Growth will be seen in all districts and boroughs. The older population will increase at the lowest rate in Ipswich (16.4%), and the highest in Mid Suffolk (23.7%).

In mid-2020, two districts in Suffolk had a population where at least one-quarter of people were estimated to be aged 65 and over (East Suffolk 27.7%, Babergh 26.5%). By 2030, only Ipswich (20.0%) and West Suffolk (24.5%) will have populations where less than a quarter of people are estimated to be 65 and over. In East Suffolk (32.2%) and Babergh (30.6%), people aged 65 and over will comprise nearly a third of the resident population.

Figure 6: Population change from 2011 to 2020 by broad age group for Suffolk local authorities

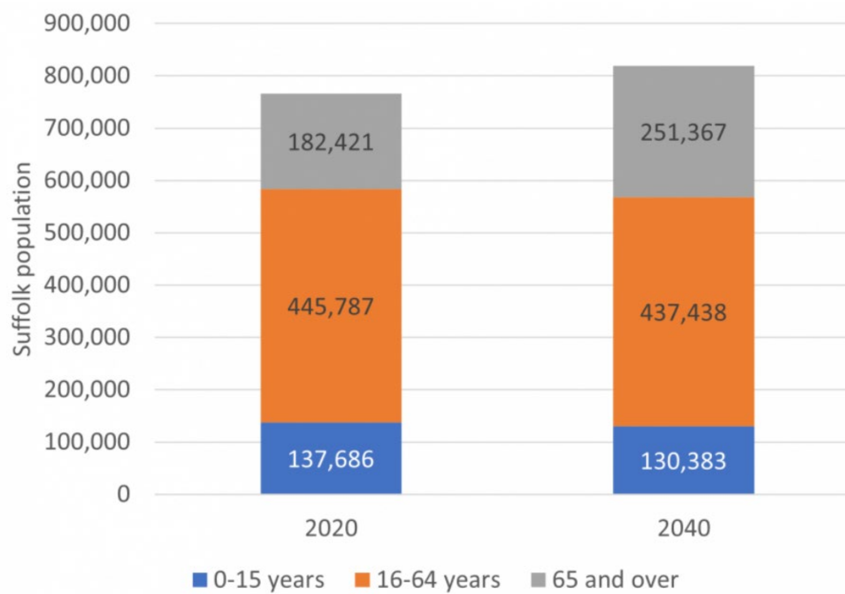


Source: Office for National Statistics. Population estimates - local authority based by five-year age band.

In 2020, an estimated 23.8% of Suffolk's population was aged 65 and over (compared to 18.5% for England). By 2040, the population of residents aged 65 and over will increase by over 37.8% (in line with England 38.3%), while the Suffolk population under 65 will fall by 2.7%, compared to growth in England of 1.0%.

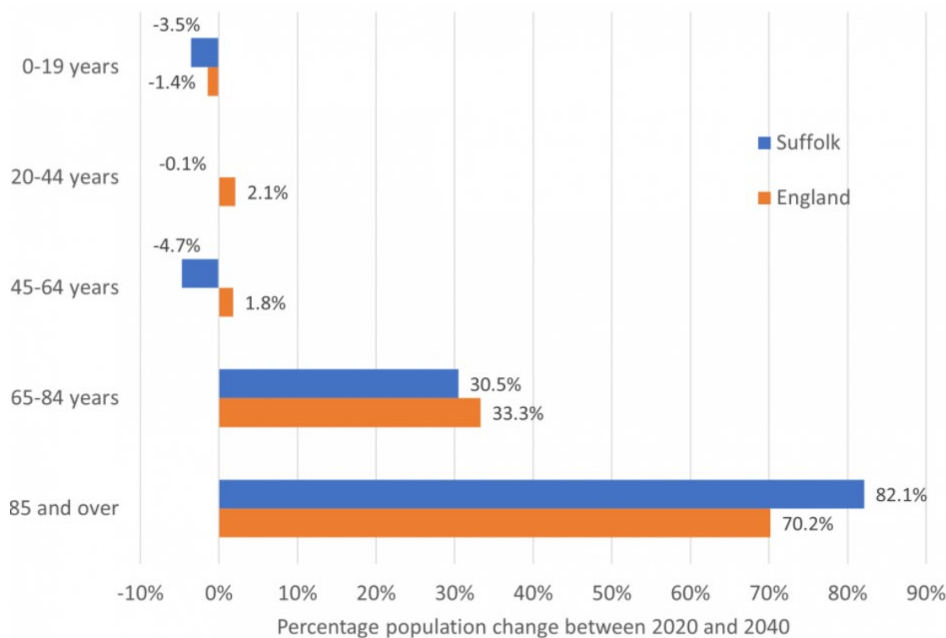
In 20 years, it is forecast that 1 in 3 Suffolk's residents will be aged 65 or over, compared to 1 in 4 for England. The number of people aged 85 or over in Suffolk is expected to increase from 25,900 to 47,200.

Figure 7: Suffolk population change 2020 - 2040, based on 2018-based projections (ONS)



Source: Office for National Statistics. Subnational Population Projections for England: 2018-Based (Report). 2020

Figure 8: Change in population 2020 to 2040



Source: Office for National Statistics. Subnational Population Projections for England: 2018-Based (Report). 2020

Suffolk Indices of Deprivation

The Index of Multiple Deprivation, commonly known as the IMD, domain indices and the supplementary indices, together with the higher area summaries, are collectively referred to as the Indices of Deprivation (IoD) 2019.

The IMD is the official measure of relative deprivation for small areas in England. It is the most widely used of the Indices of Deprivation (IoD). It ranks every small area (Lower Super Output Area or LSOA) in England from 1 (most deprived area) to 32,844 (least deprived area).

The Indices of Deprivation measure deprivation on a relative rather than an absolute scale, so a neighbourhood ranked 100th is more deprived then a neighbourhood ranked 200th, but this does not mean it is twice as deprived[6].

Changes to boundaries

Changes in boundaries have had a large impact on the indices of deprivation for Suffolk. East Suffolk Council was formed on April 1st 2019, covering the former districts of Suffolk Coastal District Council and Waveney District Council. On the same day, Forest Heath District Council and St Edmundsbury Borough Council were replaced by a single district council called West Suffolk Council.

The impact of these changes means that pockets of deprivation that were once identifiable at local authority level are no longer observable, for example the differing levels of deprivation experienced between Waveney and Suffolk Coastal. Therefore, LSOA level analysis is vital for place-based assessment of deprivation.

This also impacts data for West Suffolk, which contains the former Forest Heath authority area. Additionally, the challenges associated with estimating the characteristics of this area, due to the inclusion or exclusion of the United States Visiting Forces (USVF) population in different indicators, mean that it is difficult to establish whether the changes in relative deprivation in Forest Heath are 'real'.

Deprivation in Suffolk

The dramatic decline in relative deprivation seen in Suffolk between 2010 and 2015 has not been repeated, but neither has there been much of a recovery in Suffolk's relative position.

Suffolk continues to experience below average levels of deprivation, but it has experienced a slight increase in rank of average rank among other Upper Tier Local Authorities, from 101st in 2015 to 99th in 2019, indicating increased relative deprivation. Also note that the number of council areas has decreased from 152 to 151. This change has also resulted in an increase in deprivation relative to Suffolk's 15 nearest statistical neighbours.

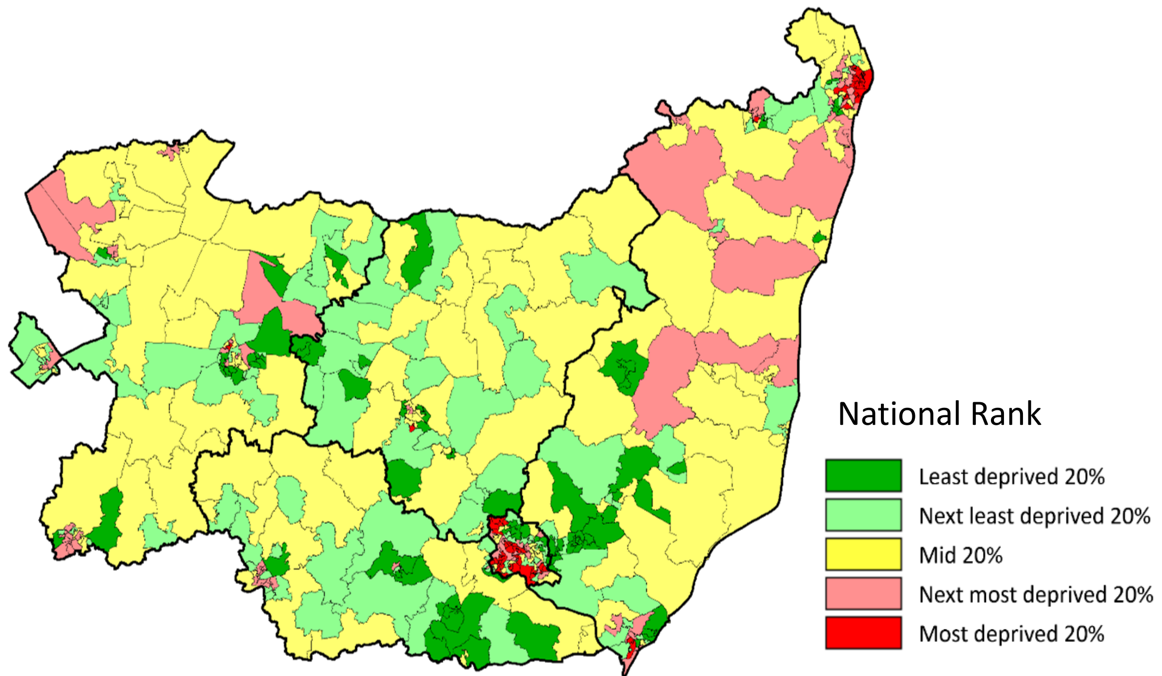
90% of the LSOAs in Suffolk that were in the most deprived 20% nationally in 2015 were still in the most deprived 20% nationally in 2019.

11.3% of Suffolk's LSOAs are in the 20% most deprived in England (50 LSOAs in Total). 96% of the 20% most deprived LSOAs in Suffolk are in either East Suffolk (20 LSOAs) or Ipswich (28 LSOAs).

Ipswich has the highest number and proportion of LSOAs in the 20% most deprived areas nationally, when compared to other local authorities in Suffolk. Ipswich is now the most deprived area in Suffolk, as changes to council configuration have led to a loss of granular detail particularly affecting Waveney.

Mid Suffolk remains the least deprived area, while West Suffolk and Babergh have seen small improvements in relative deprivation between 2015 and 2019; all other areas have declined, albeit by small amounts.

Figure 9: Indices of Multiple Deprivation quintile by LSOA in Suffolk, 2019



Source: Suffolk Public Health and Communities

Substance use prevalence estimates

These prevalence estimates for local areas were last updated in March 2019 for the period between 2016 and 2017. They are published by Liverpool John Moores University (LJMU) and contain comparisons with prevalence estimates of previous periods between 2010/11 and 2014/15[1]. There is no available data for 2015/16. At present, there is not more timely data available.

'OCU' refers to use of opiates and/or crack cocaine. It does not include the use of cocaine in a powder form, amthamine, ecstasy, or cannabis. Although many opiates and/or crack users also use these drugs it is very difficult to identify exclusive users of these drugs from the available data sources.

It is advisable to look at the prevalence rate as well as the actual numbers, because any significant changes in the number of OCUs may simply reflect fluctuations in the general population for that area. The age range employed within the study is from 15 to 64 and where the estimates have been stratified by age group, these are from 15 to 24, from 25 to 34, and from 35 to 64.

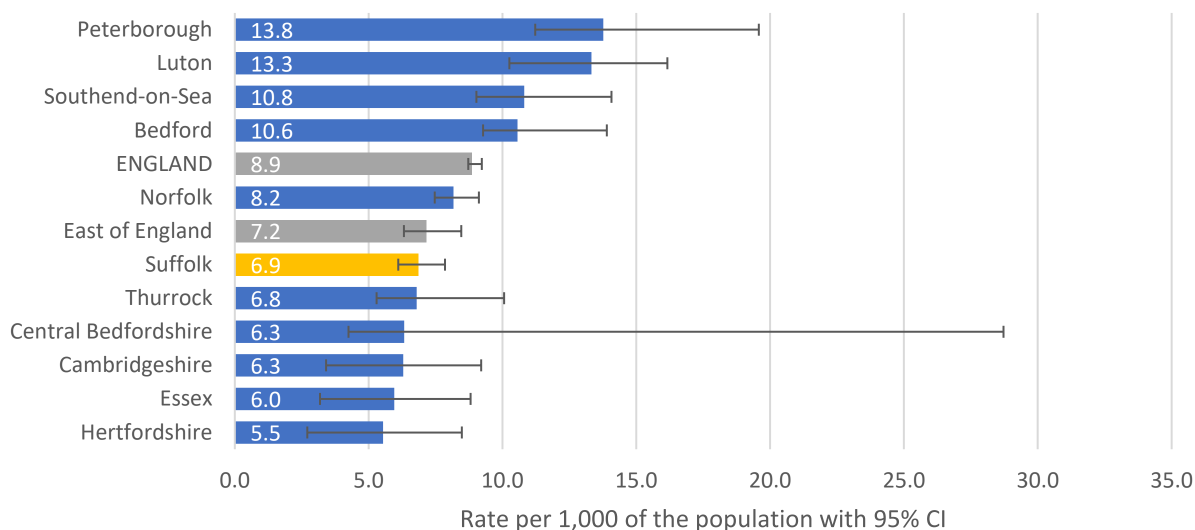
Opiate and/or crack cocaine use (OCU) in 2016/17

At a rate of 6.9 OCU per 1,000 population, Suffolk is ranked 112th highest out of 151 English local authorities.

The chart below compares the OCU prevalence rate in Suffolk with its East of England neighbours, the East of England, and England. Although lower than Southend-on-Sea, Peterborough, Norfolk, Luton, and Bedford, Suffolk's rate is statistically similar to the East of England. However, Suffolk is significantly lower than England.

Suffolk's OCU prevalence population of 3,116 people (rate of 6.86 per 1,000) in 2016/17 has increased by 265 people since 2014/15. This is not statistically significant.

Figure 10: OCU prevalence estimates for those aged 15-64 in 2016/17 (with 95% confidence intervals), rate per 1,000 of the population



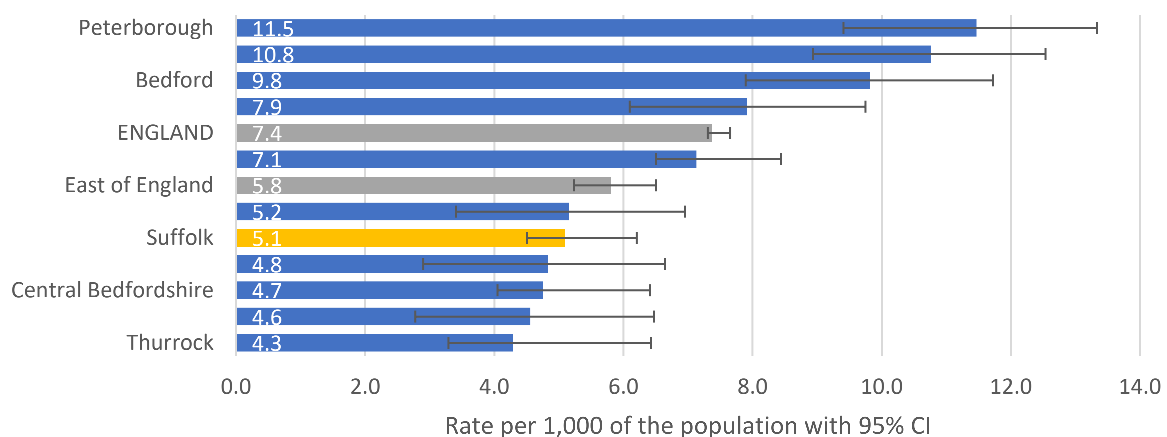
Source: Liverpool John Moores University

The charts below show opiate and crack cocaine rates separated for Suffolk compared to the East of England Lower Tier Local Authorities (LTLAs) and England.

Suffolk had the 7th highest rate of opiate users per 1,000 (5.1 per 1,000) out of the 11 LTLAs in the East of England. In 2016/17 there were 2,314 opiate users compared to 2,391 (-77) in 2014/15. This is statistically similar.

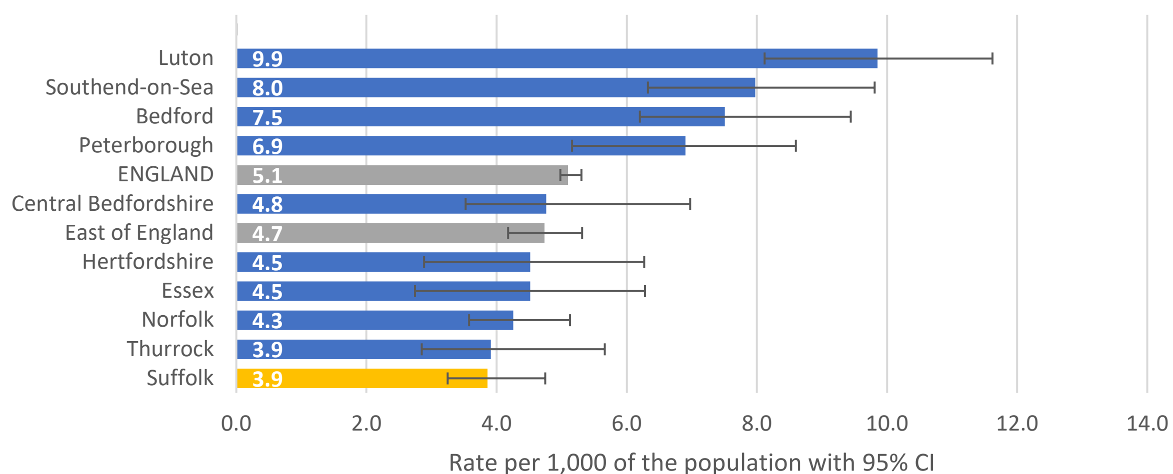
Suffolk had the 9th highest rate of crack cocaine users per 1,000 (3.9 per 1,000) out of the 11 LTLAs in the East of England. In 2016/17 there were 1,751 crack cocaine users compared to 1,097 (+654) in 2014/15. Suffolk was the only county in the East of England to see a significant increase in the number of crack cocaine users from 2014/15 to 2016/17.

Figure 11: Prevalence estimates for opiate users for those aged 15-64 in 2016/17 – rate per 1,000 of the population with 95% CI



Source: Liverpool John Moores University

Figure 12: Prevalence estimates for crack cocaine users for those aged 15-64 in 2016/17 – rate per 1,000 of the population with 95% CI



Source: Liverpool John Moores University

OCU age group analysis in 2016/17

The charts below show the estimated number and rate by age group. When looking at the number of OCU and opiate users, there are significantly more aged 35 and over (1,831 and 1,423, respectively) compared to under 25's (311 and 172, respectively). When looking at the rate, the most prevalent group is those aged 24-34; 11.0 per 1,000 for OCU users and 8.2 per 1,000 for opiate users.

Figure 13: Prevalence estimates for OCU and opiate users, raw numbers by age group for Suffolk, 2016/17

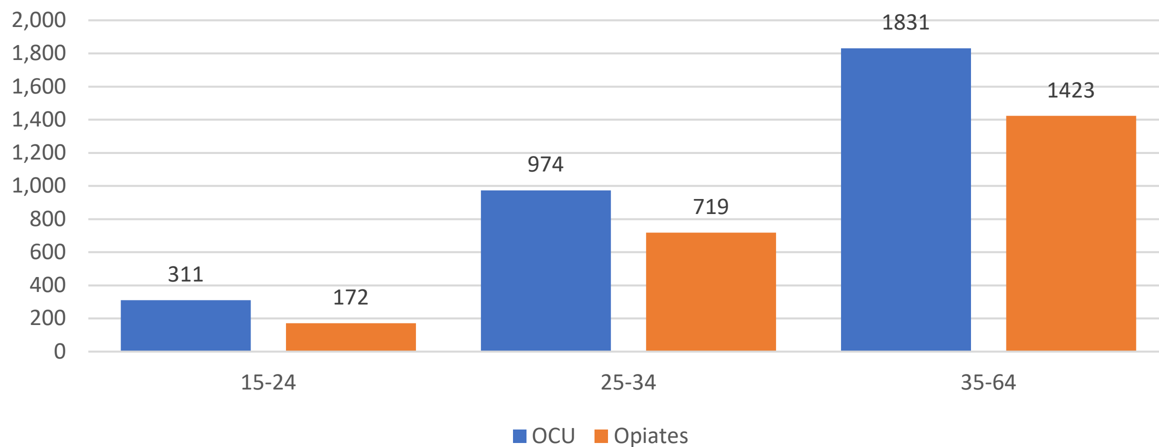
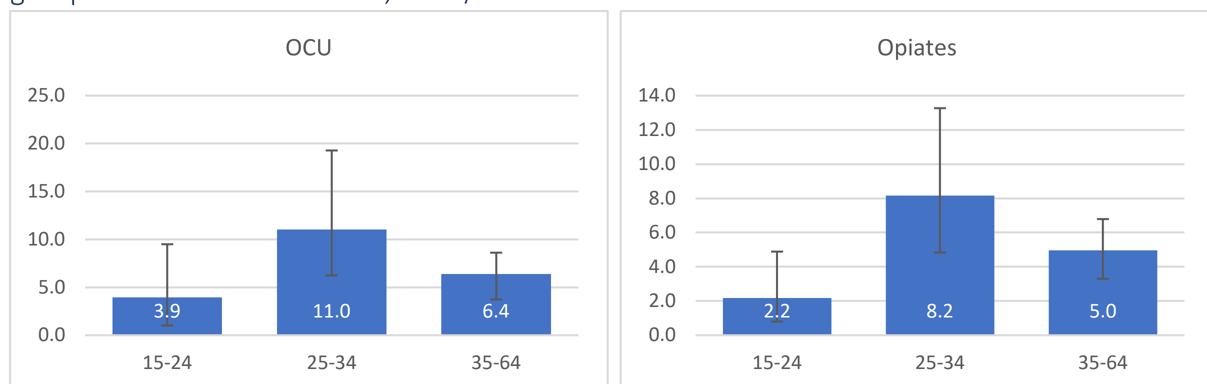


Figure 14: Prevalence estimates for OCU and opiate users, per 1,000 of the population by age group for Suffolk with 95% CI, 2016/17



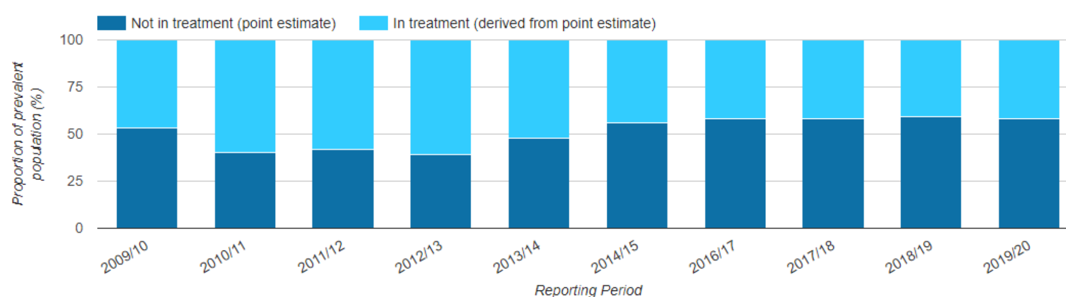
Source: Liverpool John Moores University

Unmet need for opiate and/or crack cocaine users

Figure 15 shows the estimated proportion of OCU users in Suffolk and the proportion of unmet need. In 2019/20, there was an estimated 58% of OCU users in Suffolk were not accessing treatment services.

Estimated numbers (prevalence) of opiate and / or crack users (OCUs), aged 15-64, later than 2016/17 are not yet available. Thus, for each year between 2017/18 - 2019/20, the rate of unmet need Figures have been estimated using the respective 2016/17 OCU prevalence estimate.

Figure 15: prevalence estimates and rates of unmet need for OCU treatment, Suffolk, 2009/10 to 2019/20



Unmet need	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2016/17 (%)	2017/18 (%) *	2018/19 (%) *	2019/20 (%) *
Not in treatment (point estimate)	53	40	42	39	48	56	58	58	59	58
In treatment (derived from point estimate)	47	60	58	61	52	44	42	42	41	42

Source: NDTMS View It

Alcohol prevalence estimates

The national estimates of alcohol dependence were updated in November 2018 by the University of Sheffield, for the financial year 2016/17. It estimates the number of adults (aged 18+) within each local authority with an alcohol dependency, potentially in need of specialist treatment.

The table and chart below compare the numbers and rate of estimated alcohol prevalence across the East of England local authorities.

Suffolk ranked 8 out of 11 local authorities in the East of England for the rate of alcohol dependant adults per 100. There is no statistically significant difference between Suffolk and England.

Table 3: Alcohol prevalence estimates, raw Figure, and rate per 100 of adult population, East of England local authorities, East of England, and England, 2018

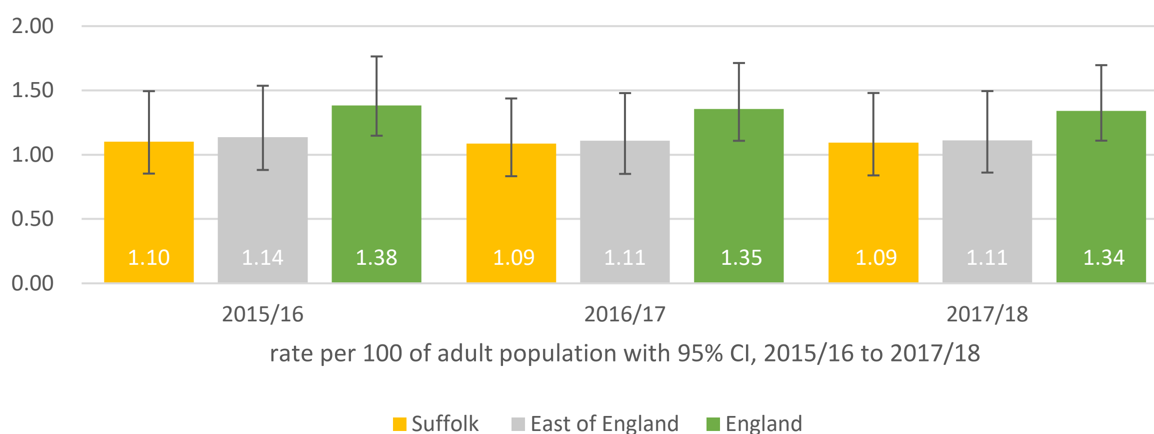
Local Authority	Estimated number of adults with alcohol dependency	Rate per 100 of the adult population
Central Bedfordshire	1,942	0.89
Hertfordshire	8,637	0.95
Essex	12,505	1.08
Suffolk	**6,609**	**1.09**
Milton Keynes	2,200	1.10
Cambridgeshire	5,674	1.10
Bedford	1,474	1.13
Norfolk	8,840	1.21
Thurrock	1,574	1.23
Luton	2,181	1.38
Southend-on-Sea	2,026	1.42
Peterborough	2,405	1.62
East of England	**56,067**	**1.11**
England	**586,780**	**1.34**

Source: University of Sheffield

The estimated number of alcohol dependant adults has increased since 2010 to 2018, from 6,468 to 6,609. However, for the period between 2010 and 2014 confidence intervals were not calculated, therefore it is not possible to comment whether this increase is statistically significant.

Suffolk was not statistically different from the East of England and England from 2015/16 to 2017/18.

Figure 16: Alcohol prevalence estimates, Suffolk, East of England, England, rate per 100 of adult population with 95% CI, 2015/16 to 2017/18

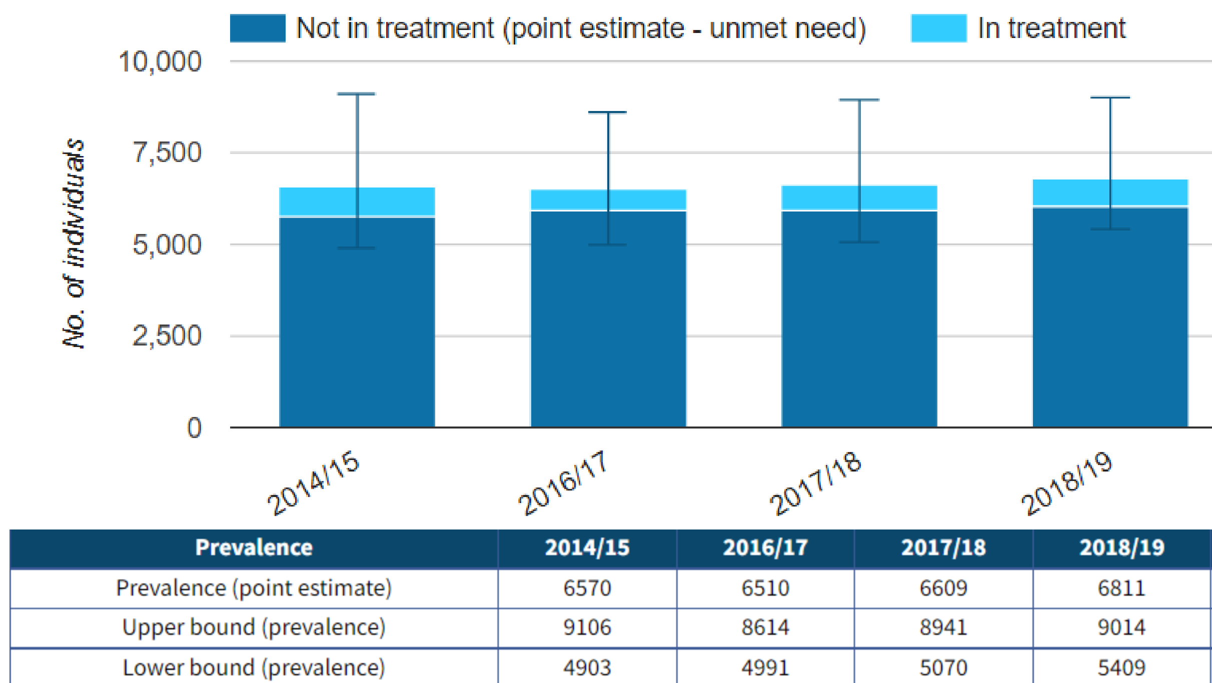


Source: University of Sheffield

Unmet need for alcohol treatment

Figure 17 shows the estimated number of dependent drinkers in Suffolk and the rate of unmet need. In 2018/19, there was an estimated 6,811 alcohol-dependent residents in Suffolk that were not accessing rehabilitation services. This represents an unmet need of 89% in 2018/19, with only an estimated 11% of alcohol-dependant residents in Suffolk accessing treatment.

Figure 17: prevalence estimates and rates of unmet need for alcohol treatment, Suffolk, 2014/15 to 2018/19



Prevalence	2014/15	2016/17	2017/18	2018/19
Prevalence (point estimate)	6570	6510	6609	6811
Upper bound (prevalence)	9106	8614	8941	9014
Lower bound (prevalence)	4903	4991	5070	5409

Source: NDTMS View It

Adults (combined drugs and alcohol)

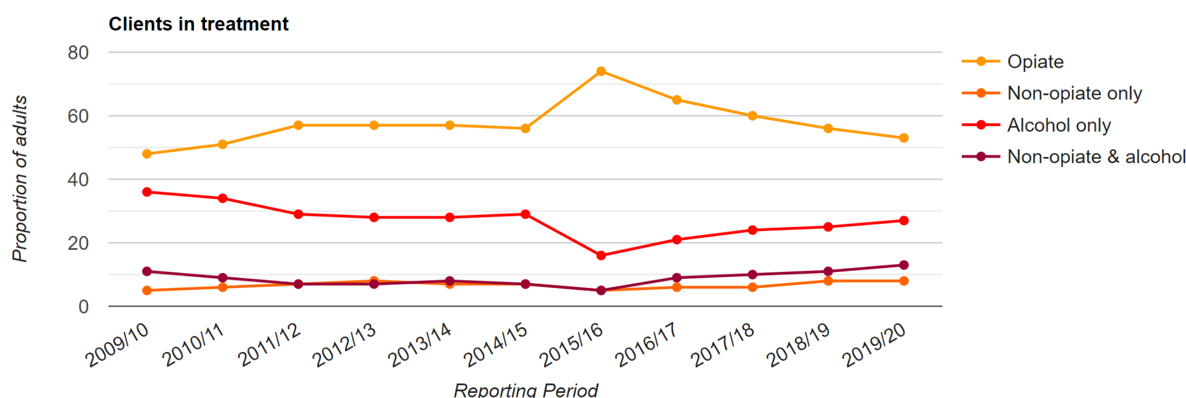
Client characteristics

Numbers in treatment – trends

In 2019/20, NDTMS reported a total of 2,345 adults receiving structured treatment in Suffolk. Individuals can access treatment for either problematic drug use, alcohol, or both.

Nearly half of adults in treatment (48%) were in treatment for opiate use, while nearly 1 in 3 (31%) were in treatment for alcohol.

Figure 18: Proportion of adults in treatment (%), 2009 – 2020, Suffolk



Source: NDTMS View It

Table 4: Number of adults in treatment, 2009 – 2020, Suffolk

Substance Category	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Opiate	1305	1315	1360	1380	1290	1220	1205	1280	1255	1220	1235
Non-opiate only	145	145	170	205	165	155	80	110	135	170	185
Alcohol only	995	880	680	685	640	635	255	410	500	540	625
Non-opiate & alcohol	295	230	160	170	185	155	85	170	200	235	300

Source: NDTMS View It

Substance use profile (all in treatment)

Substance breakdown of all clients in treatment

The distribution of substances used by all individuals in treatment is shown in Table 5 below. This substance use profile defines clients by groups of substance use and relates to any use within a client's journey. A client may therefore be categorised by one or more groups and as a result the totals in this table will be greater than the number of clients presented in the previous section. To prevent deductive disclosure, all numbers under 5 have been supressed.

Alcohol is used by almost half of all service users (49%, n=1,135). In 2019/20, 1 in 4 (25%, n=595) of service users in treatment were taking opiates. This is significantly lower than in 2015/16, when 47% of service users (n=730) reported using opiates. Cannabis use among service users has been relatively static over the last decade with 20% reporting its use during treatment.

Table 5: Number service users in treatment by substances use type, 2009/10 to 2019/20, Suffolk

Substance Use	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Opiate and crack cocaine	330	345	345	380	390	390	440	555	585	605	635
Opiate (not crack cocaine)	975	975	1015	1000	900	830	770	730	675	615	595
Crack cocaine (not opiate)	40	40	30	30	20	25	10	45	60	80	95
Cannabis	565	525	510	570	525	440	360	420	420	440	460
Cocaine	150	125	115	135	125	115	80	145	175	210	265
Benzodiazepine	260	225	215	230	200	165	150	165	145	135	150
Amphetamine (not ecstasy)	135	115	110	125	115	115	85	85	65	70	70
Ecstasy	30	30	20	30	30	30	15	20	25	30	25
Mephedrone	-	5	5	5	10	25	15	15	10	5	5
NPS	-	-	-	-	0	5	5	10	5	0	0
Hallucinogen	35	40	40	30	30	20	15	25	20	35	30
Alcohol	1595	1430	1140	1135	1090	1000	575	835	935	990	1135
Other	20	20	20	20	15	10	10	15	25	25	25

Source: NDTMS View It

Table 6: Proportion of service users in treatment by substances use type, 2009/10 to 2019/20, Suffolk

Substance Use	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Opiate and crack cocaine	12	13	15	16	17	18	27	28	28	28	27
Opiate (not crack cocaine)	36	38	43	41	39	38	47	37	32	28	25
Crack cocaine (not opiate)	1	2	1	1	1	1	1	2	3	4	4
Cannabis	21	20	22	23	23	20	22	21	20	20	20
Cocaine	5	5	5	6	5	5	5	7	8	10	11
Benzodiazepine	9	9	9	9	9	8	9	8	7	6	6
Amphetamine (not ecstasy)	5	4	5	5	5	5	5	4	3	3	3
Ecstasy	1	1	1	1	1	1	1	1	1	1	1
Mephedrone	-	0	0	0	0	1	1	1	0	0	0
NPS	-	-	-	-	0	0	0	1	0	0	0
Hallucinogen	1	2	2	1	1	1	1	1	1	2	1
Alcohol	58	56	48	47	48	46	35	42	45	46	49
Other	1	1	1	1	1	0	1	1	1	1	1

Source: NDTMS View It

Club drugs and NPS – all in treatment

Club drugs are psychoactive substances often used recreationally in nightclubs, bars, and festivals. New Psychoactive Substances (NPS) are synthesised to mimic traditional drugs and are marketed "not for human consumption" to avoid detection. They are sold under the guise of bath salts or other chemicals[7].

There are very few service users who report using club drugs and NPSs (n=30). This represents only 2% of drug and alcohol service users in Suffolk in 2019/20.

Table 7: Number of service users in treatment, club drugs and new psychoactive substances, 2009/10 to 2019/20, Suffolk

Club drugs and new psychoactive substances	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Ecstasy	30	30	20	30	30	30	15	20	25	30	25
Ketamine	30	35	35	25	30	15	15	25	20	30	25
GHB/GBL	0	0	0	0	0	0	0	5	5	5	0
Methamphetamine	0	0	0	0	5	0	5	0	0	0	0
Mephedrone	-	5	5	5	10	25	15	15	10	5	5
New Psychoactive Substances	-	-	-	-	0	5	5	10	5	0	0

Source: NDTMS View It

Age of clients (all in treatment)

The age distribution of all individuals in treatment in 2019/20 is shown in Table 8 below. Age is calculated on April 1st for clients' already in treatment or at the start of treatment for clients starting treatment in the year.

The largest proportion of service users are in the 30-49 age banding across all drug and alcohol groups, apart from 'non-opiate only' where the majority of service users (57%) are 18-29 years old.

Table 8: Age distribution of all clients in treatment 2019/20 by substance type

Age Group	Opiate	Non-opiate only	Alcohol only	Non-opiate & alcohol	All
18-29	9%	57%	9%	38%	16%
30-49	71%	41%	53%	52%	61%
50+	20%	3%	38%	10%	22%

Source: NDTMS View It

Age distribution trend

The table below shows the proportion of clients within each age group, by financial year, for all substance types combined. It can be clearly seen that proportionally clients are now older than they were 11 years ago, in 2009/10.

Although the proportion of people 30 – 49 years of age entering treatment has remained stable over the last decade, the 50+ age group has seen an increase from 14% in 2009/10 to 22% in 2019/20. The 18 -29 age group has seen a reduction from 27% in 2009/10 to 16% in 2019/20.

Table 9: Proportion of all clients in treatment by age group and year (all substance types)

Age Group	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
18-29	27	26	24	23	21	20	20	19	17	18	16
30-49	59	59	61	62	63	64	63	63	63	61	61
50+	14	15	15	15	17	17	17	19	20	22	22

Source: NDTMS View It

Gender of clients (all in treatment)

Almost three quarters of all clients are receiving treatment for drug-related substances (73.3%) and the other quarter are alcohol only (26.7%).

From a total of 2,340 clients in 2019/20, there are 780 females (33.3%) and 1,560 males (66.7%). A breakdown by substance category can be seen in the table below.

Table 10: Substance use category by gender, 2019/20, Suffolk

	Female		Male		Persons	
Substance category	**n**	**Proportion of gender**	**n**	**Proportion of gender**	**n**	**Proportion of substance**
Opiates	360	29.1%	875	70.9%	1235	52.8%
Non-opiates only	65	35.1%	120	64.9%	185	7.9%
Alcohol & non-opiates	85	28.8%	210	71.2%	295	12.6%
Alcohol only	270	43.2%	355	56.8%	625	26.7%
Total	780	33.3%	1560	66.7%	2340	100.0%

Source: NDTMS View It

Ethnicity and gender of clients

The tables below show the proportion of clients in treatment by ethic group, self-reported by the client at the start of their journey. The table includes all substances. Separate table for drug clients and alcohol only clients have been omitted as there is very little difference to the 'all substance' table and many of the ethnicity fields are supressed due to low numbers in treatment.

The majority of service users in treatment are white (96.3%) and male (66.5%).

Table 11: Proportion of all clients in treatment by ethnic group and gender (all substances), 2019/20, Suffolk

			Proportion by gender	
Ethnicity Group	**n**	**Proportion**	**Male**	**Female**
White	2240	96.3%	66.5%	33.5%
Mixed/Multiple ethnic group	55	2.4%	63.6%	36.4%
Asian/Asian British	10	0.4%	100.0%	0.0%
Black/African/Caribbean/Black British	20	0.9%	75.0%	25.0%
Other ethnic group	0	0.0%	0.0%	0.0%
Total	2325	100.0%	66.7%	34.6%

Source: NDTMS View It

Religion - new presentations

Service users accessing treatment are assessed on entering the drug and alcohol treatment services. 1,050 service users provided their religion in 2019/20. The majority (76.7%) said that they did not follow a religion. Almost 1 in 5 (17.6%) reported being Christian, while 0.5% were Muslim or Buddhist.

Table 12: Religion of adults receiving structured treatment, 2019/20

Religion	n	Proportion
None	805	76.7%
Christian	185	17.6%
Unknown	5	0.5%
Decline	5	0.5%
Other	40	3.8%
Muslim	5	0.5%
Buddhist	5	0.5%
Total	1050	100.0%

Source: NDTMS View It

Sexuality – new presentations

All substances have been combined here to allow presentation of clients' sexuality. The majority of new clients in 2019/20 were heterosexual (95.2%) followed by bisexual (2.4%). Only 1% of service users accessing treatment in 2019/20 were gay or lesbian.

Table 13: Sexuality of adults receiving structured treatment, 2019/20

Sexual Orientation	Number	Proportion
Heterosexual	1000	95.2%
Bisexual	25	2.4%
Not stated	10	1.0%
Gay/Lesbian	10	1.0%
Client asked and does not know or is not sure	5	0.5%
Other	0	0.0%
Total	1050	100.0%

Source: NDTMS View It

Disability – new presentations

From a total of 1,050 new presentations in 2019/20, over 8 out of 10 clients (83.8%) stated no disability, while 16.2% (n=170) reported one or more disabilities. 1 in 20 (5.2%) service users reported behavioural and emotional disabilities, while a similar proportion (4.3%) reported mobility-related disabilities. The full list of disabilities can be seen in table 14.

Table 14: Most common disabilities reported for new drug presentations in 2019/20

Disability	Number	Proportion
Behaviour and emotional	55	5.2%
Mobility and gross motor	45	4.3%
Learning disability	15	1.4%
Not stated	10	1.0%
Other	10	1.0%
Progressive conditions and physical health	10	1.0%
Sight	10	1.0%
Perception of physical danger	5	0.5%
Manual dexterity	5	0.5%

Disability	Number	Proportion
Hearing	5	0.5%
Personal, self-care and continence	0	0.0%
Speech	0	0.0%
Total disability	170	16.2%
No disability	880	83.8%
Total	1050	100.0%

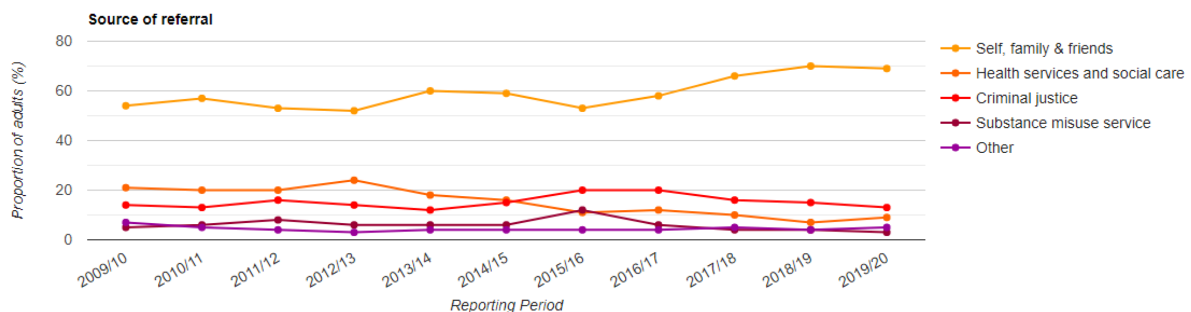
Source: NDTMS View It

Source of referral into treatment

The source of referral represents the method of referral into substance use treatment or the source which promoted their presentation. The graph below shows the proportion of clients referred by each category, by financial year. A considerable increase can be seen in the proportion of referrals from self, family & friends (54% in 2009/10 to 69% in 2019/20), while at the same time, there is a reduction in referrals from health and social care services (21% in 2009/10 to 9% in 2019/20). (See Figure 19)

Referrals for 'opiates only' show a reduction from health and social care services (10% in 2009/10 to 4% in 2019/20) (see Figure 19), while other sources of referrals remain relatively static. For alcohol only referrals, however, there has been a considerable increase in the proportion of referrals from self, family & friends (53% in 2009/10 to 74% in 2019/20) (see Figure 21).

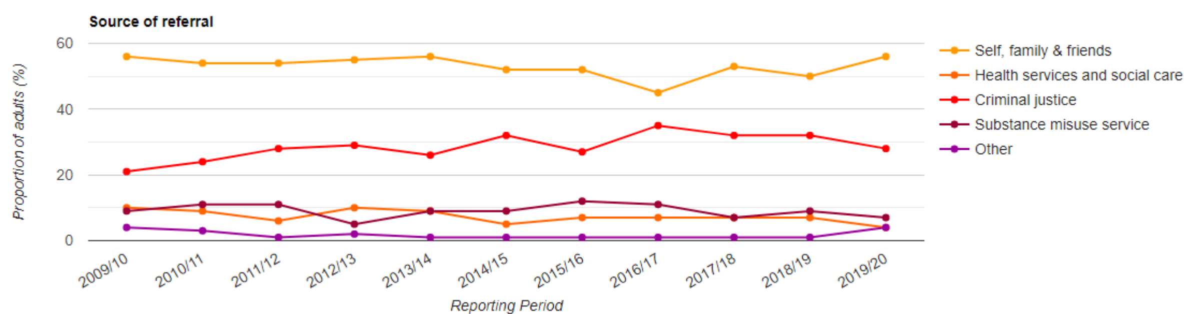
Figure 19: Source of referrals into treatment for new presentations (all substances)



Source of Referral	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Self, family & friends	54	57	53	52	60	59	53	58	66	70	69
Health services and social care	21	20	20	24	18	16	11	12	10	7	9
Criminal justice	14	13	16	14	12	15	20	20	16	15	13
Substance misuse service	5	6	8	6	6	6	12	6	4	4	3
Other	7	5	4	3	4	4	4	4	5	4	5

Source: NDTMS View It

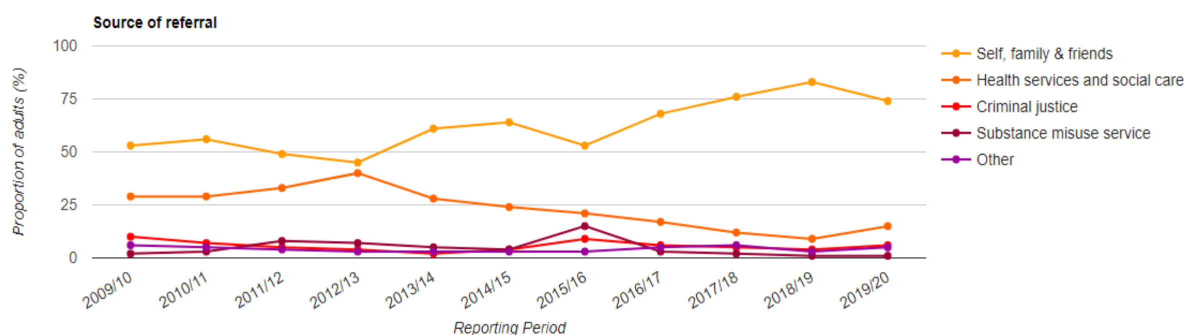
Figure 20: Source of referrals into treatment for new presentations (opiates only)



Source of Referral	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Self, family & friends	56	54	54	55	56	52	52	45	53	50	56
Health services and social care	10	9	6	10	9	5	7	7	7	7	4
Criminal justice	21	24	28	29	26	32	27	35	32	32	28
Substance misuse service	9	11	11	5	9	9	12	11	7	9	7
Other	4	3	1	2	1	1	1	1	1	1	4

Source: NDTMS View It

Figure 21: Source of referrals into treatment for new presentations (alcohol only)



Source of Referral	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Self, family & friends	53	56	49	45	61	64	53	68	76	83	74
Health services and social care	29	29	33	40	28	24	21	17	12	9	15
Criminal justice	10	7	5	4	2	4	9	6	5	4	6
Substance misuse service	2	3	8	7	5	4	15	3	2	1	1
Other	6	5	4	3	3	3	3	5	6	3	5

Source: NDTMS View It

Housing situation

Housing situation data presents the self-reported housing status of the individuals at the time they access treatment. Less than 1 in 10 (8%, n=95) of new presentations for all substances had an urgent housing problem – a similar proportion compared to England (7.4%). However, a higher proportion of opiate users had an urgent housing problem, ranging from 10% in 2009/10 to 22% in 2014/15. In 2019/20, 17% of opiate users in Suffolk had an urgent housing problem – this is similar to England (16%).

Table 15: Housing situation for new presentations, as a proportion, all substances, Suffolk, 2009/10 to 2019/20

Housing Situation	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
No problem	80	81	76	76	72	71	73	77	70	66	78
Housing Problem	11	12	14	14	16	15	14	10	12	12	13
Urgent Housing Problem	4	6	9	9	10	11	10	9	12	9	8
Other	4	2	1	1	2	3	4	4	6	13	0

Source: NDTMS View It

Table 16: Housing situation for new presentations, as a proportion, opiate users, Suffolk, 2009/10 to 2019/20

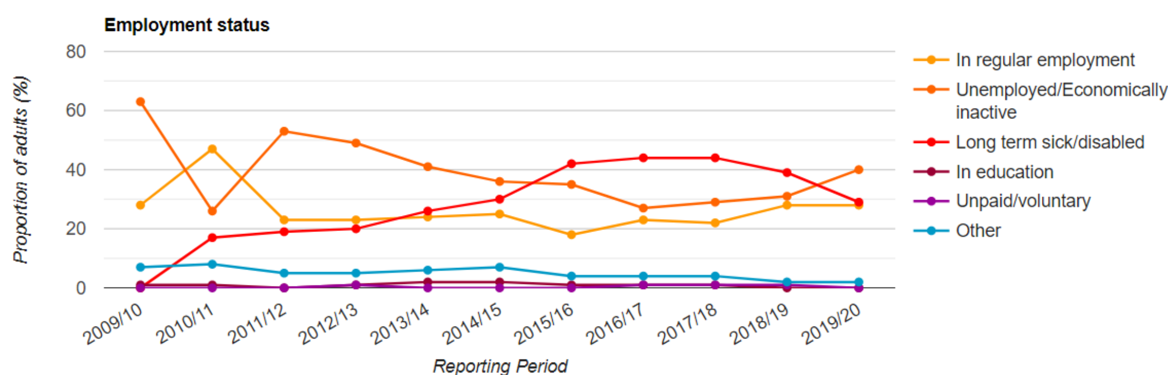
Housing Situation	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
No problem	71	72	64	66	62	59	68	71	57	60	65
Housing Problem	18	16	20	16	19	18	16	13	17	17	18
Urgent Housing Problem	10	12	16	18	20	22	15	16	24	19	17
Other	1	0	0	0	0	0	0	0	1	4	0

Employment status

The proportion of unemployed clients has reduced by 23 percentage points since 2009/10, from 63% to 40%, while those in employment entering treatment service has remained static over the same period.

Since the category of long-term sick and/or disabled was introduced in 2010, service users reporting 'long term sick and/or disabled' has increased from 17% in 2010/11 to 29% in 2019/20. This peaked in 2016-2018 when 44% of service users were long-term sick and/or disabled.

Figure 22: Employment status for new presentations, as a proportion, all substances, Suffolk, 2009/10 to 2019/20



Employment Status	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
In regular employment	28	47	23	23	24	25	18	23	22	28	28
Unemployed/Economically inactive	63	26	53	49	41	36	35	27	29	31	40
Long term sick/disabled	0	17	19	20	26	30	42	44	44	39	29
In education	1	1	0	1	2	2	1	1	1	0	0
Unpaid/voluntary	0	0	0	1	0	0	0	1	1	1	0
Other	7	8	5	5	6	7	4	4	4	2	2

Source: NDTMS View It

Parental status and safeguarding

Parents' dependent alcohol and drug use can negatively impact on children's physical and emotional wellbeing, their development, and their safety. The impacts on children include physical maltreatment and neglect, poor physical and mental health, and development of health harming behaviours in later life[8].

As we understand more about the impacts of parental problem alcohol and drug use on children, it becomes more important that all health, social care and support organisations take a whole family approach. This is where action to protect children, and enabling all children to have the best outcomes, becomes integral to organisations' service delivery.

Drug clients

In 2019/20, there were 179 children reported as living with drug users entering treatment in Suffolk.

Regarding parental status of new service user presentations, 16% (n=113) were living with their own or other children, which was similar to England (18%). A higher proportion (40%, n=287) were parents who were not living with their children. This is a higher proportion compared to England (34%).

Table 17: Parental status of new drug clients in 2019/20, Suffolk compared to England

Parental status	Local n	Proportion of new presentations	Proportion by sex M	Proportion by sex F	National n	Proportion of new presentations	Proportion by sex M	Proportion by sex F
Living with children (own or other)	113	16%	14%	19%	15,000	18%	16%	26%
Parent not living with children	287	40%	41%	37%	27,449	34%	33%	35%
Not a parent/no child contact	321	44%	44%	44%	38,526	47%	51%	39%
Missing / incomplete	2	0%	0%	0%	192	0%	0%	0%
Living with children	**Local n**		**Proportion of children by client sex M**	**F**	**National n**		**Proportion of children by client sex M**	**F**
Number of children living with drug users entering treatment in 2019-20	179		68%	32%	27,728		63%	37%

Source: Drugs commissioning support pack 2021-22

Alcohol clients

In 2019/20, there were 200 children reported as living with alcohol clients entering treatment in Suffolk.

Regarding parental status of new service user presentations, 22% (n=97) were living with their own or other children, which was similar to England (25%). A slightly higher proportion (26%, n=115) were parents who were not living with their children. This is similar to England (25%).

Table 18: Parental status of new alcohol clients in 2019/20, Suffolk compared to England

Parental status	Local n	Proportion of new presentations	Proportion by sex (M/F) M	Proportion by sex (M/F) F	National n	Proportion of new presentations	Proportion by sex (M/F) M	Proportion by sex (M/F) F
Living with children (own or other)	97	22%	16%	31%	12,873	25%	20%	33%
Parent not living with children	115	26%	30%	21%	12,947	25%	27%	22%
Not a parent/no child contact	225	51%	54%	48%	25,035	49%	52%	45%
Missing / incomplete	1	0%	0%	0%	102	0%	0%	0%
Living with children	**Local n**		**Proportion of children by client sex M**	**F**	**National n**		**Proportion of children by client sex M**	**F**
Number of children living with alcohol clients entering treatment in 2019-20	200		41%	59%	22,245		50%	50%

Source: Alcohol commissioning support pack 2019-20

Mental health

It is very common for people to experience mental ill-health and alcohol/drug use (co-occurring conditions) at the same time. Research shows that mental ill-health are experienced by the majority of drug (70%) and alcohol (86%) of alcohol users in community substance use treatment[9]. Death by suicide is also common, with a history of alcohol or drug use being recorded in 54% of all suicides in people experiencing mental-ill health[9].

Moreover, evidence shows that despite the shared responsibility that NHS and local authority commissioners have to provide treatment, care and support, people with cooccurring conditions are often excluded from services[9].

Drugs clients

Almost three quarters (72%, n=518) drug users who entered treatment in Suffolk during 2019/20 were identified as having a mental health treatment need. This is significantly higher than England (58%).

Nearly 9 out of 10 (87%) of clients identified as having a mental health need were receiving treatment for their mental health. This is significantly better than England (71%). Therefore, it is estimated that 13% of drug users (n=68) who entered treatment in Suffolk during 2019/20 had a mental health treatment need but were not accessing mental health services.

Of the 518 drug users who entered treatment in Suffolk during 2019/20 and were identified as have a mental health treatment need, the majority (66%, n=341) were receiving mental health treatment from their GP, while 1 in 5 (19%, n=97) were already engaged with the Community Mental Health Team.

Table 19: Mental health of drug clients entering treatment in 2019/20, Suffolk compared to England

Adults who entered treatment in 2019-20 and were identified as having a mental health treatment need

	Local n	Proportion of new presentations	Proportion by sex M	Proportion by sex F	National n	Proportion of new presentations	Proportion by sex M	Proportion by sex F
Opiate	247	69%	63%	83%	22,708	54%	51%	64%
Non-opiate	96	72%	68%	80%	10,844	60%	55%	72%
Non-opiate and alcohol	175	76%	69%	93%	13,854	65%	61%	77%
All	518	72%	66%	86%	47,406	58%	54%	69%

Clients identified as having a mental health treatment need and receiving treatment for their mental health

	Local n	Proportion of clients identified	Proportion by sex M	Proportion by sex F	National n	Proportion of clients identified	Proportion by sex M	Proportion by sex F
Already engaged with the Community Mental Health Team/other mental health services	97	19%	16%	23%	8,684	18%	17%	21%
Engaged with IAPT (Improving Access to Psychological Therapies)	12	2%	2%	3%	588	1%	1%	1%
Receiving mental health treatment from GP	341	66%	66%	66%	23,223	49%	48%	52%
Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem	2	0%	0%	1%	1,003	2%	2%	2%
Has an identified space in a health-based place of safety for mental health crises	0	0%	0%	0%	295	1%	1%	1%
Total individuals receiving mental health treatment	450	87%	84%	91%	33,514	71%	68%	76%

Source: Drugs commissioning support pack 2021-22

Alcohol clients

Almost three quarters (73%, n=319) alcohol users who entered treatment in Suffolk during 2019/20 were identified as having a mental health treatment need. This is statistically significantly higher than England (60%).

Nearly 9 out of 10 (91%) of clients identified as having a mental health need were receiving treatment for their mental health. This is significantly better than England (80%). Therefore, it is estimated that 9% of alcohol users (n=30) who entered treatment in Suffolk during 2019/20 had a mental health treatment need but were not accessing mental health services.

Of the 319 alcohol users who entered treatment in Suffolk during 2019/20 and were identified as have a mental health treatment need, the majority (77%, n=245) were receiving mental health treatment from their GP, while over 1 in 10 (13%, n=40) were engaged with the Community Mental Health Team.

Table 20: Mental health of alcohol clients entering treatment in 2019/20, Suffolk compared to England

Adults who entered treatment in 2019-20 and were identified as having a mental health treatment need

	Local	Proportion of new presentations	Proportion by sex		National	Proportion of new presentations	Proportion by sex	
	n		M	F	n		M	F
Client identified a mental health treatment need	319	73%	67%	81%	30,409	60%	55%	66%

Client identified a mental health treatment need and receiving treatment for their mental health

	Local	Proportion of clients identified	Proportion by sex		National	Proportion of clients	Proportion by sex	
	n		M	F	n		M	F
Already engaged with the Community Mental Health Team/Other mental health services	40	13%	13%	12%	4,898	16%	15%	17%
Engaged with IAPT	3	1%	1%	1%	491	2%	1%	2%
Receiving mental health treatment from GP	245	77%	75%	79%	18,478	61%	59%	64%
Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem	2	1%	1%	1%	474	2%	2%	1%
Has an identified space in a health-based place of safety for mental health crises	1	0%	1%	0%	122	0%	0%	0%
Total individuals receiving mental health treatment	291	91%	90%	93%	24,286	80%	77%	84%

Source: Alcohol commissioning support pack 2021-22

Geographic distribution of clients

Using local data from the current service provider, maps of Suffolk have been plotted showing which areas have the highest density of service users. They include all adult clients (18+ years) who have received structured treatment in Suffolk between 2020 and 2021. All clients in the maps are only counted once, even if they re-present. 56 clients were omitted from the maps as the postcode was either missing or invalid/incomplete.

The maps were created from raw Figures for clients on the first 4 digits of their postcode. More work will be done beyond this report to review client lists by smaller geographies and convert them to rates for more robust comparison.

Three maps are presented: all clients, alcohol-only clients, and opiate-only clients. The majority of clients live in urban areas of Suffolk, such as Ipswich, Bury St Edmunds, Lowestoft, Sudbury, and Haverhill.

Figure 23: All substance use service clients by 4-digit postcode area, Suffolk, 2020/21

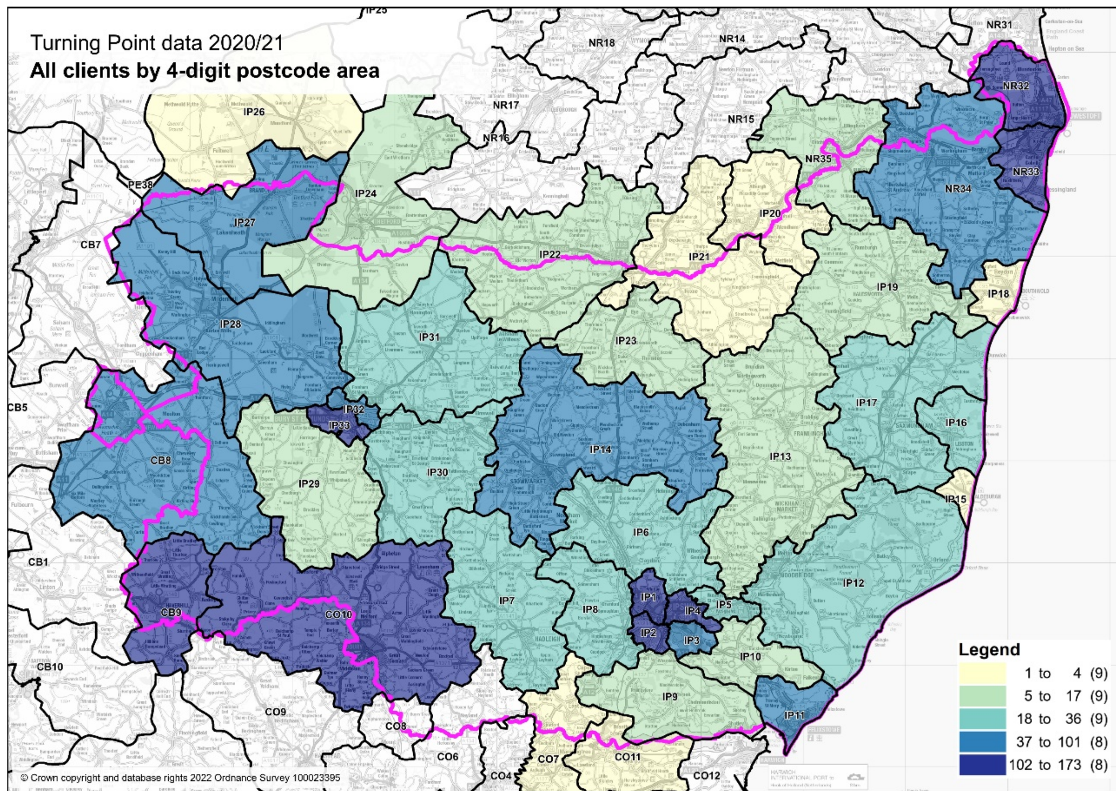


Figure 24: Alcohol-only service clients by 4-digit postcode area, Suffolk, 2020/21

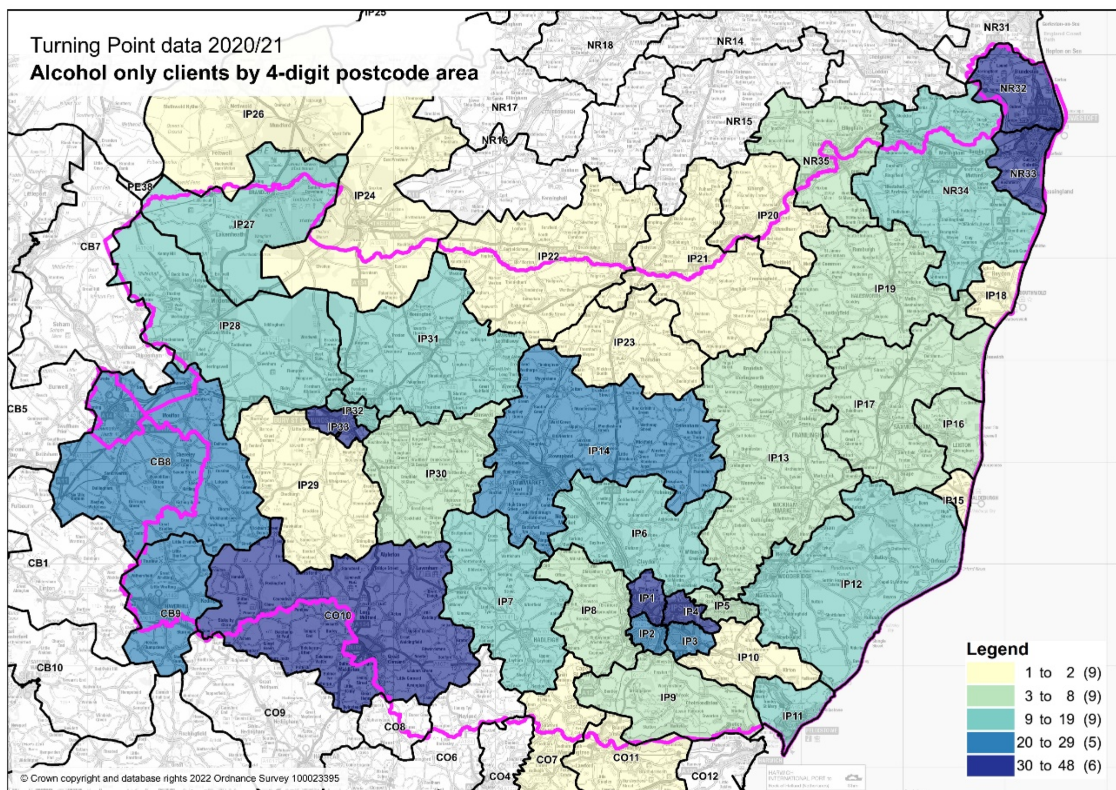
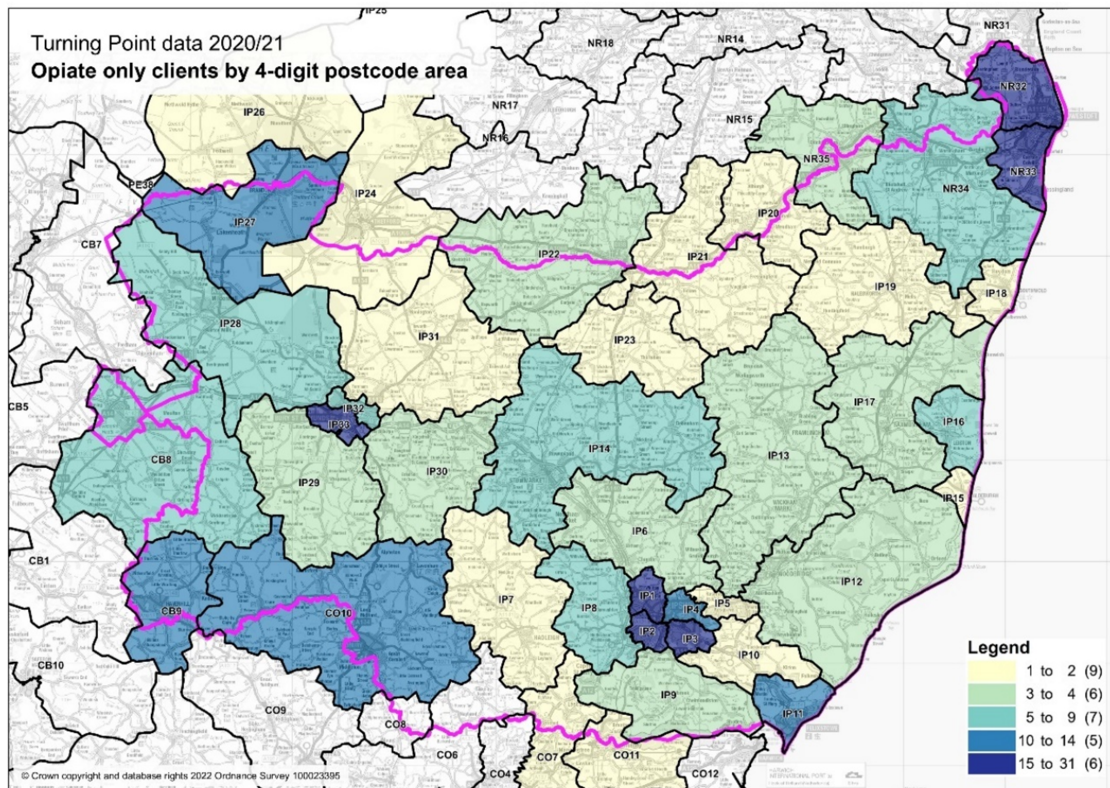


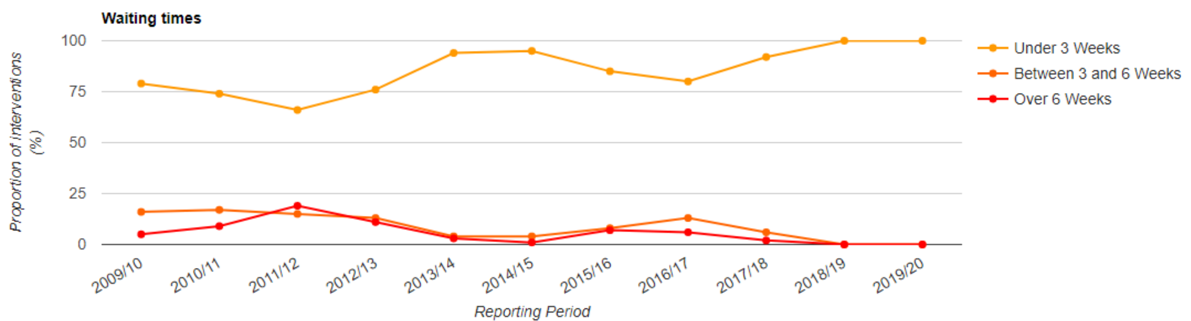
Figure 25: Opiate-only service clients by 4-digit postcode area, Suffolk, 2020/21



Access to services: waiting times

This represents the number of weeks from assessment to first treatment. Suffolk has reached 100% of all clients being seen within a 3-week period for the last 2 years (2018-2020). Please note that this data does not present the time taken from external referral (i.e., first contact with the drug and alcohol service provider) to assessment.

Figure 26: Waiting times for access to services in Suffolk, all in treatment as a proportion (all substances)



Source: NDTMS View It

Treatment and recovery outcomes

Treatment exits

All substance

Successful treatment completions for all substances in Suffolk has increased from 35% in 2009/10 to 50% in 2020/21. A similar trend can be seen across the East of England (48% to 54%) and England (43% to 50%).

In 2020/21, 1 in 3 clients (35%) dropped out of treatment. This is similar to the East of England (31%) and England (33%).

Table 21: Proportion of clients who exit treatment, Suffolk, all substances, 2009/10 – 2020/21

Treatment Exits	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)	2020/21 (%)
Successful completion	35	46	42	40	38	34	23	33	40	42	45	50
Dropped out/left	42	31	32	36	38	41	39	42	41	41	39	35
Transferred - not in custody	5	8	9	9	9	14	10	7	5	5	4	4
Transferred - in custody	3	3	4	5	6	4	7	5	4	4	3	1
Treatment declined	5	6	4	5	4	2	16	5	5	3	2	2
Died	2	2	2	1	2	1	2	4	2	2	3	4
Prison	3	2	3	1	1	2	4	3	3	1	4	3
Treatment withdrawn	3	2	3	2	2	1	1	1	1	1	0	1

Opiate users

Successful treatment completions for opiate users in Suffolk is lower than the average for all substances. The proportion of successful completions has remained relatively static over the last decade at around 25% - in 2020/21, it was 30%. This is similar to the East of England (29%) and England (25%).

Table 22: Proportion of clients who exit treatment, Suffolk, opiate users, 2009/10 – 2020/21

Treatment Exits	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)	2020/21 (%)
Successful completion	25	30	28	33	30	17	12	19	26	27	32	30
Dropped out/left	32	27	26	35	30	47	42	43	44	41	32	28
Transferred - not in custody	12	23	16	8	13	13	16	12	9	15	9	13
Transferred - in custody	8	10	12	13	16	10	14	9	9	10	7	6
Treatment declined	1	3	3	3	1	0	7	4	4	2	2	2
Died	4	3	5	3	4	4	4	7	3	3	7	11
Prison	7	3	7	3	3	6	5	4	6	2	11	11
Treatment withdrawn	8	3	3	4	3	3	0	2	0	0	0	0

Alcohol

Successful treatment completions for alcohol clients in Suffolk is higher than the average for all substances. The proportion of successful completions has remained above 50% since 2016/17, reaching 57% in 2020/21. A similar trend can be seen across the East of England (61%) and England (62%).

Table 23: Proportion of clients who exit treatment, Suffolk, alcohol users, 2009/10 – 2020/21

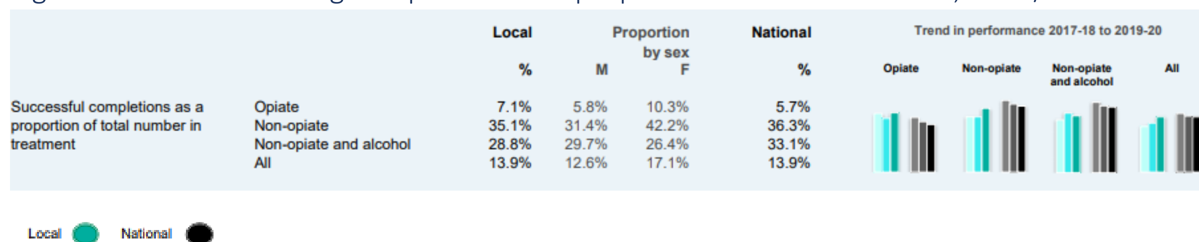
Treatment Exits	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)	2020/21 (%)
Successful completion	35	50	52	40	43	42	32	51	55	55	53	57
Dropped out/left	50	35	32	35	41	38	38	38	38	38	38	36
Transferred - not in custody	2	2	7	13	8	14	6	2	2	1	1	1
Transferred - in custody	0	0	0	0	0	0	0	2	0	1	1	0
Treatment declined	8	9	5	6	5	3	24	4	3	3	3	2
Died	2	2	1	1	1	1	0	0	2	1	3	3
Prison	1	1	1	1	0	0	0	0	2	0	1	1
Treatment withdrawn	2	3	3	2	2	1	0	2	0	0	0	0

Successful completions – as proportion of all in treatment

Drugs clients

The tables below show the proportion of drug users who successfully completed their treatment as a proportion of all those in treatment. This shows a positive improvement for all combined drug categories in 2019/20, with opiate completions in Suffolk (7.1%) above the national average (5.8%). Interesting to note, is the gender difference, with female successful completions higher than males across all drug categories (17.1% compared to 12.6%, respectively).

Figure 27: Successful drug completions as a proportion of all in treatment, 2019/20



		Local %	Proportion by sex M	Proportion by sex F	National %
Successful completions as a proportion of total number in treatment	Opiate	7.1%	5.8%	10.3%	5.7%
	Non-opiate	35.1%	31.4%	42.2%	36.3%
	Non-opiate and alcohol	28.8%	29.7%	26.4%	33.1%
	All	13.9%	12.6%	17.1%	13.9%

Source: Drugs commissioning support pack 2021-22 UKHSA

Alcohol clients

Almost 1 in 3 (31%, n=193) of alcohol clients in Suffolk exited treatment successfully in 2019/20, a lower proportion than England (38%). A similar proportion of male and female clients in Suffolk successfully exited alcohol treatment services (32% and 30%, respectively).

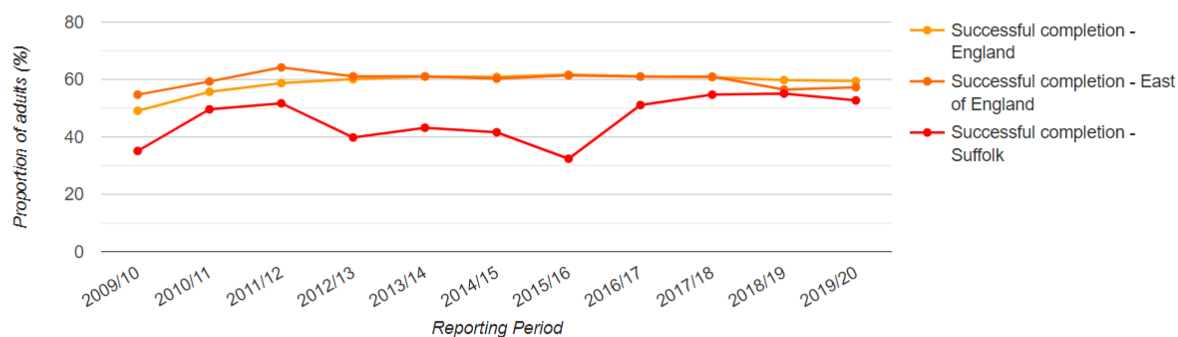
A clear improvement can be seen for Suffolk's alcohol successful completions, increasing from a year low point of 32% in 2015/16 to 53% in March 2019/20 (see Table 24). While the England and East of England averages have been consistently above 55% since 2012, the gap with Suffolk is narrowing.

Table 24: Successful alcohol completions as a proportion of all in treatment, Suffolk compared to England, 2019/20

	Local	Proportion of treatment population	Proportion by sex		National	Proportion of treatment population
	n		M	F	n	
Total individuals leaving alcohol treatment in 2019-20	366	59%	60%	57%	47,708	64%
Individuals leaving alcohol treatment successfully in 2019-20	193	31%	32%	30%	28,349	38%

Local National

Figure 28: Successful alcohol completions as a proportion of all in treatment as a trend, Suffolk, East of England, and England, 2009/10 to 2019/20



Source: NDTMS View It

Successful completions and not re-presenting

This details the number of clients that successfully completed their treatment (free of dependence) who do not then re-present to treatment again within 6 months.

Individuals achieving this outcome demonstrate a significant improvement in health and wellbeing in terms of increased longevity, reduced blood-borne virus transmission, improved parenting skills and improved physical and psychological health[ii].

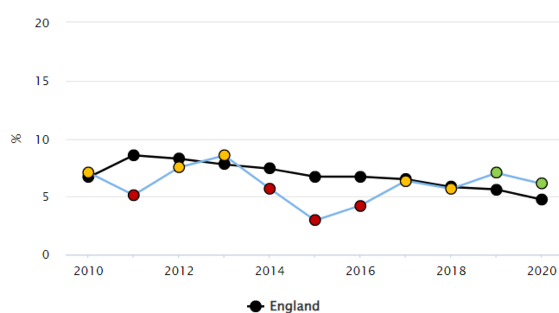
[ii] 4 UKHSA's PHOF indicator rationale

It aligns with the ambition of both public health and the Government's drug strategy of increasing the number of individuals recovering from addiction. It also aligns well with the reducing reoffending outcome [UKHSA Indicator 1.13] as offending behaviour is closely linked to substance use, and it is well demonstrated that cessation of drug use reduces re-offending significantly. This in turn will have benefits to a range of wider services and will address those who cause the most harm in local communities.

Opiate users

Suffolk has had a significantly higher proportion of opiate users who completed drug treatment compared to England in 2019 (7.0% compared to 5.6%, respectively) and 2020 (6.1% compared to 4.7%, respectively).

Figure 29: Successful completion of drug treatment, opiate users, Suffolk compared to England, 2010 - 2020



Recent trend: No significant change

Period		Suffolk Count	Value	95% Lower CI	95% Upper CI	East of England	England
2010	Similar	93	7.1%	5.8%	8.6%	7.5%	6.7%
2011	Worse	70	5.1%	4.1%	6.4%	9.1%	8.6%
2012	Similar	104	7.5%	6.2%	9.0%	7.8%	8.3%
2013	Similar	111	8.5%	7.1%	10.2%	7.4%	7.8%
2014	Worse	71	5.7%	4.5%	7.1%	8.1%	7.4%
2015	Worse	36	2.9%	2.1%	4.0%	6.5%	6.7%
2016	Worse	54	4.2%	3.3%	5.5%	6.9%	6.7%
2017	Similar	80	6.4%	5.1%	7.8%	7.4%	6.5%
2018	Similar	69	5.7%	4.5%	7.1%	6.3%	5.8%
2019	Better	88	7.0%	5.7%	8.6%	5.9%	5.6%
2020	Better	75	6.1%	4.9%	7.6%	5.1%	4.7%

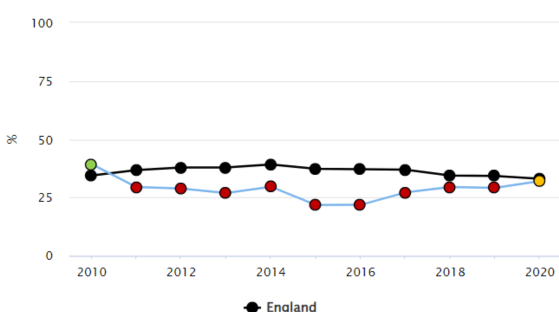
Source: Calculated by Office for Health Improvement and Disparities (OHID): using data from th e National Drug Treatment Monitoring System

Compared with England: Better 95% Similar Worse 95% Not applicable

Non-opiate users

The chart below shows that Suffolk successful completions for non-opiate users has been historically statistically significantly lower than England from 2011 to 2019. However, successful completions for non-opiate users are similar for 2020 (32.0% compared to 33.0%, respectively).

Figure 30: Successful completion of drug treatment, non-opiate users, Suffolk compared to England, 2010 to 2020



Recent trend: No significant change

Period		Suffolk Count	Value	95% Lower CI	95% Upper CI	East of England	England
2010	Better	161	39.3%	34.7%	44.1%	37.5%	34.4%
2011	Worse	102	29.5%	24.9%	34.5%	41.0%	36.8%
2012	Worse	110	28.9%	24.5%	33.6%	37.2%	37.9%
2013	Worse	93	26.9%	22.5%	31.8%	35.1%	37.8%
2014	Worse	103	29.6%	25.0%	34.6%	40.1%	39.2%
2015	Worse	51	21.8%	17.0%	27.5%	35.8%	37.3%
2016	Worse	55	21.8%	17.2%	27.3%	33.9%	37.1%
2017	Worse	86	27.1%	22.5%	32.3%	37.2%	36.9%
2018	Worse	118	29.5%	25.2%	34.1%	37.7%	34.4%
2019	Worse	139	29.1%	25.2%	33.4%	35.6%	34.2%
2020	Similar	158	32.0%	28.1%	36.3%	36.0%	33.0%

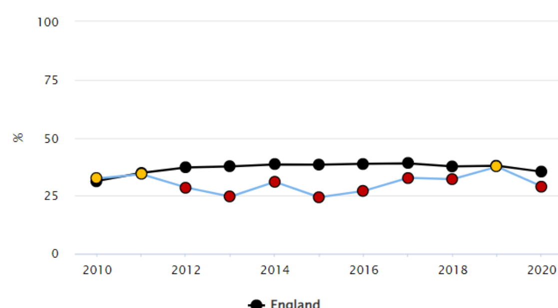
Source: Calculated by Office for Health Improvement and Disparities (OHID): using data from th e National Drug Treatment Monitoring System

Compared with England: Better 95% Similar Worse 95% Not applicable

Alcohol

Suffolk has presented a statistically significant lower proportion of successful treatment completions among alcohol clients compared to England since 2012, apart from 2019 when Suffolk was similar to England. In 2020, 29.0% of Suffolk alcohol clients successfully completed treatments compared to 35.3% for England.

Figure 31: Successful completion of alcohol treatment, Suffolk compared to England, 2010 to 2020



Recent trend: No significant change

Period		Suffolk Count	Value	95% Lower CI	95% Upper CI	East of England	England
2010	●	290	32.4%	29.4%	35.5%	34.9%	31.4%
2011	●	245	34.2%	30.8%	37.8%	37.6%	34.8%
2012	●	193	28.5%	25.2%	32.0%	38.4%	37.1%
2013	●	168	24.6%	21.5%	27.9%	34.4%	37.5%
2014	●	207	30.9%	27.6%	34.5%	36.7%	38.4%
2015	●	101	24.3%	20.4%	28.6%	36.5%	38.4%
2016	●	97	27.0%	22.7%	31.8%	36.0%	38.7%
2017	●	164	32.7%	28.7%	36.9%	38.2%	38.9%
2018	●	172	32.1%	28.3%	36.2%	35.9%	37.6%
2019	●	227	37.5%	33.7%	41.4%	34.2%	37.8%
2020	●	210	29.0%	25.8%	32.4%	30.8%	35.3%

Source: Calculated by Office for Health Improvement and Disparities (OHID): using data from th e National Drug Treatment Monitoring System

Compared with England ••• Better 95% Similar Worse 95% Not applicable

Health protection & harm reduction

Injecting behaviour

People who inject drugs (PWID) experience substantially worse health outcomes than the general population. The coronavirus (COVID-19) pandemic has had a significant impact, limiting access to blood-borne virus (BBV) testing and safe injecting equipment, which has likely widened health inequalities[10]. Sharing of injecting equipment is the single biggest factor in blood-borne virus transmission among individuals who use and inject drugs, it also elevates the risk of premature mortality.

The full impact of the COVID-19 pandemic and the resulting restricted access to services on the health and wellbeing of PWID in the UK remains to be seen[11]. Continued public health monitoring of infectious diseases and other drug-related harms among PWID is critical to understanding the impact of COVID-19 on national HIV and viral hepatitis elimination efforts, as well as on the health inequalities experienced by this marginalised group.

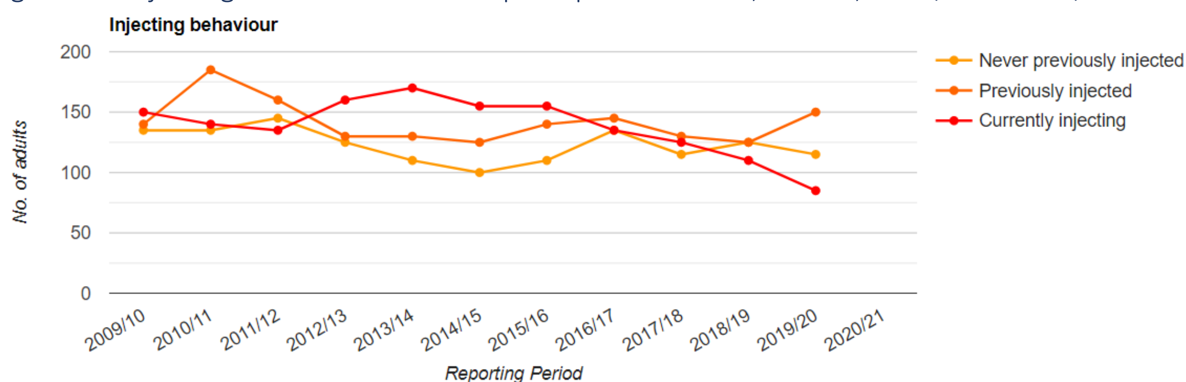
Opiate users

The injecting behaviour at time of presentation represents whether the client has injected in the last 30 days (categorised as current), previously or never. In 2019/20, 43% of opiate users in treatment had previously injected, while a quarter (24%) were still injecting. A third of opiate users in treatments (33%) had never previously injected (see Figure 32 below).

The proportion of opiate users in treatment services in Suffolk that have previously injected has remained similar to England and the East of England since 2009/10. For the first time in 2019/20, Suffolk reported a higher proportion of opiate users in service who had previously injected compared to England and the East of England (see Figure 32). Although it is too early to know if this represent a

trend, Suffolk Public Health and Communities will continue to monitor injecting behaviour to see whether opiate use is changing in Suffolk.

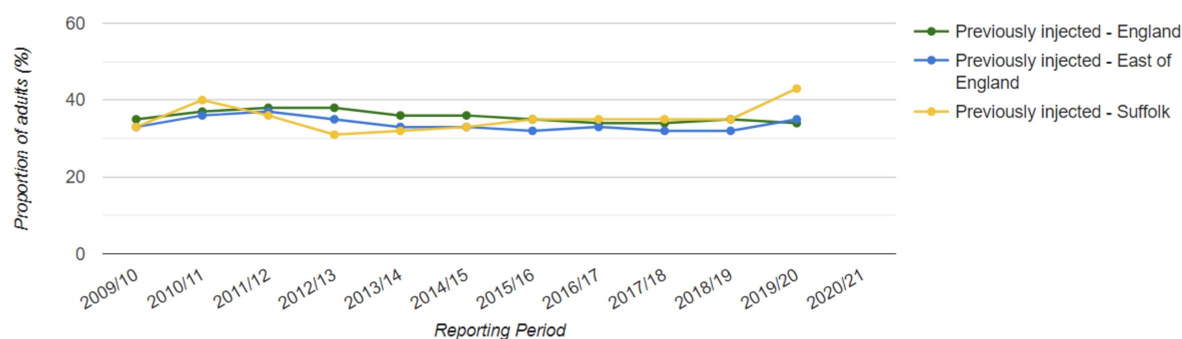
Figure 32: Injecting behaviour for new opiate presentations, Suffolk, 2009/10 – 2019/20



Injecting Behaviour	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Never previously injected	32	29	33	30	27	26	27	33	31	35	33
Previously injected	33	40	36	31	32	33	35	35	35	35	43
Currently injecting	35	30	31	39	41	41	38	33	34	31	24

Source: NDTMS View It

Figure 33: Injecting behaviour for new opiate presentations, previously injected only, Suffolk compared to England and the East of England, 2009/10 – 2019/20



Injecting Behaviour	Area	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Previously injected	England	35	37	38	38	36	36	35	34	34	35	34
Previously injected	East of England	33	36	37	35	33	33	32	33	32	32	35
Previously injected	Suffolk	33	40	36	31	32	33	35	35	35	35	43

Source: NDTMS View It

Needle exchange

Pharmacy based Needle Exchange Service, is an easy to access and user-friendly service and which respects the confidentiality of all injecting drug users. Pharmacy staff will proactively signpost people who inject drugs to drug treatment services who can provide wider health services including a broader range of injecting paraphernalia, wound checking, the promotion of safer injecting or alternative drug taking practices. Treatment services, Blood-borne Virus testing and inoculation to reduce the risk of blood-borne virus infection & access to overdose awareness and basic first aid training.

Pharmacy data shows that 123,081 1ml syringes and syringe barrels were collected through the Needle Exchange Scheme in 2020/21. This ranged from 95 to 44,789 depending on the pharmacy. Needle Exchange data attributed to each of the pharmacies in Suffolk has been mapped by CCG.

Figure 34: Number of 1ml syringes and syringe barrels provided by pharmacy, West Suffolk Clinical Commissioning Group (WSCCG), 2020/21

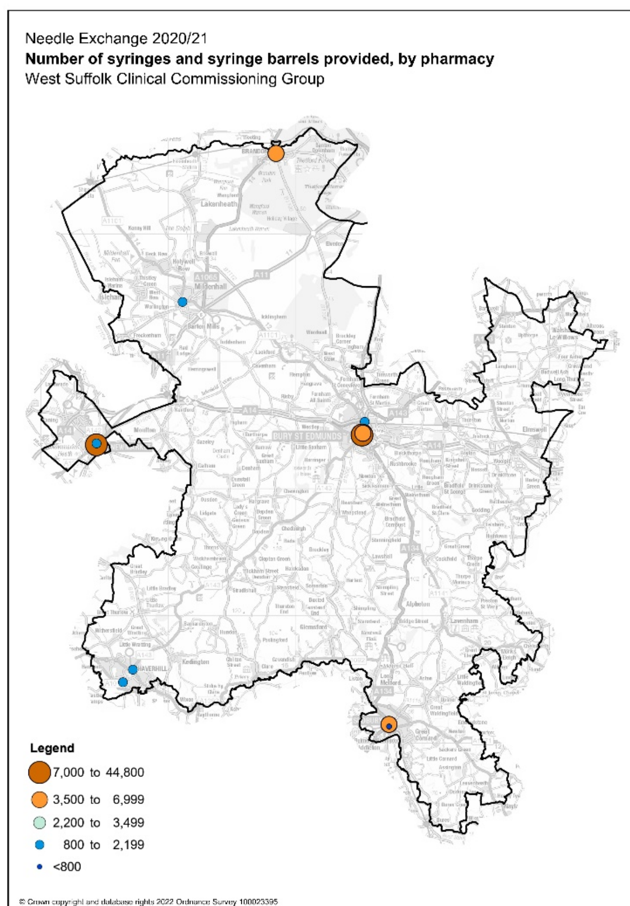


Figure 45: Number of 1ml syringes and syringe barrels provided by pharmacy, Ipswich and East Suffolk Clinical Commissioning Group (IESCCG), 2020/21

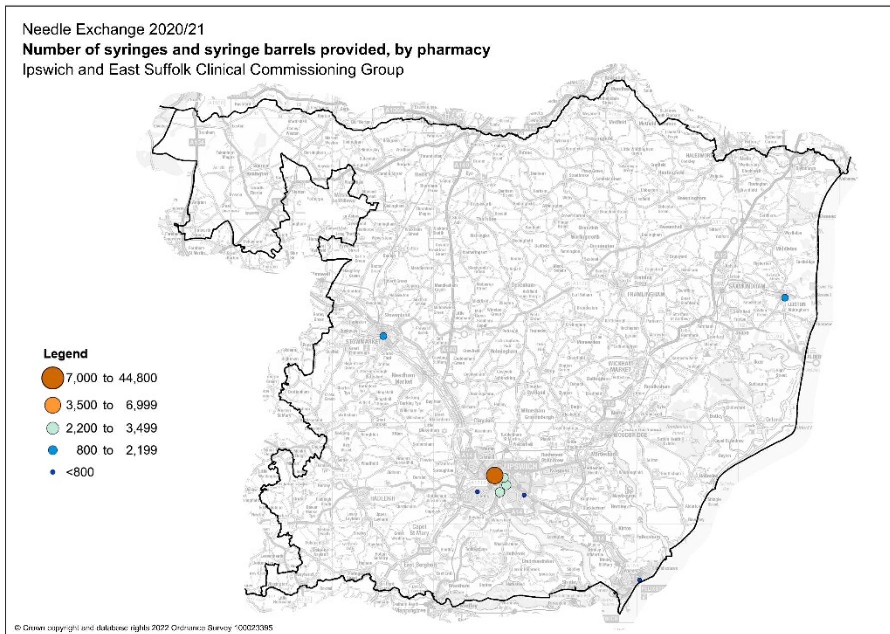
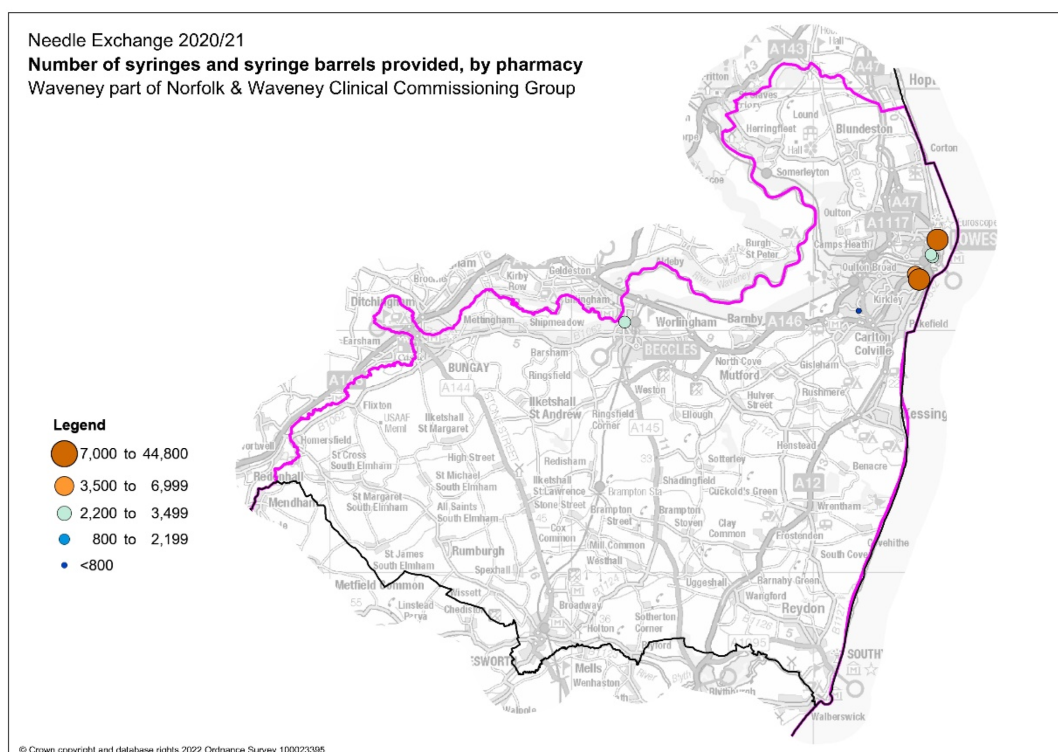


Figure 36: Number of 1ml syringes and syringe barrels provided by pharmacy, Waveney element of Norfolk and Waveney Clinical Commissioning Group (NWCCG), 2020/21



Blood-borne virus status

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. Eliminating hepatitis C as a major public health threat requires the identification and treatment of many more infected people who use drugs[10].

Hepatitis C testing and referral data will vary from area to area depending on local systems and pathways, the availability of test results to providers and where/how Hepatitis C treatment is provided, so it needs to be assessed and understood locally more than compared to national Figures[10].

Blood-borne virus status: new presentations to treatment

Hepatitis B virus (HBV) vaccination

HBV vaccination is recommended for all people who currently inject drugs and those who are likely to 'progress' to injecting, for example those who are currently smoking heroin and/or crack[12]. Immunisation is also recommended for all sentenced prisoners and all new inmates entering prison in the UK[12].

In 2019/20, 42% (n=532) clients in treatment who were eligible for an HBV vaccination accepted one. Of those, only 1 in 5 (21%, n=113) completed the course of the vaccination.

HBV vaccine uptake is known to be particularly low among younger PWID and recent initiates to injecting; however, the 'Unlinked Anonymous Monitoring (UAM) Survey of HIV and viral hepatitis among Persons Who Inject Drugs' data shows that these individuals report recent contact with services, such as general practice, prison health services and drug treatment, highlighting missed opportunities for HBV vaccination[10].

Table 26: Hepatitis B virus (HBV) vaccination status for drug use clients, Suffolk compared to England, 2019/20

Hepatitis B	Local n	Proportion of eligible clients	Proportion by sex M	Proportion by sex F	National n	Proportion of eligible clients	Proportion by sex M	Proportion by sex F
Clients in treatment in 2019-20 eligible for a HBV vaccination who accepted one	532	42%	41%	46%	49,524	40%	39%	41%
Of those:								
the proportion who started a course of vaccination	81	15%	14%	18%	7,964	16%	16%	17%
the proportion who completed a course of vaccination	113	21%	21%	21%	15,349	31%	32%	29%

Source: Drugs commissioning support pack 2021-2022 UKHSA

Hepatitis C virus (HCV)

People who have ever injected drugs are the group most affected by HCV in the UK, with over 90% of infections diagnosed in England thought to have been acquired through injecting drug use[13]. In 2020, 60% of UAM Survey participants in England, Wales and Northern Ireland had antibodies to HCV, indicative of being ever infected, an increase of 17% since 2011[13].

People are considered to have chronic HCV infection when they test positive for HCV ribonucleic acid (RNA) in addition to HCV antibodies. In England, Wales and Northern Ireland in 2020, 20% of people who injected drugs in the last year had chronic HCV. This is a significant decrease from 33% in 2016, when the level of chronic infection was at its highest, during the past decade, and from 28% in 2019[10].

In 2019/20, 61% of Suffolk clients in treatment who were eligible for a HPC test received one, compared to 69% nationally.

Table 27: Hepatitis C virus (HCV) status for drug use clients, Suffolk compared to England, 2019/20

	Local	Proportion	Proportion		National	Proportion	Proportion	
		of eligible	by sex			of eligible	by sex	
	n	clients	M	F	n	clients	M	F
Hepatitis C								
Clients in treatment in 2019-20 eligible for a HCV test who received one	958	61%	61%	60%	119,154	69%	69%	69%
Previous or current injectors in treatment in 2019-20 eligible for a HCV test who received one	659	78%	78%	78%	73,018	87%	86%	87%
Clients who have a positive hep C antibody test*	151	26%	26%	26%	22,332	28%	28%	28%
Clients who have a positive hep C PCR (RNA) test*	88	18%	19%	15%	9,958	15%	15%	15%
Clients referred to hep C treatment	30	3%	3%	3%	8,344	7%	7%	7%
Previous or current injectors in treatment in 2019-20 referred to Hep C treatment	27	4%	5%	3%	6,804	9%	9%	10%

Source: Drugs commissioning support pack 2021-2022 UKHSA

Drug related deaths

Drug related deaths and deaths from drug poisoning are two sperate indicators of mortality associated with substance use. A definition of each is provided below before reviewing the current data for Suffolk.

Drug related deaths

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[iii] as mental and behavioural disorders due to use of: opioids (F11), cannabinoids (F12), sedatives or hypnotics (F13), cocaine (F14), other stimulants, including caffeine (F15), hallucinogens (F16) and multiple drug use and use of other psychoactive substances (F19)
- any of the substances controlled under the Misuse of Drugs Act 1971 are involved, this includes class A, B and C drugs

Drug poisoning

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.

Drug related deaths

In England and Wales, most drug-related deaths are certified by a coroner following an inquest and cannot be registered until the inquest is completed, therefore the 'drug related death' cannot be

[iii] The International Classification of Disease (ICD) is a standard diagnostic tool created by the World Health Organization (WHO), for monitoring the incidence and prevalence of diseases and related conditions.

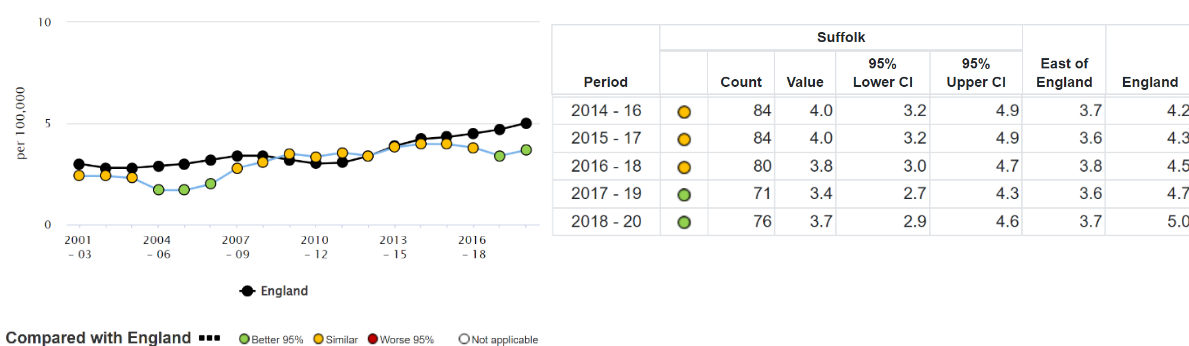
The ICD has diverse clinical applications and is used not just by doctors but also by paramedic staff, insurance companies, researchers, and policy makers. ICD is used to classify diseases and store diagnostic information for clinical, quality, and epidemiological purposes

registered until the inquest concludes. This can take months or even years before the death is registered. In line with other mortality statistics, drug-related death Figures are based on deaths registered in a particular year, rather than those occurring each year. This allows timelier publications, but can make trends difficult to interpret, especially for smaller geographical areas[iv].

According to the latest ONS report[iv], the majority (80%) of drug-related deaths nationally are from accidental poisoning.

Drug-related deaths is included as an indicator within the Public Health Outcomes Framework (PHOF) and Figure 37 below shows how Suffolk compared with England between 2001-03 and 2018- 20. Suffolk currently has a rate of 3.7 deaths per 100,000 compared to England's 5.0. While England has seen an increase in the rate of deaths per 100,000 from 2013-15 to 2018-20 (3.9 per 100,000 to 5.0 per 100,000, respectively), Suffolk has been statistically lower than England since 2017-19.

Figure 37: Deaths from drug misuse, Suffolk compared to England, 2001-03 to 2018-20



Period	Suffolk					East of England	England
		Count	Value	95% Lower CI	95% Upper CI		
2014 - 16		84	4.0	3.2	4.9	3.7	4.2
2015 - 17		84	4.0	3.2	4.9	3.6	4.3
2016 - 18		80	3.8	3.0	4.7	3.8	4.5
2017 - 19		71	3.4	2.7	4.3	3.6	4.7
2018 - 20		76	3.7	2.9	4.6	3.7	5.0

Source: UKHSA PHOF

Deaths from drug misuse

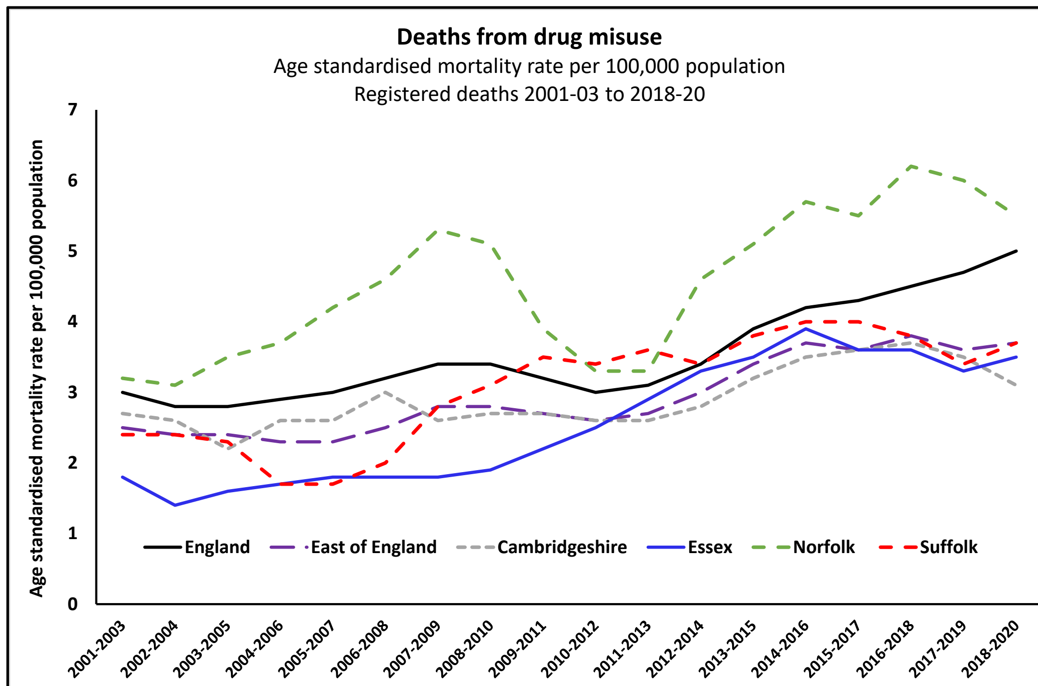
Deaths from drug misuse is a subset of deaths from drug poisoning, involving controlled drugs only. There were 76 deaths related to drug misuse in Suffolk in 2018-20. This is 58.5% of all deaths from drug poisoning.

More than 7 in 10 deaths from drug misuse (71.1%, n=54) were of males; females accounted for 28.9% (n=22). The age standardised mortality rate for Suffolk in 2018-20 was 3.7 per 100,000 (95% CIs: 2.9-4.6). This is statistically significantly lower than England (rate: 5.0; 5.9-5.1) and similar to the East of England (rate: 3.7; 3.5-4.0). It is also similar to the rates of the neighbouring counties of Cambridgeshire, Essex and Norfolk.

The trend for deaths from drug misuse in Suffolk is similar to that for deaths from drug poisoning, as shown in the graph below. Data at LTLA level is too incomplete to illustrate graphically or undertake meaningful analysis.

[iv] ONS, Deaths related to drug poisoning in England and Wales: 2017 registrations

Figure 38: Deaths from drug misuse, age standardised mortality rate per 100,000 population, 2001/03 to 2018/20

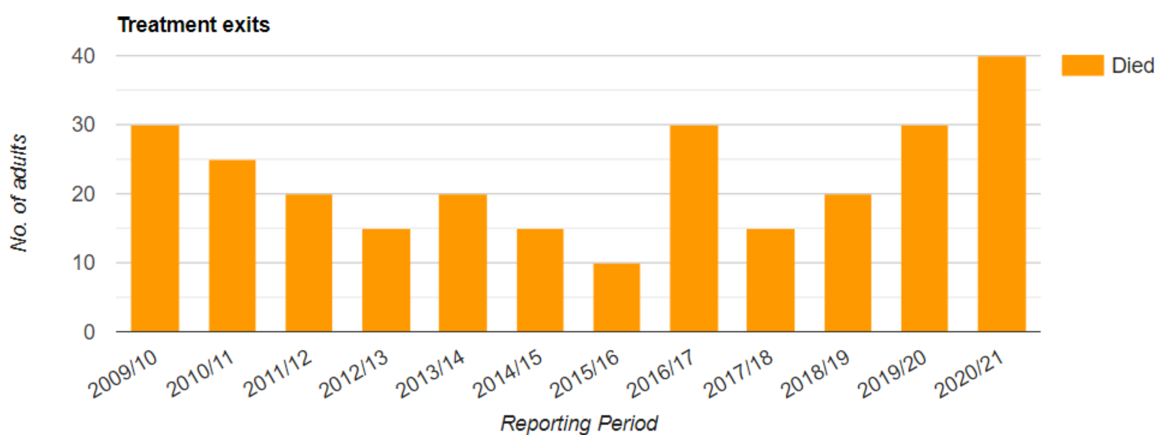


Deaths while in treatment

Figure 39 below shows the increased number of deaths for those receiving structured treatment in Suffolk, from 15 in 2017/18 to 40 in 2020/21. Proportionally, those who died in treatment went from 1.7% in 2017/18 to 3.8% in 2020/21. Please note: although these deaths were registered in the same year, from the data it is not possible to ascertain whether these clients actually died in that year. This is due to the length of time it takes to complete a coroner's inquest, it can take months or even years for a drug-related death to be registered.

The composition of the deaths while in treatment since 2017/18 have predominantly been opiate users. Out of the 40 deaths in 2020/21, 25 (62.5%) were opiate users and 15 (37.5%) were alcohol only users.

Figure 39: Number of deaths in treatment, all users, Suffolk, 2009/10 to 2020/21



Source: NDTMS View It

Deaths from drug poisoning in Suffolk

There were 130 deaths of Suffolk residents related to drug poisoning (involving controlled and/or uncontrolled substances) in 2018-20. Almost two-thirds (63.8%) were of males (n=83) and just over a third (36.2%) were females (n=47).

Numbers of deaths have been increasing in Suffolk since 2001-03, as has been the case in neighbouring counties. The table below shows numbers of deaths for four three-year periods. The same is true of districts within Suffolk County, with East Suffolk having the largest number of deaths.

In 2018-20 East Suffolk accounted for 37.7% of all deaths in the county from drug poisoning.

Table 28: Number of deaths from drug poisoning, persons, selected years

	2003-05	2008-10	2013-15	2018-20
Cambridgeshire	78	76	82	116
Essex	124	139	224	280
Norfolk	143	174	191	224
Suffolk	**89**	**98**	**111**	**130**
Babergh	7	8	5	12
East Suffolk	37	39	42	49
Ipswich	19	22	27	27
Mid Suffolk	6	5	11	14
West Suffolk	20	24	26	28

Age standardised mortality rates (deaths from drug poisoning)

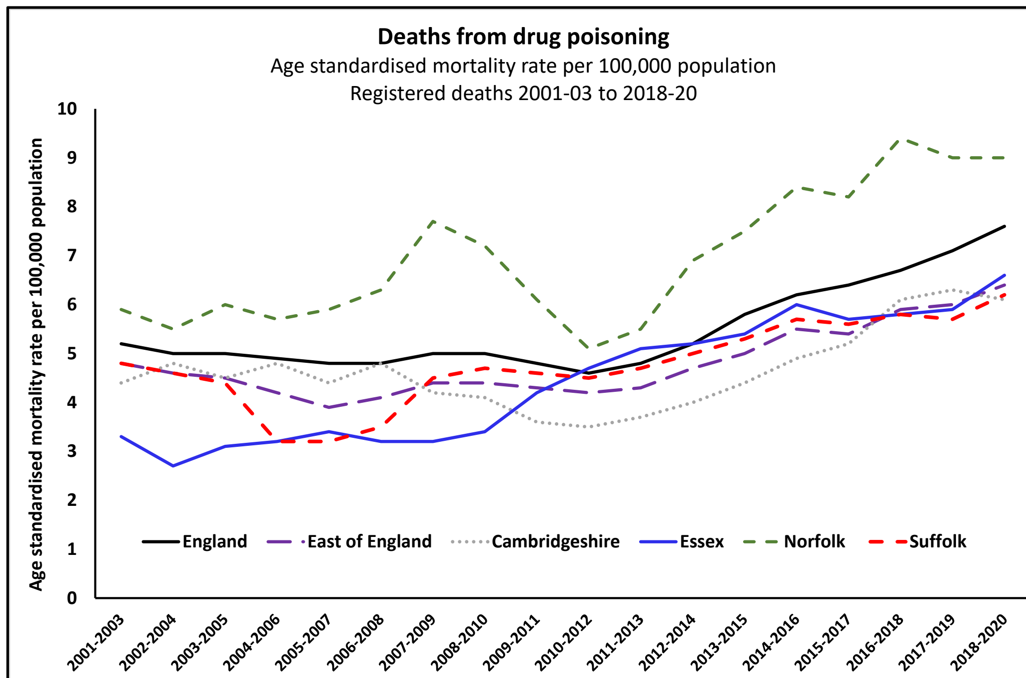
Suffolk's age standardised mortality rate per 100,000 in 2018-20 was 6.2 per 100,000 population (95% CI: 5.2-7.3). This is statistically significantly lower than England (rate: 7.6; 7.5-7.8) and similar to the East of England (rate: 6.4; 6.0-6.8)

However, this is the highest rate seen in Suffolk over the period for which data has been published (since 2001-03), as shown in the chart below. Rates have been increasing in all areas shown above, but only Norfolk has had rates consistently higher than the national average.

Compared to neighbouring counties, Suffolk had a similar rate to Cambridgeshire and Essex, but statistically significantly lower than Norfolk (rate: 9.0 per 100,000, 95% CIs: 7.8-10.2; n=224) in 2018-20. In 2018-20, the age standardised mortality rate from drug poisoning for males in Suffolk was 8.0 per 100,000 (95% CIs: 6.3-9.9); although similar to the East of England rate, this is statistically significantly lower than the England rate.

For females in Suffolk in 2018-20, the age standardised mortality rate was 4.5 per 100,000 (95% CIs: 3.3-6.1); this was similar to both the regional and national rates.

Figure 40: Deaths from drug poisoning, age standardised mortality rate per 100,00 population, registered deaths from 2001/03 to 2018/20

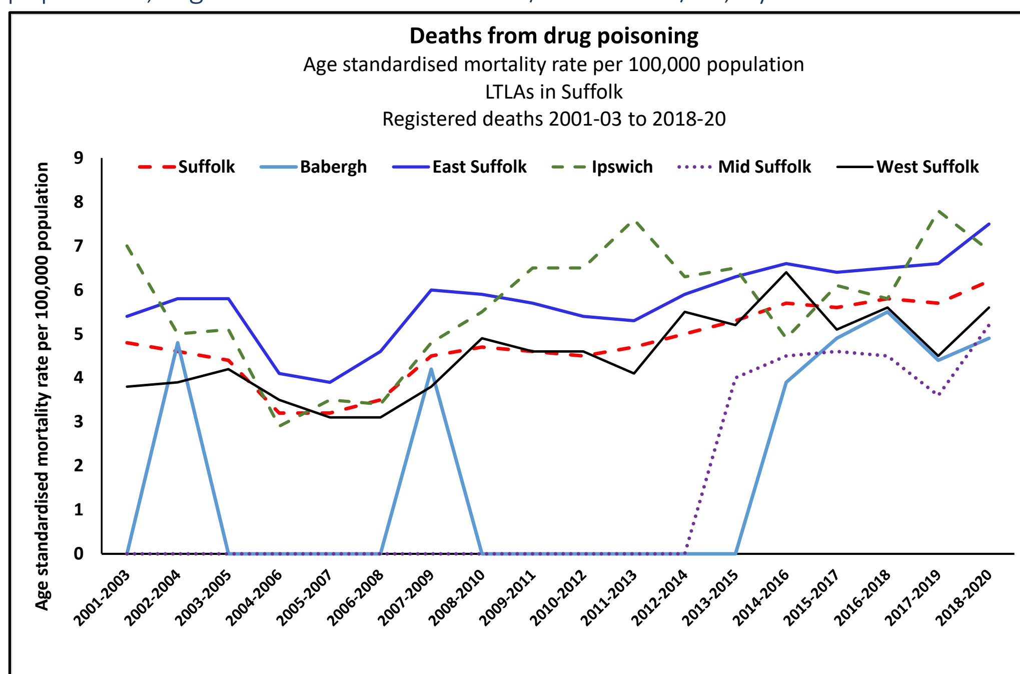


Age standardised mortality rates (deaths from drug poisoning): lower tier local authorities in Suffolk

Within Suffolk, East Suffolk had the highest age standardised mortality rate from drug poisoning in 2018-20 of 7.5 per 100,000 (95% CIs: 5.5-10.0; n=49). This is similar to the county, regional and national rates. Babergh had the lowest rate: 4.9 per 100,000 (95% CIs: 2.5-8.6; n=12). This is similar to the county, regional and national rates.

Data for Babergh and Mid Suffolk is not available for all periods shown in the chart below because rates are not calculated in instances where the number of deaths is under 10.

Figure 41: Deaths from drug poisoning, age standardised mortality rate per 100,00 population, registered deaths from 2001/03 to 2018/20, by Suffolk LTLAs



Harm prevention: alcohol specific

What is the national and regional picture?

The main findings show that the percentage of adults[14]:

- who abstain from alcohol in England has increased from 15.5% in 2011 to 2014 to 16.2% in 2015 to 2018. In 2015 – 18, the proportion of adults who abstained from alcohol in East of England was significantly lower than England (12.5% compared to 16.2%).

- Binge drinking on the heaviest drinking day in England has reduced from 16.4% in 2011 to 2014 to 15.4% in 2015 to 2018. Data for 2015 – 18 shows that the East of England was statistically similar to England (14.5% compared to 15.4%).

- Drinking over 14 units of alcohol a week in England has reduced from 25.3% in 2011 to 2014 to 22.8% in 2015 to 2018. The East of England was statistically similar to England for 2015 – 18 (23.1% compared to 22.8%).

In England, a greater percentage of the population of the most deprived areas abstain from alcohol, while binge drinking and drinking over the recommended 14 units a week was more common in less deprived areas. However, a significantly lower proportion of people in deprived areas abstained from alcohol compared to those in less deprived areas (see Figure 42). This does not match indicators for alcohol-related harm, especially mortality and admissions, where the more deprived areas experience the greatest burden of harm[14].

For the period 2016 to 2018, there were an estimated 59,000 new alcohol-related cancer registrations – this equates to approximately 19,670 new cancer cases each year. The incidence rate

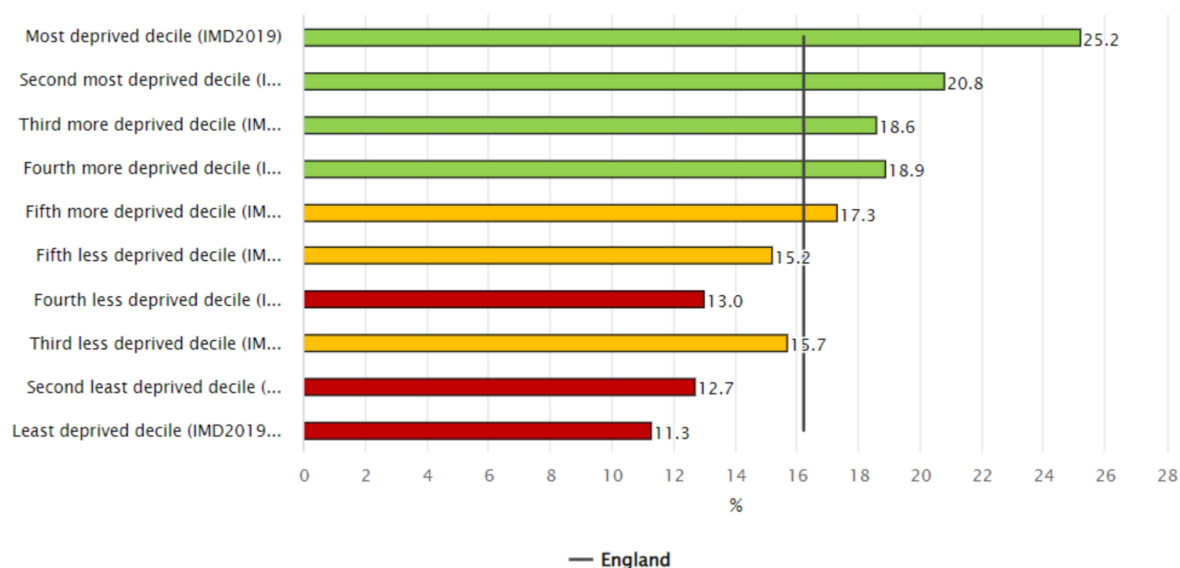
of alcohol-related cancer increased gradually between 2004 to 2006 and 2011 to 2013. However, since 2012 to 2014 there have been minor reductions in the incidence rate. The incidence rate of alcohol-related cancer per 100,000 population between 2015 to 2017 and 2016 to 2018 has remained static for females and has slightly decreased for males[14].

Figure 43: Area profile for consumption and availability of alcohol, England compared to East of England, 2015 – 18

Indicator	Period	East of England			England			
		Recent Trend	Count	Value	Value	Worst	Range	Best
Percentage of adults who abstain from drinking alcohol	2015 - 18	–	-	12.5%	16.2%	12.4%		23.6%
Percentage of adults binge drinking on heaviest drinking day	2015 - 18	–	-	14.5%	15.4%	19.9%		13.2%
Percentage of adults drinking over 14 units of alcohol a week	2015 - 18	–	-	23.1%	22.8%	25.7%		20.1%

Source: Fingertips, UK Health Security Agency

Figure 44: Percentage of adults who abstain from drinking alcohol, East of England, by Indices of Multiple Deprivation (IMD) decile, 2015 – 18



Source: Fingertips, UK Health Security Agency

What is the local picture?

Mortality

Alcohol-related mortality

Alcohol consumption is a contributing factor to hospital admissions and deaths from a diverse range of conditions. Alcohol misuse is estimated to cost the NHS about £3.5 billion per year and society, as a whole, £21 billion annually[15].

The Government has said that everyone has a role to play in reducing the harmful use of alcohol - this indicator is one of the key contributions by the Government (and the Department of Health and Social Care) to promote measurable, evidence-based prevention activities at a local level, and supports the national ambitions to reduce harm set out in the Government's Alcohol Strategy. This ambition is part of the monitoring arrangements for the Responsibility Deal Alcohol Network. Alcohol-related deaths can be reduced through local interventions to reduce alcohol misuse and harm[15].

Alcohol-related mortality in Suffolk is significantly lower than England (32.3 per 100,000 compared to 37.8 per 100,000, respectively). While Ipswich (37.4), West Suffolk (35.5), East Suffolk (32.7), and Babergh (28.1) are statistically similar to England (37.8), Mid Suffolk (24.3) is significantly lower than England.

Figure 45: Alcohol-related mortality, directly standardised rate per 100,000, England, Suffolk and LTLAs, 2020

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	20,468	37.8	37.3	38.3
Suffolk	→	273	32.3	28.5	36.4
Ipswich	→	47	37.4	27.4	49.8
West Suffolk	→	65	35.5	27.4	45.3
East Suffolk	→	100	32.7	26.4	39.9
Babergh	→	31	28.1	18.9	40.2
Mid Suffolk	→	30	24.3	16.2	34.8

Source: Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Esti mates.

Source: Fingertips, UK Health Security Agency

Alcohol-specific mortality

Alcohol-specific mortality are defined as deaths which have been wholly caused by alcohol consumption, registered in the calendar year for all ages.

Suffolk has a significantly lower rate of alcohol-specific deaths (7.9 per 100,000) compared to England (10.9 per 100,000). Regarding Suffolk's lower-tier local authorities, East Suffolk has the highest rate (9.8, statistically similar to England), while Mid Suffolk has the lowest rate (3.4, significantly lower than England).

Figure 46: Alcohol-specific mortality, directly standardised rate per 100,000, England, Suffolk and LTLAs, 2017-2019

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	17,357	10.9	10.7	11.1
Suffolk	–	185	7.9	6.8	9.1
East Suffolk	–	78	9.8	7.7	12.2
Ipswich	–	32	8.7	5.9	12.3
West Suffolk	–	42	8.1	5.8	11.0
Babergh	–	21	6.6	4.1	10.2
Mid Suffolk	–	12	3.4	1.8	6.0

Source: Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Esti mates

Source: Fingertips, UK Health Security Agency

Mortality from chronic liver disease

Liver disease is one of the top causes of death in England and people are dying from it at younger ages. Most liver disease is preventable, and much is influenced by alcohol consumption and obesity prevalence, which are both amenable to public health interventions.

Suffolk has a significantly lower rate of deaths from chronic liver disease (8.7 per 100,000) compared to England (12.2 per 100,000). Regarding Suffolk's lower-tier local authorities, Ipswich has the highest rate (10.9, statistically similar to England), while Mid Suffolk had the lowest rate (4.9, significantly lower than England).

Figure 47: Mortality from chronic liver disease, directly standardised rate per 100,000, England, Suffolk and LTLAs, 2017-2019

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	19,443	12.2	12.1	12.4
Suffolk	–	209	8.7	7.6	10.0
Ipswich	–	41	10.9	7.8	14.8
West Suffolk	–	56	10.5	7.9	13.6
East Suffolk	–	72	8.7	6.8	11.1
Babergh	–	23	7.6	4.8	11.4
Mid Suffolk	–	17	4.9	2.8	7.8

Source: Calculated by OHID: Population Health Analysis (PHA) team from the Office for National Statistics (ONS) Annual Death Registrations Extract and ONS Mid Year Population Estimates

Source: Fingertips, UK Health Security Agency

Hospital admissions

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. There are two measures used in Local Alcohol Profiles for England (LAPE) and elsewhere to assess this burden: the Broad and the Narrow measure. Only the 'Narrow' measure has been used for the purposes of this report.

Narrow definition: A measure of hospital admissions where the primary diagnosis (main reason for admission) is an alcohol-related condition. This represents a Narrower measure. Since every hospital admission must have a primary diagnosis, it is less sensitive to coding practices but may also understate the part alcohol plays in the admission.

In general, the Broad measure gives an indication of the full impact of alcohol on hospital admissions and the burden placed on the NHS. The Narrow measure estimates the number of hospital admissions which are primarily due to alcohol consumption and provides the best indication of trends in alcohol-related hospital admissions.

Although Suffolk has a significantly lower hospital admission rate for alcohol-related conditions compared to England (480 per 100,000 compared to 519 per 100,000, respectively), Ipswich is the only LTLA with a significantly higher admission rate (600 per 100,000) comparted to England (see Figure 48).

When looking at admission episodes for alcohol-related conditions by gender, Ipswich is the only LTLA in Suffolk to show a significantly higher rate for males (798 per 100,000) and females (416 per 100,000) compared to England (695 and 359 per 100,000, respectively).

Figure 48: Admission episodes for alcohol-related conditions (narrow), directly standardised rate per 100,000, England, Suffolk and LTLAs, 2019/20

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	280,184	519	517	521
Suffolk	–	3,754	480	464	496
Ipswich	–	758	600	557	644
West Suffolk	–	857	493	460	527
Babergh	–	473	467	425	513
East Suffolk	–	1,213	451	425	478
Mid Suffolk	–	453	405	368	445

Source: Calculated by Public Health England: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Ye ar Population Estimates.

Source: Fingertips, UK Health Security Agency

Figure 49: Admission episodes for male alcohol-related conditions (narrow), directly standardised rate per 100,000, England, Suffolk and LTLAs, 2019/20

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	180,942	695	692	698
Suffolk	–	2,381	617	592	643
Ipswich	–	488	798	728	873
Babergh	–	306	617	548	692
West Suffolk	–	520	607	555	661
East Suffolk	–	785	583	542	626
Mid Suffolk	–	281	506	448	570

Source: Calculated by Public Health England: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Ye ar Population Estimates.

Source: Fingertips, UK Health Security Agency

Figure 50: Admission episodes for female alcohol-related conditions (narrow), directly standardised rate per 100,000, England, Suffolk and LTLAs, 2019/20

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	99,243	359	357	362
Suffolk	–	1,373	355	336	375
Ipswich	–	270	416	368	469
West Suffolk	–	337	389	349	434
Babergh	–	167	334	284	390
East Suffolk	–	428	333	301	368
Mid Suffolk	–	171	313	267	364

Source: Calculated by Public Health England: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Ye ar Population Estimates.

Source: Fingertips, UK Health Security Agency

Hospital admissions: Ipswich

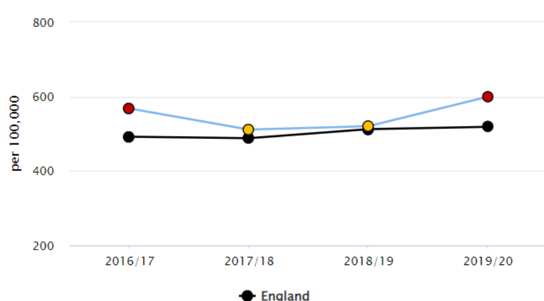
As seen above, Ipswich is the only LTLA in Suffolk that presents a significantly higher hospital admission rate for alcohol-related conditions compared to England, both for males and females.

Figure 51 to 54 show that although Ipswich was statistically similar to England in 2018/19, there has been a significantly higher rate of hospital admissions for alcohol-related conditions in 2019/20 (600 per 100,000) compared to England (519 per 100,000) and the East of England (484 per 100,000). The same trend can be seen for males and females in the Ipswich LTLA.

It must be noted, however, that the rate of admission rate for alcohol-related conditions for males in 2019/20 is significantly higher than females (798 per 100,000 compared to 416 per 100,000). A similar trend is seen across England and the East of England.

The highest rates of admissions for alcohol-related conditions in Ipswich is among the 40 to 64 age banding. Those aged 40 to 64 in Ipswich, both male and female, were the only age banding across all of Suffolk's LTLAs to show a significantly higher rate of admission for alcohol-related conditions compared to England. Therefore, Suffolk Public Health and Communities and system partners should make a concerted effort to tackle problem drinking in Ipswich residents aged 40 to 64.

Figure 51: Admission episodes for alcohol-related conditions (narrow), directly standardised rate per 100,000, Ipswich, 2016/17 to 2019/20, females



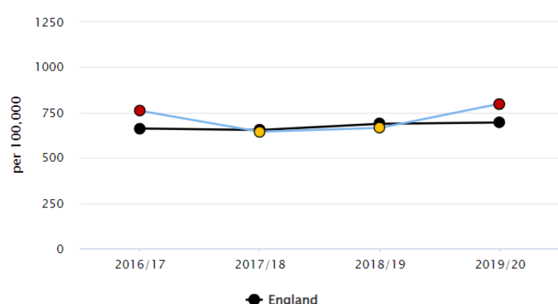
Recent trend: Could not be calculated

Period		Ipswich Count	Value	95% Lower CI	95% Upper CI	East of England	England
2016/17	●	711	568	527	612	446	492
2017/18	●	649	511	472	552	460	488
2018/19	●	661	521	481	562	490	512
2019/20	●	758	600	557	644	484	519

Source: Calculated by Public Health England: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mi d Year Population Estimates.

Source: Fingertips, UK Health Security Agency

Figure 52: Admission episodes for alcohol-related conditions (narrow), directly standardised rate per 100,000, Ipswich, 2016/17 to 2019/20, males



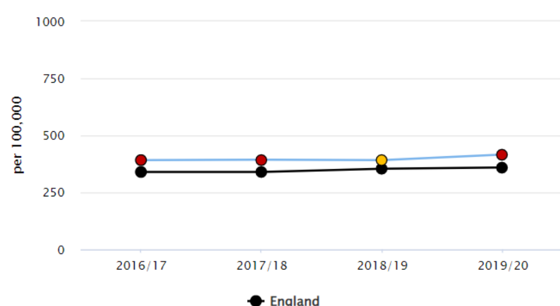
Recent trend: Could not be calculated

Period		Ipswich Count	Value	95% Lower CI	95% Upper CI	East of England	England
2016/17	●	459	759	690	833	586	662
2017/18	●	392	643	580	711	597	654
2018/19	●	407	665	601	733	635	687
2019/20	●	488	798	728	873	626	695

Source: Calculated by Public Health England: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mi d Year Population Estimates.

Source: Fingertips, UK Health Security Agency

Figure 53: Admission episodes for alcohol-related conditions (narrow), directly standardised rate per 100,000, Ipswich, 2016/17 to 2019/20, females



Recent trend: Could not be calculated

Period		Ipswich Count	Value	95% Lower CI	95% Upper CI	East of England	England
2016/17	●	253	391	344	443	322	340
2017/18	●	257	394	347	445	338	339
2018/19	●	254	392	345	443	359	354
2019/20	●	270	416	368	469	358	359

Source: Calculated by Public Health England: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mi d Year Population Estimates.

Source: Fingertips, UK Health Security Agency

Figure 54: Admission episodes for alcohol-related conditions (narrow), 40 to 64 years, directly standardised rate per 100,000, England, Suffolk and LTLAs, 2019/20

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	143,151	798	794	802
Suffolk	–	1,871	750	716	785
Ipswich	–	409	974	882	1,073
West Suffolk	–	436	798	725	877
Babergh	–	235	725	634	825
East Suffolk	–	576	695	639	756
Mid Suffolk	–	215	584	508	668

Source: Calculated by Public Health England: Population Health Analysis (PHA) team using data from NHS Digital - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Ye ar Population Estimates.

Source: Fingertips, UK Health Security Agency

Children and young people

Introduction

While the majority of children and young people do not use drugs, and most of those who do are not dependent, drug and alcohol misuse can have a major impact on children and young people's health, their education, their families and their long-term chances in life[16]. It is for these reasons that local authorities are strongly encouraged to continue to invest in substance related service provision across the different levels of need from schools to treating children and young people's substance use.

This chapter provides key performance information about children and young people (under the age of 18 years) accessing specialist substance use interventions in Suffolk alongside national data for comparison. The data is taken from the National Drug Treatment Monitoring System (NDTMS)[v] which, for children and young people, reflects specialist treatment activity reported for those with problems around both alcohol and drug misuse.

[v] NDTMS Children and young people quarterly activity report

Evidence suggests that effective specialist substance use interventions contribute to improved health and wellbeing, better educational attainment, reductions in the numbers of children and young people not in education, employment, or training (NEET) and reduced risk-taking behaviour, such as offending[17].

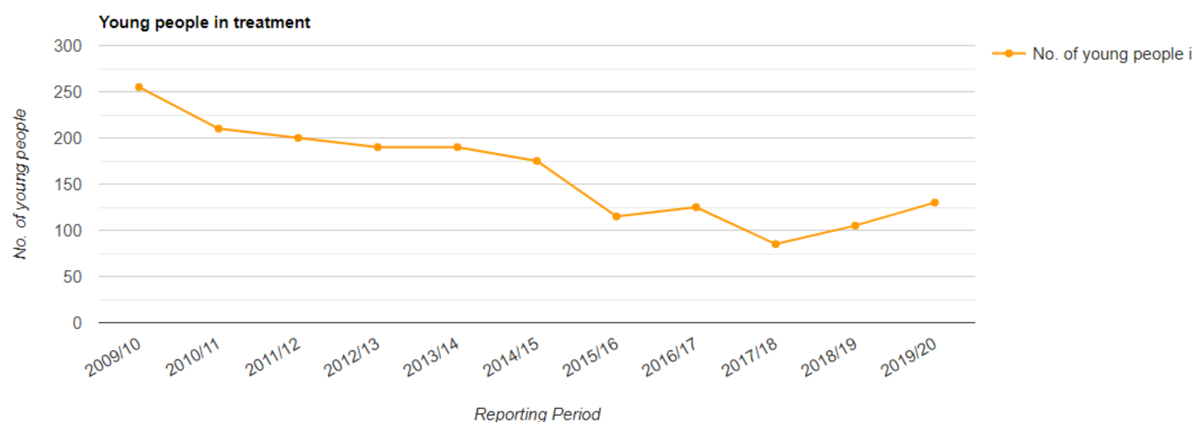
When presenting this data, some categories are omitted due to the low numbers of children and young people involved. An example is referral sources, where only the top 4 categories are included.

NB Some totals presented here will differ to those in the commissioner support packs. The children and young people activity report was used as the main data source here (instead of the commissioner support packs), as there was more information available, in a format that allowed trends to be plotted.

Number in treatment

There were 130 children and young people in treatment during 2019/20. 2017/18 presented the lowest number in treatment (n=85) in the last decade, while the last 3 years of data show an increasing number of children and young people in treatment (+45 from 2017/18 to 2019/20).

Figure 55: Number of children and young people in treatment, Suffolk, 2009/10 – 2019/20



No. of young people in treatment	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
No. of young people in treatment	255	210	200	190	190	175	115	125	85	105	130

Source: NDTMS View It

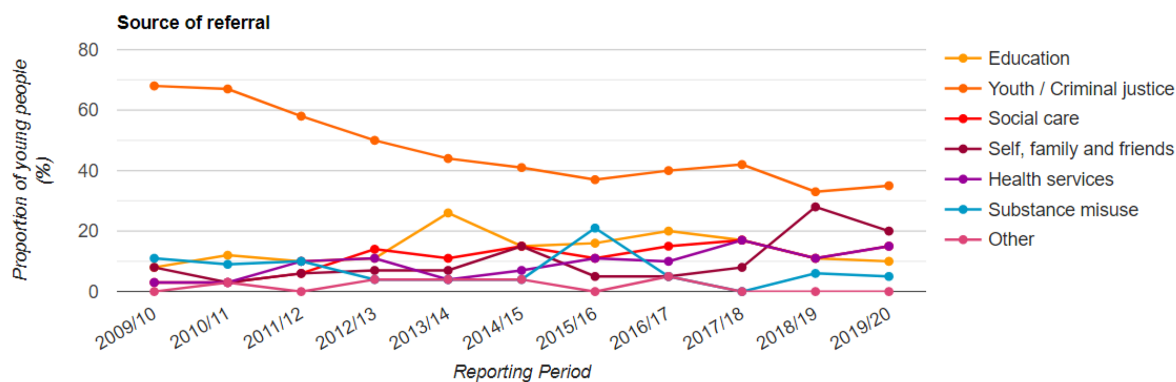
Referral sources (routes into treatment)

Children and young people come to specialist services from various routes but are typically referred by education, youth justice, children and family services and self, family and friends. Data in the chart and table below show the number and percentage of referrals in each year, for new presentations. As each individual episode is counted, there may be more episodes than new clients due to clients presenting more than once.

In 2019/20, the highest proportion of referrals for children and young people came from 'youth / criminal justice' (35%). This trend has been constant for over a decade. In recent years, referrals from 'friends and family' have increased, from 5% in 2016/17 to 20% in 2019/20.

Referrals from health services and social care continue to make up around 1 in 5 referrals annually.

Figure 56: Children and young people referral sources Suffolk, 2009/10 – 2019/20



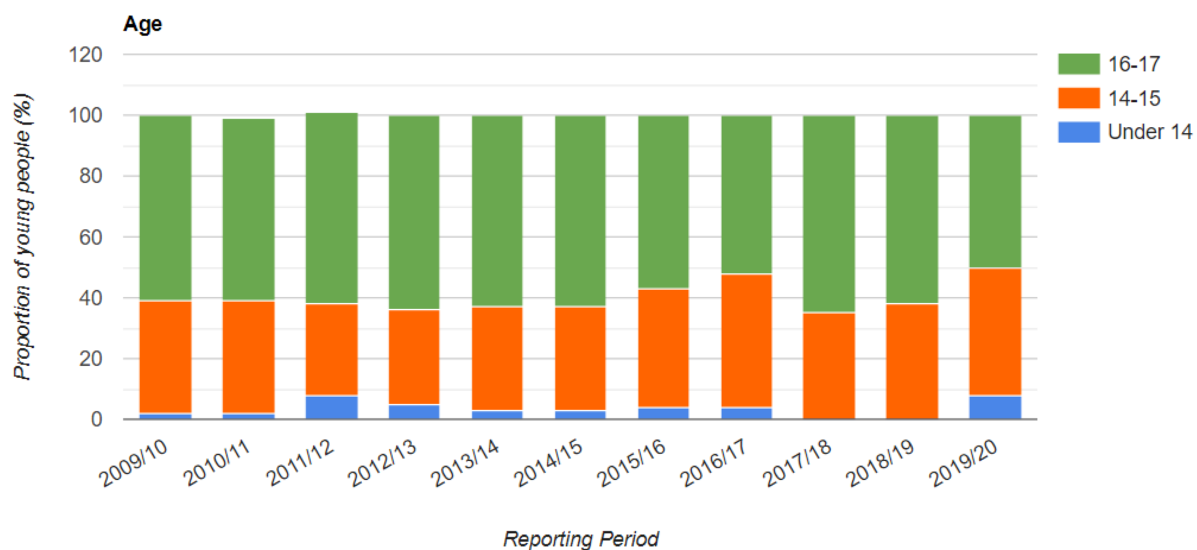
Source of Referral	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Education	8	12	10	11	26	15	16	20	17	11	10
Youth / Criminal justice	68	67	58	50	44	41	37	40	42	33	35
Social care	3	3	6	14	11	15	11	15	17	11	15
Self, family and friends	8	3	6	7	7	15	5	5	8	28	20
Health services	3	3	10	11	4	7	11	10	17	11	15
Substance misuse	11	9	10	4	4	4	21	5	0	6	5
Other	0	3	0	4	4	4	0	5	0	0	0

Source: NDTMS Children and young people quarterly activity report

Age of children and young people receiving specialist treatment

Half (50%) of children and young people in treatment service across Suffolk were 16-17 years of age in 2019/20. 2 out of 5 (42%) were 14-15 years of age, while just under 1 in 10 (8%) were under 14. Please note that the percentages for those under 14 fluctuate from year to year due to the small numbers of under 14s in treatment.

Figure 57: Age of children and young people receiving treatment in Suffolk, 2009-10 to 2019/20



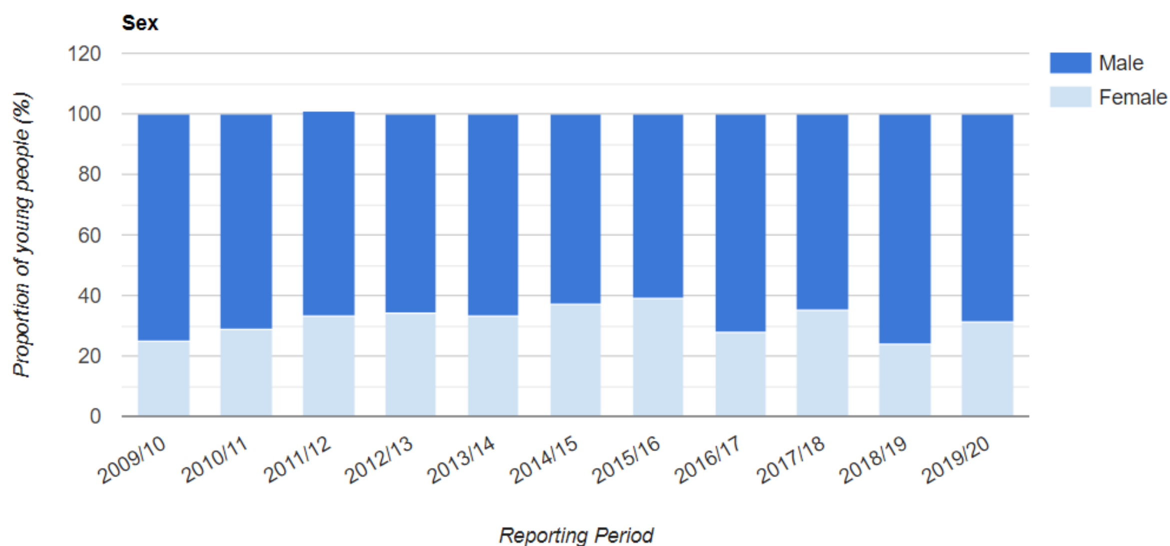
Age (young people)	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Under 14	2	2	8	5	3	3	4	4	0	0	8
14-15	37	37	30	31	34	34	39	44	35	38	42
16-17	61	60	63	64	63	63	57	52	65	62	50

Source: NDTMS Children and young people quarterly activity report

Gender of children and young people receiving specialist treatment

The majority of children and young people in treatment services in Suffolk over the last decade were male. In 2019/20, two-thirds (69%) of children and young people in treatment were male.

Figure 58: Gender of children and young people receiving treatment in Suffolk, 2009-10 to 2019/20



Sex (young people)	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Female	25	29	33	34	33	37	39	28	35	24	31
Male	75	71	68	66	67	63	61	72	65	76	69

Source: NDTMS Children and young people quarterly activity report

Education, employment, and training

Several categories have been removed from the table below due to low number of clients. The remaining data shows there is a reducing trend in the proportion of those engaged in mainstream or alternative education, an increase in those on an apprenticeship/training scheme, but also an increase in NEETs (Not in employment, education or training).

In 2019/20, the majority (56%) of children and young people accessing structured treatment services were in mainstream education. Just over 1 in 5 (22%) were in alternative education, while just under 1 in 5 (17%) were not in employment, education, or training (NEET).

Table 29: Education, employment and training for children and young people receiving structured treatment in Suffolk, 2009/10 – 2019/20

Education and employment status	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Mainstream education	62	40	52	35	46	44	42	29	33	35	56
Alternative education	33	13	21	31	23	24	21	41	33	24	22
Not in employment or education or training (NEET)	0	33	17	19	19	24	21	24	17	24	17
Apprenticeship or training	0	7	7	8	8	4	5	6	8	6	0
Employed	0	3	3	4	4	4	5	0	8	6	6
Persistent absentee or excluded	5	3	0	4	0	0	5	0	0	6	0
Economically inactive - health issue or caring role	0	0	0	0	0	0	0	0	0	0	0
Voluntary work	0	0	0	0	0	0	0	0	0	0	0

Source: NDTMS Children and young people quarterly activity report

Accommodation status of children and young people receiving specialist treatment

Nearly three quarters (74%) of children and young people accessing specialist treatment services in Suffolk lived with their parents or relatives. 1 in 10 (11%) lived independently in settled accommodation. Approximately 1 in 20 (5%) lived in care, in supported housing, or in unsettled accommodation.

Table 30: Accommodation status of children and young people in Suffolk receiving specialist treatment, 2009/10 – 2019/20

Accommodation status	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Living with parents or other relatives	78	70	80	74	72	73	76	61	73	65	74
Young people living in care	3	9	7	7	10	12	12	17	9	6	5
Young people supported housing	3	6	3	11	7	12	6	11	9	12	5
Independent - settled accommodation / no housing problem	8	3	3	0	3	0	6	11	9	18	11
Independent - unsettled acccommodation / housing problem	5	9	7	4	3	4	0	0	0	0	5
Independent - no fixed abode	3	3	0	4	3	0	0	0	0	0	0
Young people living in secure care	0	0	0	0	0	0	0	0	0	0	0

Source: NDTMS Children and young people quarterly activity report

Substances cited

Table 31 below presents the substances cited by children and young people, for any episode in the year. Individuals may have cited more than one problematic substance; therefore, the number of substances may be greater than the number clients in treatment.

Cannabis continues to be the most prevalent substance used, with 92% of those in treatment citing its usage in 2019/20. Thereafter, alcohol was used by nearly half (46%) of children and young people in treatment in 2019/20. Just over 1 in 10 (12%) cited cocaine or 'other'. The category 'Other substance' includes amphetamines, ecstasy, solvents, opiates, NPS, nicotine and other. These have been grouped together due to the small number of citations.

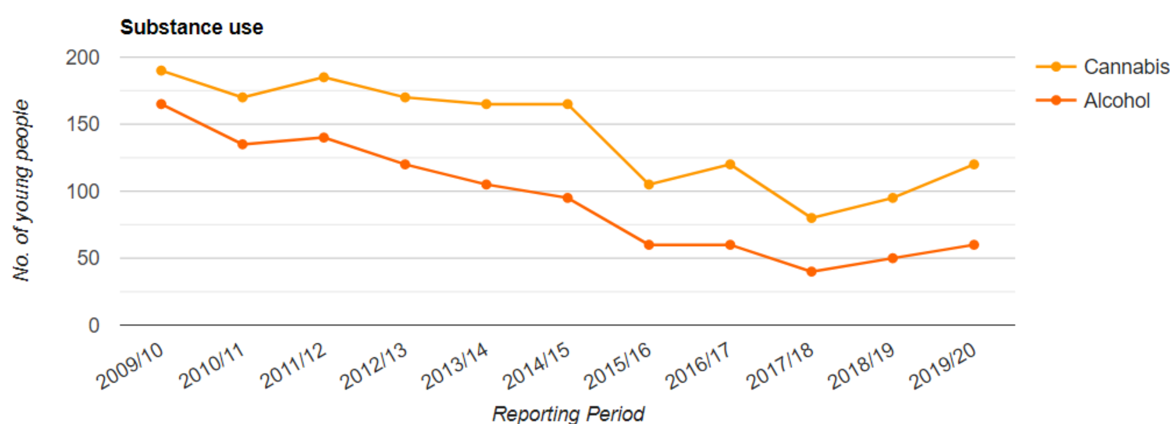
Table 31 shows that 120 children and young people cited using cannabis in 2019/20, while 60 cited using alcohol. Although both substances saw an overall reduction in number from 2014/15 to 2017/18, the number of children and young people citing both substances have increased from 2017/18 onwards.

Table 31: Substances cited by children and young people receiving structured treatment in Suffolk, 2009/10 – 2019/20

Substance Use	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Cannabis	75	81	93	89	87	94	91	96	94	90	92
Alcohol	65	64	70	63	55	54	52	48	47	48	46
Ecstasy	4	5	10	18	16	17	9	12	18	19	12
Cocaine	6	7	5	8	13	9	13	16	24	19	12
Other	2	5	3	0	3	3	0	0	0	5	4
Benzodiazepines	0	0	0	0	0	0	0	0	0	5	4
Solvents	4	2	3	5	8	6	4	8	6	5	0
Other opiates	0	0	0	0	0	0	4	0	0	0	0
New psychoactive substances	-	-	-	-	0	0	0	4	0	0	0
Crack	0	0	0	0	0	3	0	0	0	0	0
Codeine	0	0	0	0	0	0	0	0	0	0	0
Ketamine	8	10	18	13	13	6	4	4	6	5	8
Heroin	0	2	0	0	0	3	0	0	0	0	0
Nicotine (adjunctive use only)	0	2	3	0	0	3	0	0	0	0	4

Source: NDTMS Children and young people quarterly activity report

Figure 59: Substances cited by children and young people receiving structured treatment in Suffolk, cannabis and alcohol, 2009/10 – 2019/20



Substance Use	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
Cannabis	190	170	185	170	165	165	105	120	80	95	120
Alcohol	165	135	140	120	105	95	60	60	40	50	60

Source: NDTMS Children and young people quarterly activity report

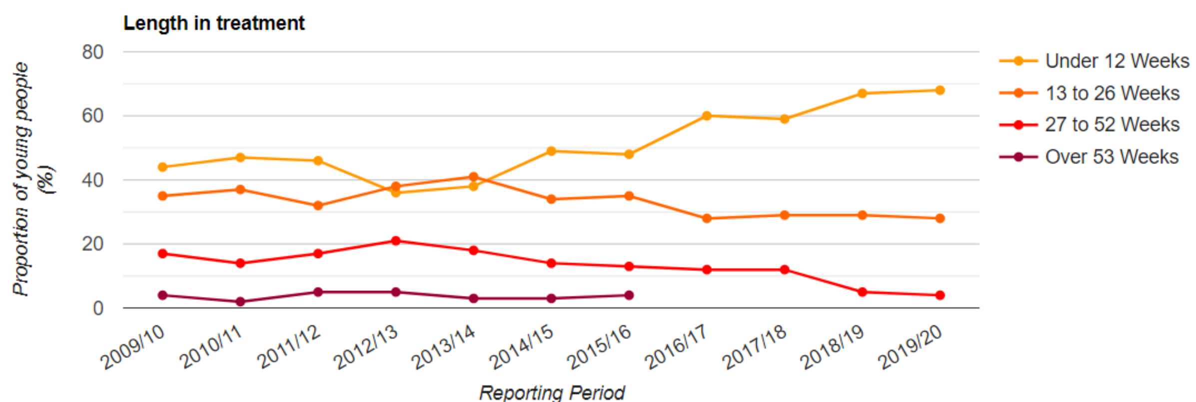
Length of time in treatment and interventions

In 2019/20, over two thirds (68%) of children and young people spent under 12 weeks in treatment services. This continues the trend since 2016/17 where the majority of children and young people in treatment service in Suffolk have spent under 12 weeks in treatment.

In 2019/20, just over a quarter (28%) of children and young people spent 13 – 26 weeks in treatment, while only 4% spent 27 to 52 weeks in treatment (see Figure 60).

Figure 60 shows that in 2019/20 Suffolk continues have a higher proportion of children and young people exiting services after 12 weeks (68%) compared to England (42%) and the East of England (56%).

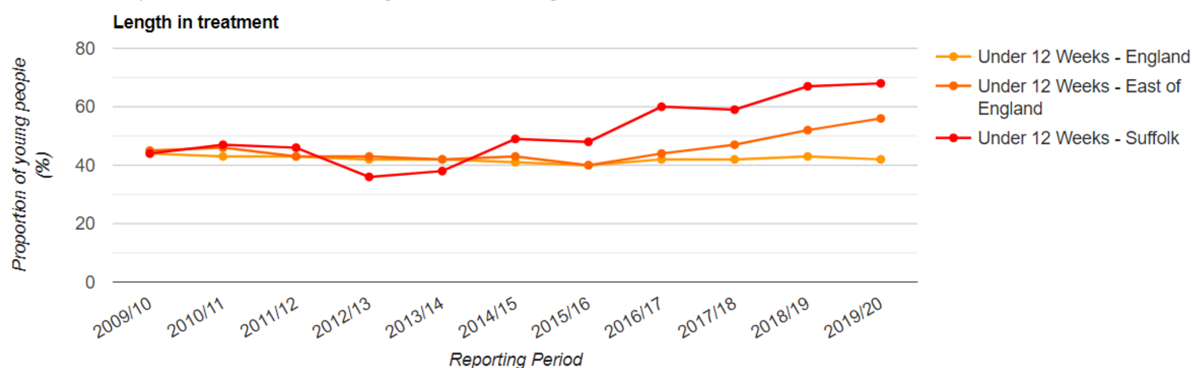
Figure 60: Length of time in treatment for children and young people in Suffolk, 2009/10 – 2019/20



Length in treatment	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Under 12 Weeks	44	47	46	36	38	49	48	60	59	67	68
13 to 26 Weeks	35	37	32	38	41	34	35	28	29	29	28
27 to 52 Weeks	17	14	17	21	18	14	13	12	12	5	4
Over 53 Weeks	4	2	5	5	3	3	4	-	-	-	-

Source: NDTMS Children and young people quarterly activity report

Figure 61: Length of time in treatment for children and young people in Suffolk, under 12 weeks compared to East of England and England, 2009/10 – 2019/20



Accommodation status	Area	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Under 12 Weeks	England	44	43	43	42	42	41	40	42	42	43	42
Under 12 Weeks	East of England	45	46	43	43	42	43	40	44	47	52	56
Under 12 Weeks	Suffolk	44	47	46	36	38	49	48	60	59	67	68

Source: NDTMS Children and young people quarterly activity report

Exiting services

This section shows the number of children and young people who have left specialist interventions successfully and the proportion that return to treatment, commonly referred to as re-presentations. Children and 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 all their problems. The data may help with monitoring the effectiveness of specialist interventions e.g., a high representations rate may suggest room for improvement.

In 2019/20, 81% of children and young people in treatment services successfully completed their course of treatment. However, 1 in 5 (19%) dropped out or left the service. Although this is a higher drop out proportion that England (12%) and the East of England (19%), the higher percentage is due to the relatively low number of children and young people accessing Suffolk services. This can lead to fluctuation in percentages over time.

Table 32: Children and young people treatment exits in Suffolk, 2009/10 – 2019/20

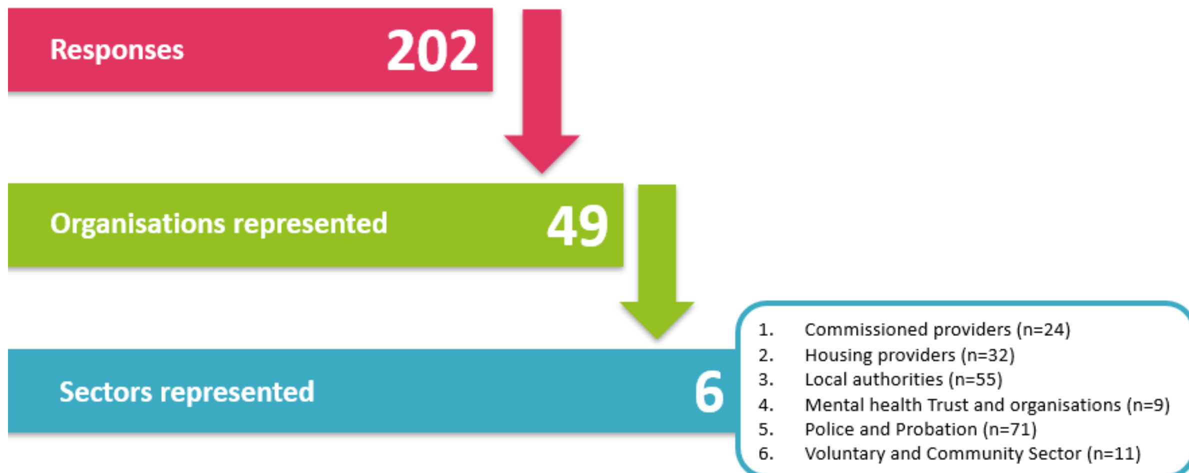
Treatment Exits	2009/10 (%)	2010/11 (%)	2011/12 (%)	2012/13 (%)	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)	2019/20 (%)
Successful completion	62	65	71	73	63	76	73	68	85	85	81
Dropped out/left	23	23	14	15	22	10	13	26	15	15	19
Referred on	3	10	7	8	4	10	7	0	0	0	0
Treatment declined	3	3	4	4	7	3	7	5	0	0	0
Prison	5	0	0	0	4	0	0	0	0	0	0
Other	5	0	4	0	0	0	0	0	0	0	0

Source: NDTMS Children and young people quarterly activity report

Drug and Alcohol Stakeholder Survey

Suffolk Public Health and Communities and the Suffolk Constabulary jointly disseminated a drug and alcohol stakeholder survey from December 2021 to January 2022. The drug and alcohol stakeholder survey received 202 responses from 49 Suffolk-based organisations. The 49 organisations were aggregated into 6 defined sectors for analysis purposes.

Figure 62: Summary of respondents, drug and alcohol stakeholder survey, 2022

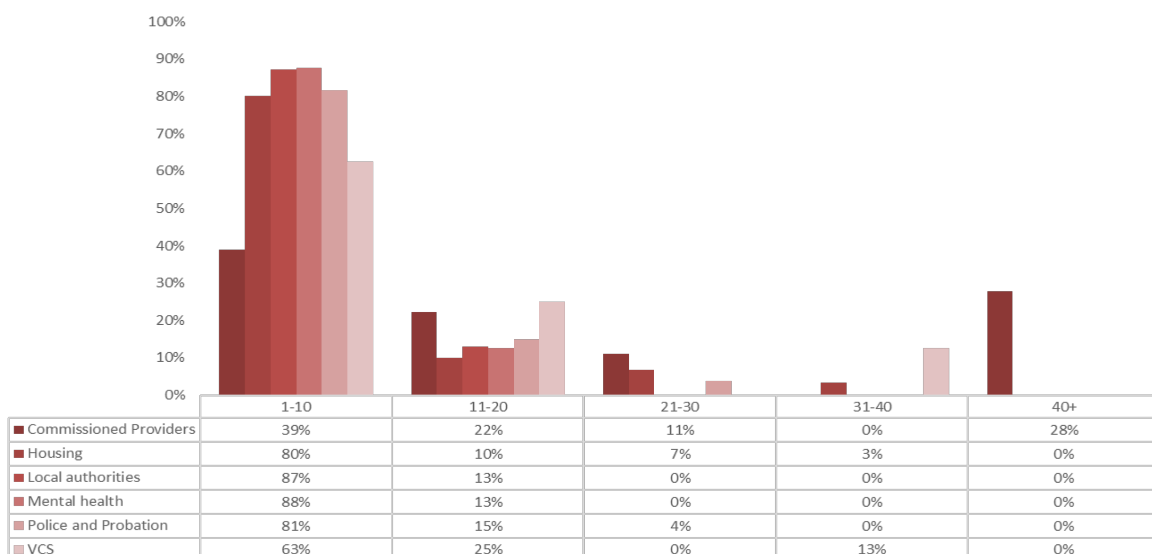


Findings

Workload

The majority of respondents worked with under 10 service users per week. Only Turning Point, Suffolk's main drug and alcohol recovery service, reported working with over 40 service users per week.

Figure 63: Please give an indication of how many service users you personally work with per week

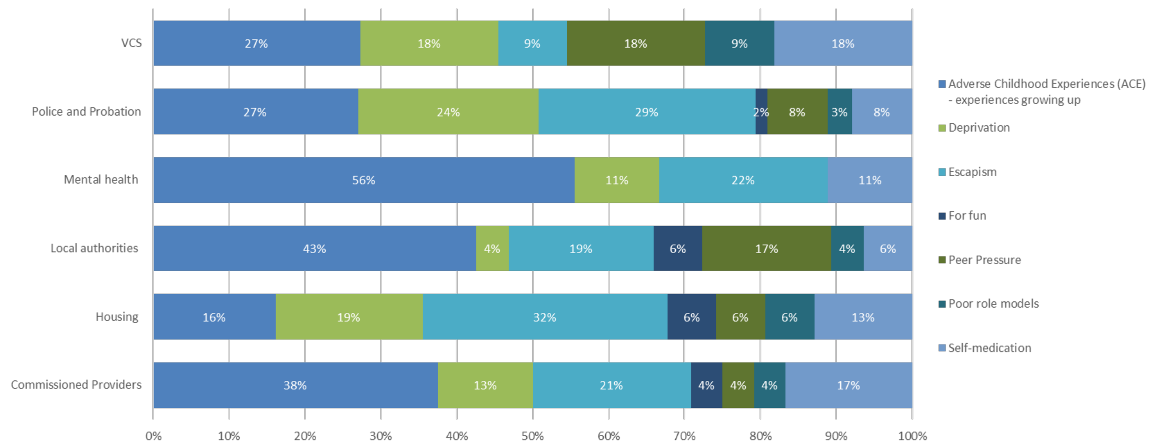


	1-10	11-20	21-30	31-40	40+
Commissioned Providers	39%	22%	11%	0%	28%
Housing	80%	10%	7%	3%	0%
Local authorities	87%	13%	0%	0%	0%
Mental health	88%	13%	0%	0%	0%
Police and Probation	81%	15%	4%	0%	0%
VCS	63%	25%	0%	13%	0%

Perceptions of drug use

Overall, 1 in 3 respondents (32%) thought the main trigger for drug use was adverse childhood experience (ACE), followed by escapism (24%), and deprivation (16%).

Figure 64: What do you understand as the main trigger of drug misuse? (n=185)

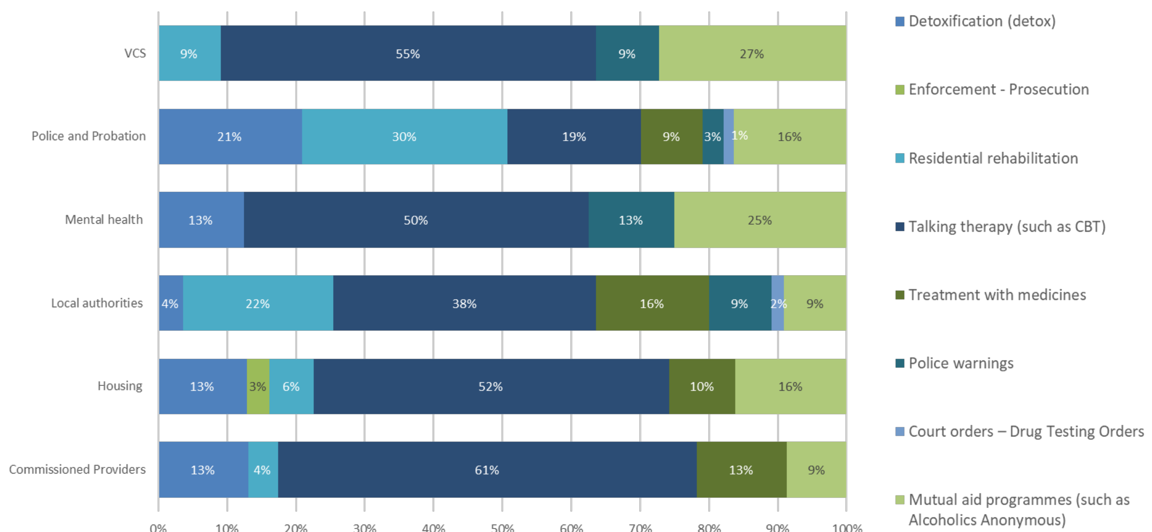


Supporting those who use substances

Overall, respondents thought that talking therapy should be offered to support people who use drugs (38%), followed by residential rehabilitation (18%).

Talking therapies made up the highest proportion of responses for each sector, apart from the police who thought that residential rehabilitation should be the primary support service (30%), followed by detox (21%). This could reflect the severity of drug users police encounter during their work.

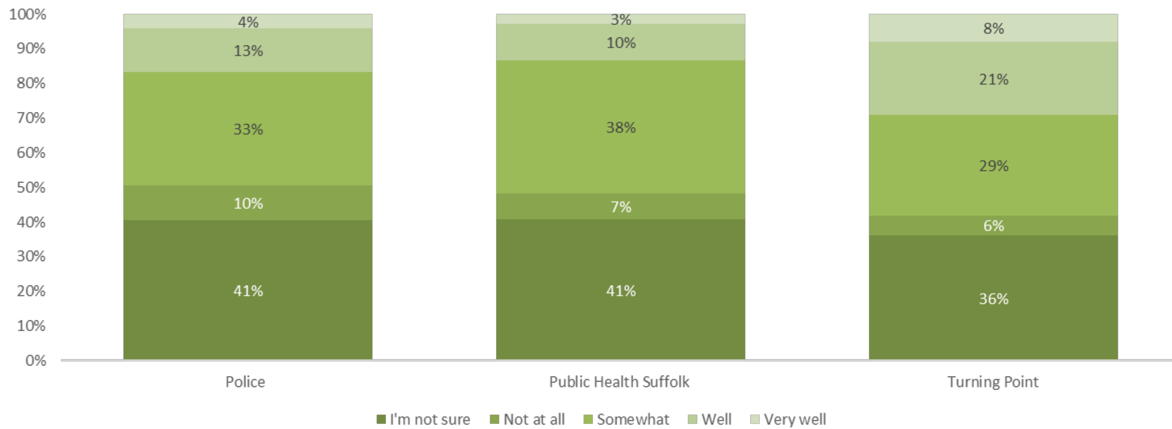
Figure 65: How should people who use drugs be supported? (N=199)



Effectiveness of current services

While 29% of respondents thought that Turning Point are dealing well or very well with drug misuse, only 17% have the same opinion of the police and 13% of Suffolk Public Health and Communities. 1 in 10 respondents (10%) thought that the police are not dealing with drug use at all.

Figure 66: In your opinion, how well do you think the following organisations are dealing with drug misuse? (n=200)

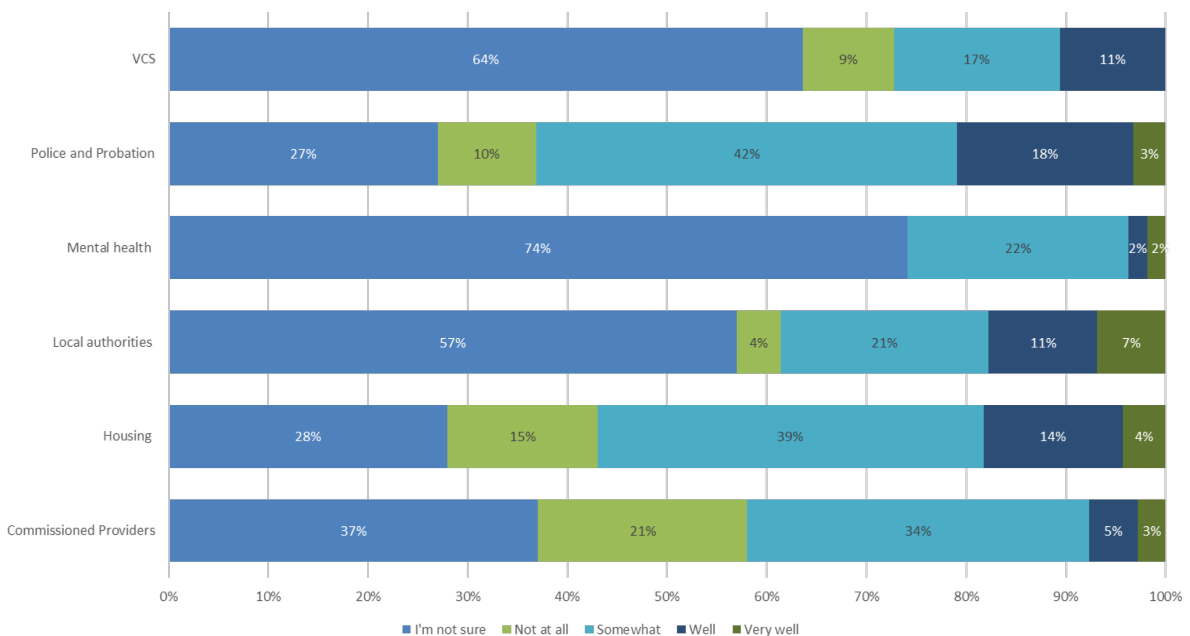


Suffolk Constabulary

A higher proportion of police respondents reported that the police were doing well or very well when dealing with drug misuse (22%) compared to their peers in other sectors.

Interestingly, high proportions of the other sectors felt they were unable to respond to the question. This could present an opportunity for the police to publicise their work and collaborate across the system.

Figure 67: In your opinion, how well do you think Suffolk Police are dealing with drug misuse (n=200)

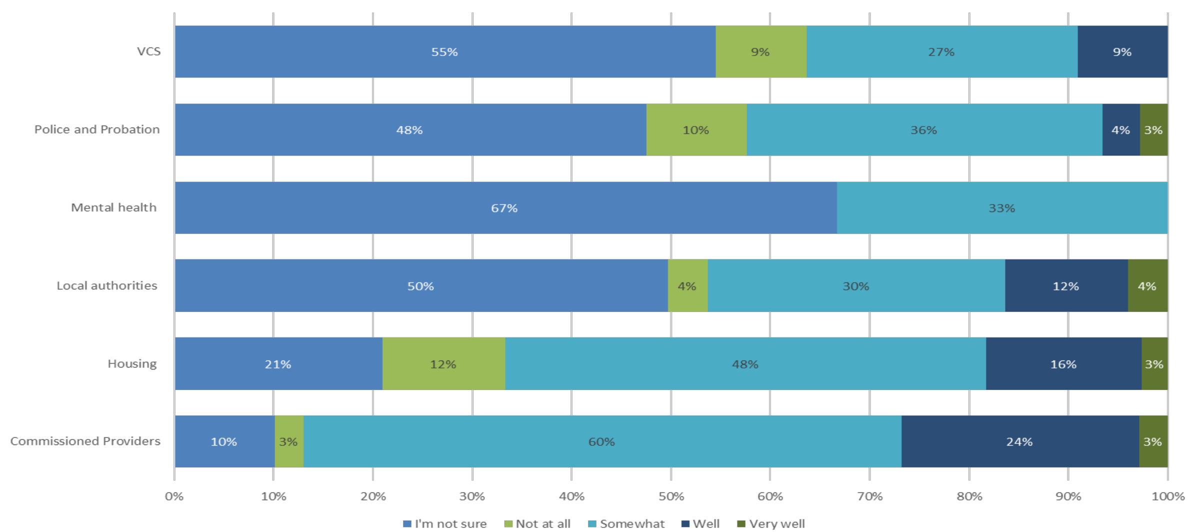


Suffolk Public Health and Communities

Over a quarter (27%) of commissioned providers, such as Turning Point, think that PHS are dealing with drug misuse well or very well. Conversely, only 7% of the police and 9% of the VSC sector thought that PHS were doing well or very well.

As with the police, the high proportions of respondents that were unable to respond highlights an opportunity for publicising PHS's work.

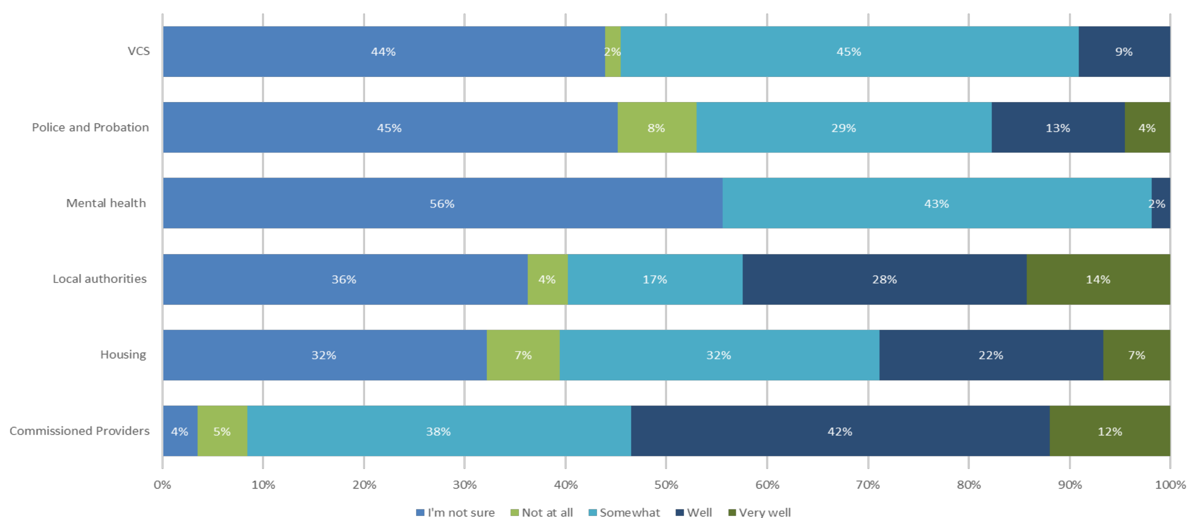
Figure 68: In your opinion, how well do you think Suffolk Public Health and Communities are dealing with drug misuse (n=200)



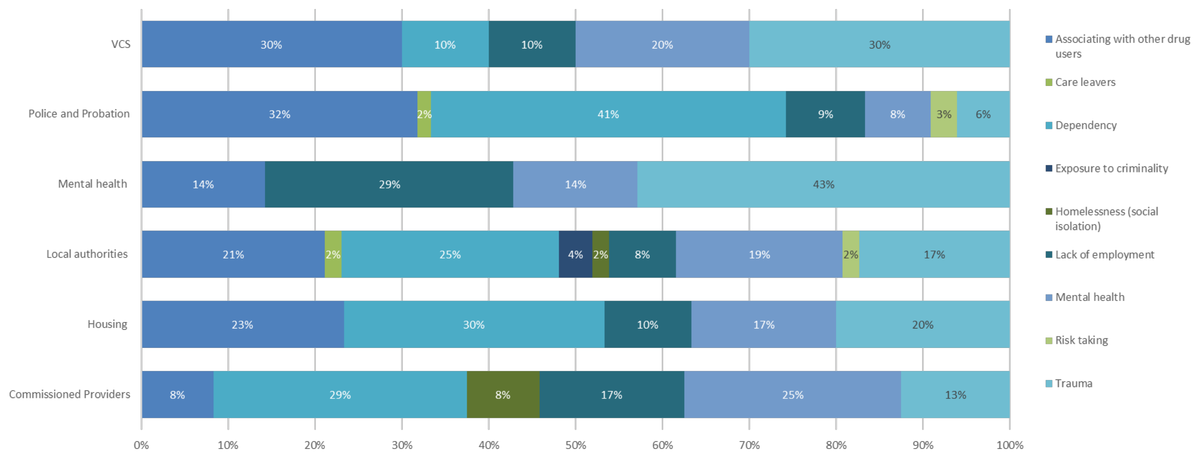
Turning Point

Respondents were more positive towards Turning Point, with 29% of housing, 42% of local authority, and 17% of police reporting that Turning Point are dealing with drug misuse well or very well.

Figure 69: In your opinion, how well do you think Turning Point (Suffolk's drug treatment provider) are dealing with drug misuse? (n=200)



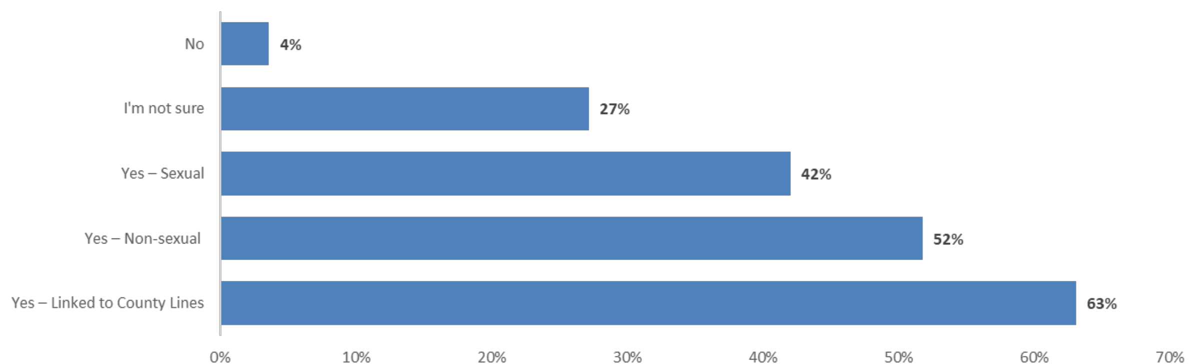
Vulnerability



Nearly 1 in 3 (30%) think that dependency makes drug users vulnerable, while 1 in 4 (24%) reported vulnerability was linked to associating with other drug users.

15% of respondents think that mental health and trauma are the most likely thing to make drug users vulnerable. 1 in 10 (11%) thought unemployment, while only 2% thought homelessness.

Figure 70: What makes drug users in Suffolk vulnerable to drug use? (n=189)



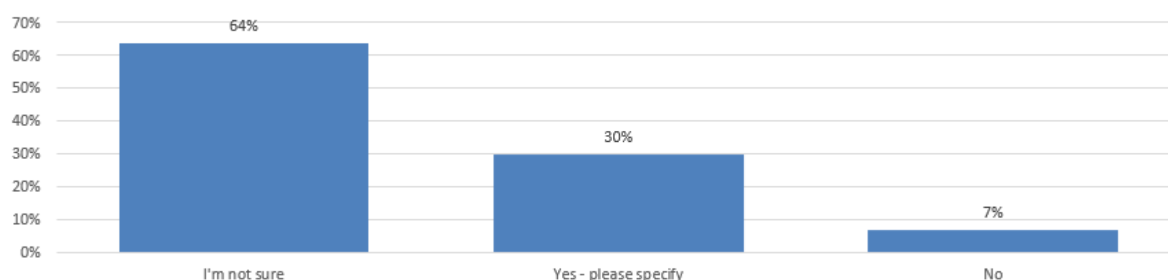
Almost 2 out of 3 respondents (63%) said that they know drug users who have been threatened or subject to violent crime due to county lines, while over half (52%) said that they know drug users that have been threatened or subject to non-sexual violence.

2 out of 5 (42%) respondents said that they know drug users that have been threatened or subject to sexual violent crime due to their drug use.

Figure 71: To your knowledge are drug users threatened with or subject to violent crime due to their drug use? (n=195)

Please note that responses will not equate to 100% due to ability to provide multiple responses.

Hidden needs



Almost 1 in 3 respondents (30%) said that there was a demographic of people who take drugs that are hidden to the local authority and/or police. Of these, the majority of said that middle class drug users were hidden (n=25).

Figure 72: Is there a demographic of people who take drugs that are hidden to local authorities or the police? (n=192)

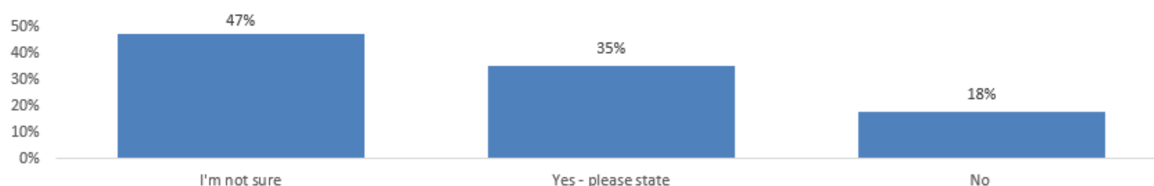
	Commissioned Providers	Housing	Local authorities	Mental health	Police	Total (n=45)
Middle-aged / elderly users	1		3			4
Middle class users	8	1	10	1	5	25
Weekend users	1	2				3
Young drug users			1	1		2
Prescription drug users			1	1	1	3
Cocaine users		1	1		2	4
Functional users		1	1		2	4

Service provision during the COVID-19 pandemic

Of those who reported that their service had changed due to COVID-19 (and provided a reason), 1 in 5 had seen more complex drug and alcohol use (21%). 1 in 5 (21%) also described more complex mental health needs among service users (21%).

16% reported more referrals and/or increased demand, while 1 in 10 (9%) noted that there was increased staff turnover due to ongoing pressures.

Figure 73: Has your service seen any changes relating to COVID-19? (n=197)



	Commissioned providers	Housing	Local authorities	Mental health	Police	VCS	Total	Proportion of total (n=56)
More drug / alcohol use	3	2	3	2	2		12	21%
More complex need (MH)	3	1	2		4	2	12	21%
Move to phone / online	5		5	1			11	20%
More referrals / increased demand	4	1	1	1	1	1	9	16%
Less face to face	1	1	3	1	2		8	14%
Staff turnover due to pressure	3		1	1			5	9%
Less under 18s in service	1						1	2%
More cuckooing					1		1	2%

Gaps in service provision

1 in 5 respondents (22%) thought that there were gaps in service provision due to a lack of funding and resources across the system.

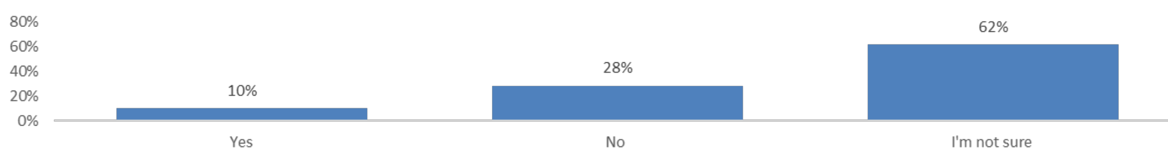
Similarly, 1 in 5 respondents (19%) thought that there were gaps due to access to mental health services – these comments often related to capacity and lack of support/collaboration between NHS mental health services and the wider system.

Table 33: What do you think the gaps in the service provision are, working with people with substance use issues? (n=120)

Please note: 13 responses were removed as they were non-responses

	Commissioned providers	Housing	Local authorities	Mental health	Police	VCS	Total	Proportion of total (n=120)
Lack of resource / funding	7	5	5		8	1	26	22%
Mental health services (capacity / no support)	5	3	6	2	6	1	23	19%
Shorter waiting lists / availability	3	3	3		1	1	11	9%
Better collaboration	1	1	2	3	3	1	11	9%
No rural service / small towns / community	2	3	2		2	1	10	8%
More / affordable rehab	1	2	2	1	3		9	8%
Face-to-face contact time	1	1	4		1		7	6%
Early help (0-25)		1	5		1		7	6%
Lack of evidenced-based provision / employee training	1		3	1	1		6	5%
Dual diagnosis	1	2	1	2			6	5%
Education	1				1	2	4	3%
Lack of follow-up			3			1	4	3%
Holistic model	1				1	1	3	3%
Less punitive rules in services				1	1	1	3	3%
Need to work with wider family	1		1				2	2%
Review GP opiate prescriptions			1				1	1%

Effective partnership working in Suffolk



Of the 45 respondents that left comments, 1 in 4 (24%) said that drug and alcohol service users could not access or found it hard to access mental health services. This was often dovetailed with respondents stating that there are poor referral systems (i.e., lack of quality and information for both the professional and service user) (18%).

Some respondents noted poor collaboration (18%) and communication (16%) across the drug and alcohol system regarding service user handovers/pathways, but also information sharing on a strategic level.

Figure 74: Do you think treatment services in Suffolk are working together as effectively as possible? (n=190)

	Commissioned providers	Housing	Local authorities	Mental health	Police	VCS	Total	Proportion of total (n=45)
Can't access MH	4		3		2	2	11	24%
Poor collaboration			3	2	3		8	18%
Poor quality / info re referrals	1	1		2	2	1	7	16%
Poor communication	1	3	2	1			7	16%
Not enough staff	1	1	1		3		6	13%
Not enough funding			2		1		3	7%
Different approaches			1		1		2	4%
Stigma attached to Turning Point	1						1	2%
No contact with IDT	1						1	2%
COVID-19 has affected service offer					1		1	2%
Not enough support for CYP						1	1	2%
Best offer for funding available	1	1	1		1		4	9%
Good systems across some services		1					1	2%
Good youth justice service			1				1	2%

Health Outreach Project (EPUT) is excellent				1			1	2%

Challenges facing treatment services

The majority of respondents (53%) said that funding and resources were the biggest challenges facing treatment services. This had an impact on access and waiting times (20%), staffing issues (18%), and high caseloads (10%).

Commissioned providers noted that staff turnover is high due to pressures caused by poor pay, lack of proper training, lack of resources, and the necessity to handle high caseloads, which can lead to burnout. All these comments hinged on funding.

Nearly 1 in 5 respondents (18%) thought that engaging service users in a sustainable way was the biggest challenge to the treatment services. These comments also often related to funding regarding demand outweighing resources, leading to poor interaction/continuity with service users.

Table 34: What do you think the challenges are relating to treatment services? (n=137)

Please note: 12 responses were removed as they were non-responses

	Commissioned providers	Housing	Local authorities	Mental health	Police	VCS	Total	Proportion of total (n=137)
Funding / resources	12	9	17	4	26	4	72	53%
Access / waiting lists		6	11	2	7	1	27	20%
Staffing issues	10	6	2		7		25	18%
Engaging service user		4	9	1	11		25	18%
High case load	3	1	6		4		14	10%
Location of services / funding travel	1	3	2		1		7	5%
Medical model does not work	2		3				5	4%
Access to rehab	1	1				2	4	3%
Scale of the problem		1			1	1	3	2%
Long-term community support					1	2	3	2%
Policies too rigid		1		1			2	1%
Mental health			1		1		2	1%
Not enough youth work	1						1	1%
Education		1					1	1%

Opportunities for treatment services

Over a quarter of respondents (29%) said that 'opportunities' were reliant on improved funding, resources, and staffing.

Nearly 1 in 5 respondents (17%) thought that there was an opportunity to align drug and alcohol service across Suffolk. Some of these comments were linked to making service pathways easier to understand for both professionals and service users (6%), early intervention (4%), and information sharing (3%).

Table 35: What opportunities are there for treatment services? (n=70)

Please note: 41 responses were removed as they were non-responses

	Commissioned providers	Housing	Local authorities	Mental health	Police	VCS	Total	Proportion of total (n=70)
Opportunities reliant on ongoing challenges (i.e., funding / staffing)	5	3	4	2	6		20	29%
Align services	1	1	3	2	4	1	12	17%
Using service users more	1		1	1	1	1	5	7%
Make services easier to access / clear pathways	1		3				4	6%
Holistic approach / engagement			1	1	2		4	6%
Early intervention		2			1		3	4%
Increased community / outreach services			2	1			3	4%
Information sharing		1	1				2	3%
Fundraising with service users	1						1	1%
Engage CYP			1				1	1%
Decrease stigma across services					1		1	1%
Increase education across school / community					1		1	1%

Interviews with stakeholder and service users

Suffolk Public Health and Communities held semi-structured interviews with 45 stakeholders and 17 substances use service users between February and March 2022. Each interview was approximately one hour and covered 4 areas of interest:

1. **Situational awareness:** understanding professionals' and service users' place within the substance use system and awareness of commissioned services.
2. **Perceptions of current services:** understanding perceptions and experiences of Turning Point and wider substance use services in Suffolk
3. **Understanding the Suffolk system:** understanding current working practices at a system level, including challenges and opportunities
4. **Hidden needs:** exploring populations that are not served by current substance use services, including opportunities for engaging hidden populations

Thematic analysis has been completed for each of the interviews. Where appropriate each question has been distilled into themes. This chapter will review stakeholders' responses before going on to service user feedback.

Stakeholders

Situational awareness: people, space, and place

Q: What part of the system do you occupy?

Suffolk Public Health and Communities interviewed 45 professionals across 18 organisations, covering all areas of Suffolk. Opening the interviews to a wide range of stakeholders ensured that all parts of the system were reached, including senior management and front-line staff across local authorities, primary care, secondary care, housing, probation, and VSCE organisations. The table below lists interviewees organisations and sector type.

Table 36: Interviewee's organisation and sector

Organisation	Data collection method		Gender		Age	Ethnicity
	Interviews	Focus group	Male	female		
Turning Point						
Ipswich	1			1	Working age	White British
Lowestoft	1			1	Working age	White British
Bury	-	1(n=2)	1	1	Working age	White British
Probation Hostel (The Cottage)		1(n=4)		4	Working age	White British
Ipswich Hospital		1(n=2)		2	Working age	White British
Norfolk and Suffolk Foundation Trust (NSFT)	1		1		Working age	White British
Julian Support	2		1	1	Working age	White British
West Suffolk Council	1		1		Working age	White British
Essex Partnership University NHS Foundation Trust (EPUT)	1		1		Working age	White British

Organisation	Data collection method		Gender		Age	Ethnicity
	Interviews	Focus group	Male	female		
East Suffolk Council	1		1		Working age	White British
Ipswich Borough Council (Housing Options Team)	1	1(n=2)		3	Working age	White British
Suffolk county Council School nurse		1(n=3)		3	Working age	White British
Health Outreach		1(n=3)	1	2	Working age	White British
West Suffolk Hospital (Liaison team)	1		1		Working age	White British
Suffolk Family Carers		1(n=3)	2	1	Working age	White British and Asian British
Probation (General)		1(n=2)	1	1	Working age	White British
Burlington Road Surgery	1		1		Working age	White British
GP in Beccles and Forensic Physician	1		1		Working age	White British
Lowestoft MEAM (making every adult matter) Team	1		1		Working age	White British
BHK Training	1			1	Working age	White British

Do current services work for service users?

Q: Do you think the way you work with service users works for them?

Services work for service users when there is integration across the system

Interviewees agreed that their respective service worked best when there was integration and collaboration between all services in the system. Lack of integration was cited as reasons why service users may see the whole system as "not working"; i.e., if one service within a service users' recovery journey is not integrated appropriately or communicating effectively, all of the services within the pathway will get a poor reputation.

'Yes it does. [Service users] have lots of interrelated issues that impact on one another. You need to work in an integrated way to help these people – it needs the whole system to work together'.

Service work best when they're not timebound

Services that fall under the Rough Sleeper Initiative or those offering wider family support mentioned that services often work best when they're not timebound, noting that recovery from substance use is often a lengthy process involving wider determinants such as mental health recovery and/or securing employment and housing.

'Yes, because the service is not time bound. There is an understanding that these families will need intense support for a long period of time. Many of these families will recover over months and years, while some, unfortunately, will not recover at all'.

COVID-19 has impacted service delivery

COVID-19 has severely impacted service delivery for all the organisation who were interviewed. Face-to-face engagement has been reduced, although many organisations noted that they tried to continue delivering face-to-face interventions / engagement with the service users most in need. For many, reduced face-to-face engagement meant decreased visibility among those in need and poorer access to service provision.

However, many noted that new ways of working – such as online and telephone consultations – were beneficial for certain service users, such as those who were more rural or in full-time employment. It is clear that there will be a move to hybrid working for many organisations in the recovery sector.

'The pandemic has led to better engagement with Haverhill and Sudbury online and over the phone. But we – and the clients - want more face-to-face time and that reduces capacity for other work'.

System partners' understanding of substance use services in Suffolk

Q: Are you aware of Turning Point? What role do they play in the System?

Proximity relates to knowledge of Turning Point

All stakeholders had a clear understanding of Turning Points role within the recovery system. But a clear understanding of exactly what Turning Point offers and who they can help was less clear, largely dependent on a stakeholder's day-to-day involvement with Turning Point. For example, services that work closely with Turning Point on a day-to-day basis have a very good and clear understanding of what Turning Point offer and provide, while some services that signpost to Turning Point (or have limited contact with Turning Point) have less of an understanding of the pathways, service offer, and level of substance use a service user needs to be at to access Turning Point.

'Not hugely aware of what they're doing at the moment. Many services have taken a step back during the pandemic and there is a lot less face to face work – this has been quite problematic'.

System partners' perception and experience of Turning Point and wider substance use services in Suffolk

Local perceptions of Turning Point

Q: What is your perception of Turning Point?

Proximity relates to positive perceptions of Turning Point

Positive sentiment towards Turning Point was often predicated on how often stakeholders engaged with Turning Point, and, more importantly, what classification of service user they were signposting to Turning Point. For example, stakeholders from homelessness organisations were less likely to provide positive feedback as many do not think that the current pathways are working effectively.

Negative feedback was often accompanied and caveated by an understanding that Turning Point are trying their best to run a service with limited capacity and a system where demand outweighs supply.

'Improved massively. Used to have a very negative perception of them. Now that I work with them, I see them in a better light. No funding, lack of staff, and dealing with very chaotic people – under those circumstance, they're doing a great job'.

'Generally, quite positive. I work with their clinicians, and we work jointly. Working closely with [Turning Point] has been vital. I have been able to access fast-track assessments if I'm concerned that someone is very high risk'.

Staff turnover and capacity

Stakeholders noted that Turning Point had faced capacity and staffing issues over the last few years. This has created a strain on some pathways, led to reduced communication, a less visibility at key partnership meetings across the county. Additionally, there was a perception that the staffing issues meant that some service users were seeing multiple key workers resulting in an unequal continuity of care across Suffolk.

'There is a big turnover of staff, so it's not easy to keep a handle of who is dealing with what, which creates some difficulties along the way. The lack of staff means that key workers often change or there's sometimes no reply to calls or emails'.

Staff training

Some stakeholders, particularly from a clinical background, thought that Turning Point staff would benefit from more robust, ongoing training. They acknowledged that Turning Point provide a fantastic service, however they though that 1) staff were more likely to stay with Turning Point if there was accredited training, and 2) service users would benefit if front line staff had additional training in mental health.

'People that work there would benefit from more training. They're stuck on the front line straight away. If you're a brain surgeon, you're not put straight into the operating theatre. If you're expecting to deal with substance use as a medical condition, you need the right training'.

Direct working with substance use services in Suffolk

Q: What has been your experience of working with Turning Point?

Positive process regarding hospital detoxification

Alcohol Specialists Nurses thought that the handover from secondary care to Turning Point was working very well. Although the secondary care detoxification process and pathway has taken time to establish and embed, the Nurses thought that current processes and working relationships with Turning Point staff provided a robust continuity of care for the service users.

'We make a plan by the [patient's] bedside before the patient leaves hospital, working directly with the case worker from Turning Point. This ensures a smooth transition from hospital to Turning Point'

Waiting times

Long waiting times were an issue for services and organisations referring directly into Turning Point. However, many noted that this was not necessarily Turning Point's fault. Rather, it was due to the surge in demand during the pandemic and the reduced capacity across the system to see service users face-to-face.

Those with the ability to refer service users directly often spoke of "fast-tracking" service users via emergency slots or through a named contact at Turning Point. It was apparent that knowing and engaging with named individuals at Turning Point led to priority access.

'Waiting times are hideous. If they self-refer, they're waiting for 5-6 weeks. However, we have 2 emergency referral slots a week that speeds things up. I use more than 2 and send them via email. Access to services at the right time is critical for these people. Waiting any longer than necessary will see the chance of recovery lost'.

Non-attendance at partnership meetings

There was a clear consensus among interviewees that Turning Point sporadically attend partnership meetings. Stakeholders thought that this limited Turning Point's ability to work effectively in partnership with wider recovery organisations and also limited communication and collaboration.

'There's a distinct lack of attendance to Housing First monthly meetings. This is a national scheme – put the person, regardless of issues, into a property and wrap around intensive support. Organisations such as police involved but Turning Point don't seem to be involved'.

'Turning Point are less than visible. I can't remember ever seeing them at system meetings. We had 6 weekly meetings to look at our frequent flyers and Turning Point attend on an ad hoc basis, if at all'.

Communication

Communication was discussed in all stakeholder interviews. Responses were wide ranging, from incredibly positive to very negative. Interviewees who had day-to-day engagement with Turning Point and were fundamental to the recovery pathway, such as hospital detox services or front-line outreach services, had positive experiences communicating with Turning Point. Having a 'named contact' was often cited as the reason. However, those working in wider recovery settings, such as housing or NSFT, reported much poorer communication. After probing, many of those reporting poor communication via email or telephone were referring to Turning Point's generic email and switch board.

'Many times, I've tried to call them and don't get a call back. I've sent quite lengthy emails to Turning Point regarding known service users, but I've very rarely got an email back. It's not great really – even a 'thank you' would be nice. But I know services have been hacked away at over the years – it's not easy, they're short staff, and they don't have as much experience as they used to'.

Understanding the Suffolk system

Current challenges for substance use services in Suffolk

Q: What do you think the challenges are relating to drug use and treatment services?

Partnership working

All interviewees acknowledged that better partnership working, and further collaboration is needed in Suffolk if the surge in demand across recovery services due to the pandemic, especially among alcohol users, is to be tackled effectively. Many said that the recovery system and pathways across Suffolk are better than they used to be, however, the pandemic has led to less face-to-face engagement between organisations and between organisations and service users. This is an area that the majority of stakeholders were eager to rectify going forward.

A cornerstone of partnership working for many interviewees stemmed from a need to treat service users holistically by incorporating more community and VCSE organisations into the recovery process.

'There's a safety guard between outreach, mental health, and Turning Point. It needs to be there, but it falls down quite a lot. We feel let down for our clients'.

'I wouldn't say we work together by any stretch of the imagination. We've never worked with people with such complex needs over the last 2 years of the pandemic. It's all budget driven, performance driven, and we're all challenged. We're firefighting our own parts of the system which doesn't allow us to work together effectively'.

Funding

Funding was a topic of conversation for nearly all stakeholders interviewed. It was generally accepted that reduced funding from central government over the last decade has led to many recovery services being "overstretched". In turn, this has meant reduced capacity across workforces, a labour shortage due to low wages, and for some organisations, an inability to commit to long-term programmes of work due to non-recurrent or diminishing funding streams.

Prominent themes interlinked with challenges regarding funding were:

- Funding for additional staff within the recovery system (i.e., key workers);
- Funding outreach in educational and community settings;
- Cross-system funding of a dual diagnosis service for Suffolk; and
- A roll-out of Specialist Alcohol Nurses to A&E departments to enact a preventative strategy for "frequent flyers".

'We see the difficulty faced for clients accessing support, be it prescriptions, rehab, enough staff etc, due to the lack of funding. We find that quite difficult. It's an uphill battle'.

Educational outreach

School nurses and stakeholders who work with children and young people indicated that educational outreach has been depleted in recent years. Stakeholders saw educational outreach as a valuable tool in educating children and their families about personal substance use and substance use within the

family. School nurses noted that outreach should be directed towards schools where there are higher safeguarding cases for substance use among families.

'More educational outreach would be beneficial, not only for the kids but the parents too. A lot has changed in the last 10 years, such as county lines in the bigger towns. There used to be a lot of educational outreach, but it seems to have disappeared – even before the pandemic'.

Outreach

All stakeholders who work directly with Turning Point wanted to see more outreach delivered across Suffolk. 'Outreach' was described as delivering services in service users' home for the most chaotic cases and delivering outreach at a 'place' / community level such as Integrated Neighbourhood Teams (INTs) and Primary Care Networks (PCNs). This, along with dual diagnosis, was the most prevalent theme.

At present, Turning Point have three main Hubs in Suffolk making service provision largely confined to Ipswich, Bury St Edmunds, and Lowestoft. However, satellite offices are becoming more functional as COVID-19 restrictions ease. Delivering at a 'place' level, whether co-locating and partnering with INTs and PCNs, in areas of rurality and/or areas where there are higher prevalence of alcohol and substance use was a priority for stakeholders and service users alike.

'Outreach is the future. Working with people are marginalise and vulnerable, who access health care on their own turn means that services need to be deliver in an outreach capacity; where that's on the street, in a hostel or housing accommodation, or in their own home. Outreach needs to be an option for these people'.

'One problem: lack of outreach appoints from Turning Point. Can't go to [the service users'] houses, their hostel, etc. Some people want the service to come to them and won't "access" the service. However, I understand there isn't always the funding or capacity for this'.

Specialist treatment services for rough sleepers

Many stakeholders working directly with rough sleepers commented that the current structured format for recovery does not work effectively for the most chaotic communities suffering from substance use, mental health, and homelessness. Many mentioned the option of an integrated pathway for rough sleepers that is separated from conventional pathways. However, interviewees also acknowledged that this would be an additional cost reliant on additional funding.

'Some of the homeless population won't access Turning Point. They'll have periods of trying to access the service and prescribing, but they won't stay in the service for very long as they're very chaotic. It ends up being a cycle as they miss an appointment every month which puts them to the start of the process again'.

'A lot of our most chaotic clients won't attend set meetings. Turning Point need to go to them. A lot of practitioners from other organisations have a day a week where they sit in the health outreach office.

It would be a real benefit if Turning Point could do this. We've offered, but there isn't a lot of movement at the moment due to capacity'.

Dual diagnosis

Dual diagnosis is one of the key gaps identified in service provision for those with moderate to severe substance use problems and mild to moderate mental-ill health. This was one of the most common themes across all interviews with stakeholders.

There was frustration across interviewees that there is not a statutory service that individuals can access to address their mental health and substance use needs. Stakeholders noted that alcohol and drug use is often just one factor in the complex challenges someone faces in their life. Substance use may be a means to cope with mental distress. It can also contribute to experiences of mental-ill health. Substance use problems and mental-ill health can contribute to each other; and it's often impossible to overcome one without getting to grips with the other.

'Dual diagnosis continues to be one of our biggest obstacles. We all had training on this, but it didn't work. Staff knew about drugs etc and mental health conditions, but they couldn't change the 'system', which causes the blockages. The dual diagnosis protocol was written years ago, but we can't seem to work our way through it'.

Community aftercare

Community aftercare was largely raised by Turning Point staff, noting that service users do not often have strong support networks when they're discharged. Community assets, such as recovery cafes, were a vital aftercare support mechanism that Turning Point staff would signpost to when service users were going through treatment and ending treatment. It was noted that many community-based assets had been closed permanently during the pandemic, which has left a gap in the recovery community.

'There used to be so much in the community that would bridge the gap when clients are discharged. These assets – like recovery cafes – have all disappear and shut down during the pandemic. It takes away the sense of a recovery community after someone has been through recovery'.

Criminal justice link workers

Probation, housing, and rough sleeper interviewees noted that no new appointment to the Criminal Justice Key Worker role within Turning Point had been made since the predecessor's departure in September 2021. This has led to poor continuity of care for those leaving prison and has created a breakdown of communication between probation services and Turning Point. However, it has been noted that Turning Point have addressed this issue while writing this report.

'The named Criminal Justice Link Worker left their position in September which left a huge gap for us. We used to have clear communication with Turning Point, and it showed us how valuable the Link Worker was. Without it, we don't have a good continuity of care and it's the service user that is impacted the most'.

Improving the substance use offer in Suffolk

Q: How do you think Suffolk and/or Turning Point could improve the drug and alcohol offer?

Focus on harm reduction and prevention in the community

At present, Turning Point have three main Hubs in Suffolk making service provision largely confined to Ipswich, Bury St Edmunds, and Lowestoft. Delivering at a 'place' level, whether co-locating and partnering with INTs and PCNs, in areas of rurality and/or areas where there are higher prevalence of alcohol and substance use was a priority for stakeholders and service users alike.

Taking a preventative, harm reduction ethos instead of abstinence was important for a lot of stakeholders. Many commented that addiction was a lifelong journey and therefore harm prevention and enabling substance users to live as close to healthy as possible should be paramount.

'Look at the big picture; the country as a whole faces death due to overdose. Prevention of death and promotion of health need to be centre stage, regardless of where the service user is on their recovery journey. Service users should be shown safer routes to drug taking. Quite a large proportion of drug users would access service quicker if harm reduction was promoted as a primary aim of the service'.

Education and training of workforces

Upskilling the wider recovery workforce on substance use was seen as an opportunity by many stakeholders. Specifically, upskilling workforces on dual diagnosis, Adverse Childhood Experiences, recovery signposting, and discussing substance use in broader health terms were clear themes. For example, several GPs mentioned that having a greater understanding of substance use issues would allow them to introduce prevention or harm reduction into their health-related conversations with patients.

There was also a lack of understanding regarding Turning Point's role within the system. Therefore, all system partners that signpost to Turning Point or work with Turning Point should be updated on exactly what Turning Point do and *do not* offer.

'We need training for pharmacies regarding drug users. This can make or break a needle exchange intervention. Good training at a needle exchange will lead to positive relationships between drug users and pharmacies, they're a crucial part of the system'.

'We need to train the professionals in the system to be able to signpost people to drug and alcohol services when they're talking to patients etc about health, not just when talking directly about drug and alcohol use'.

Whole system approach to recovery

A whole system approach to recovery was directly associated to the theme 'partnership working' seen in the "challenges" section above. Stakeholders realise that COVID-19 has intrenched inequalities, increased the number of people needing recovery services, and brought with it increasingly complex

cases. Many stakeholders said that their respective organisations had become insular during the pandemic due to COVID-19 restrictions. This in turn hampered communication and much of the whole system approach to recovery that had been built up previously.

'The best outcomes come from collaboration and making sure each organisation is saying the same thing'.

'Drug and alcohol addiction are areas that are far too big and far too all encompassing for one or two organisations to tackle. It's a systemic issue with society that is often grounded in childhood trauma and ongoing mental health issues. It needs the whole system to work together to tackle it from the roots'

Improved interagency working for children and young people who have parents or carers misusing substances

Improved interagency working and raising awareness of substance use in families was critical for those working with children and young people. Suffolk's Local Safeguarding Children Boards (LSCB) and the Suffolk Safeguarding Partnership continue to positively impact children and young people who have parents or carers with problematic substances. However, stakeholders have said that the lessons learned from these cases should be used more explicitly to improve interagency working and training across the Suffolk system.

'We always discuss the drug or alcohol user. The child in the scenario is often not spoken about or forgotten. There are loads of lessons that can come from our Safeguarding Partnerships that will help wider services and schools identify a pupil that might be in need. We can use this information to train staff to look beyond the drug user and help to family, the child'.

Hidden needs

It was suggested across a number of views from various stakeholders' participants that there is a need for a more in-depth exploration of the views of people including those from various ethnic background, women (with various needs including those with children and sex workers), children and young people and older people.

Older people

Older people have been identified as a group the Suffolk system is missing with the number accessing drug and alcohol services/support relatively low.   Alcohol consumption in those over 50 has continue to increase and this has been exacerbated by the COVID 19 pandemic. Suffolk has an older population than England as a whole; these older people are distributed throughout the County and also between urban and rural locations. Research evidence suggests alcohol harm in older people is underestimated and some people who might consider themselves healthy are in fact putting themselves at risk through excessive alcohol consumption. Yet there is no clear national or local public health message about alcohol for older people.

An Health Needs Assessment focused on people aged 50 and over was undertaken in 2016 by Suffolk Public Health and Communities. The report highlighted increasing alcohol use in this age group and set out recommendations in the following areas:

- Effective Mechanism to drive implementation of alcohol strategy;
- Communication and dissemination of a clear simple message about alcohol in older people;
- Increasing the delivery of Identification and brief advice services;
- Improve and expand on effective joint working between treatment services and other organisations across the Suffolk system; and
- Raising awareness about services available for people who are concerned about their alcohol use.

Service users

Suffolk Public Health and Communities aimed to interview service users across the recovery system, including the treatment service, but due to time constraints and service capacity only service users from Turning Point and the Recovery Forum were interviewed

Suffolk Public Health and Communities conducted semi structured individual interviews and focus groups with substance use service users from various organisations within Suffolk. Four individual interviews and 3 focus groups were held in Turning Point across the 3 treatment hubs (see fig 1 above for detailed information of service users). Service users and peer mentors were interviewed. Most of the participants (n=12) were alcohol user while the others (n=2) used a mixture of alcohol and drugs. The other 3 service users were recruited across the systems with 1 from probation hostel in Ipswich and the other 2 through the recovery forum Network. Service Users were offered a £10 all for one voucher as 'a thank you' for their participation.

The interviews and focus group covered 4 areas of interest:

1. **Situational awareness:** understanding service users' awareness of commissioned services and other treatment and support services in the system
2. **Perceptions of current services:** understanding perceptions and experiences of Turning Point, law enforcement and wider substance use services in Suffolk
3. **Engagement and Harm reduction:** understanding current service provision and practices that encourage access to service
4. **Hidden needs:** exploring populations that are not served by current substance use services, including opportunities for engaging hidden populations

Interviews were conducted individually and in group settings, both virtually and in person. Everyone interviewed were either in treatment, recovery or abstinent from substance use. Where appropriate each question has been distilled into themes.

Below are characteristic of the service users who participated in this engagement work.

Table 37: Service user characteristics

Organisation	Data collection method		Gender		Age	Ethnicity
	Interviews	Focus group	Male	female		
Turning Point						
Ipswich	1	1 (n=2)	-	3	Working age	White British
Lowestoft	3	1 (n=4)	4	3	Working age and retired	White British
Bury	-	1(n=4)	4	-		
Probation Hostel	1		1		Working age	White British
Recovery Forum	2		1	1	Working age	White British and Asian British

Situational awareness

Q: What services are you aware of?

This question was to understand service users' awareness of available treatment and support services. Most of the service users were aware of Turning Point and have accessed one or more of their services. Others felt there was little or no awareness or knowledge of Turning Point in the community. Most service users are aware of AA, Mutual aids. For some service users they preferred the anonymity of AA or mutual aid, while other felt they benefitted more from the structured treatment approach of Turning Point. Many service users interviewed within the alcohol intervention group either self-referred to their GP or were referred by their GP to seek treatment and support from Turning Point. They insisted they were unaware of Turning Point before their GP referral and recommended Turning Point be more present in the community.

"Went to GP – referred through GP. Long waiting times. I had to ask for help first before being referred – no one picked me up in the system before".

Treatment services should be more proactive in their approach

Most service users felt there is a lack of awareness of treatment services in community. And where people are aware of the service there is a lack of acceptance of the services provided. They advised an awareness drive to remove the misconceptions around treatment service and that treatment service be proactive in making their presence known within the Suffolk community.

Improved communication

Improved communication within and across services and systems was highly recommended. Most services users felt there is a gap in awareness across most support services and organisation as they have a misunderstanding of the services on offer and limitations of each service. This was attributed to lack of communication across the board as well as how disjointed these services are.

Perceptions and experience of current services

Q: Perception of drug and alcohol services in Suffolk

Positive approach to treatment

Overall service users' experiences of treatment services were quite positive. This was attributed to their approach to treatment. They have seen some improvement not just around their substance use but their life in general.

"Was just sitting at home. Now socialising – now peer mentoring, then into pre-hab"

Hybrid and flexibility around treatment offer

Service users were very appreciative of the hybrid nature of Turning Point services during the pandemic as they could access individual and group sessions either online or in person. Having this support was valuable in their recovery. In addition, having the option and opportunity to access services online was more suited for people dealing with anxiety and social issues.

Long waiting times

Turning Point have been dealing with capacity issues within their workforce and experience difficulties recruiting as mentioned in the stakeholders' chapter thereby impacting on their service provision leading to high caseloads and long waiting times. Most services users expressed their frustrations especially around waiting times between referral and assessment. They experienced heightened anxiety level but expressed some type of relief that they are finally in the process of getting help.

"Waiting made me anxious, but glad that something was going to happen".

Societal and individual stereotype around substance use

There is associated stigma and shame with substance use and this extends to how society and most health professionals treat those who misuse substances. These perceptions and past personal or anecdotal experiences acts as a barrier to help seeking or accessing available support. Sometimes most service users project their own personal shame or embarrassment of substances misuse to perceived actions of others.

"It had a huge impact on my family. They held an intervention with me and said if you don't go to TP we'll disown you. Then I had to get over the stigma and embarrassment of being an alcoholic".

Perceived focus on drug use

There was a general sense or perception among service users that existing substance use services are geared or more focused on drugs than alcohol, although statistics has shown a continuous rise in alcohol use compared to drug use. They postulated that current alcohol support/intervention are very limited with short timescale. There was little or no aftercare support or a structured recovery pathway. They suggested that equal focus should be accorded to alcohol and other misused substances.

Police and substance use

Q: Perception of how police deal with drug and alcohol consumption

Constraint between compassion and criminalisation/enforcing law

Service users discussed the broad range of opinions held by police officers in relation to substance use. Some were seen to be compassionate, however many encounters with the police were seen as punitive and "hard-line". Many service users noted that this was to be expected due to the nature of policing taking a punitive stance rather than a preventative approach.

'Difficult one. Again, they are constrained by the laws that are in place. I have met so many police officers that feel differently about drug users. Some of them have a more compassionate view, some have a hard-line view – i.e., they are criminals, they need to be punished'

'We need to move towards a public health approach and away from this crime and punishment angle' that 'would allow us to treat people with dignity and respect and help them to thrive'

Negative perceptions/attitude and past experiences with Law enforcement agency

There is a high level of distrust for the Police and perceptions are mainly negative. This is often attributed to lack of understanding of the laws in place where officers have to enforce and uphold rather than focus on reasons for breaking the law. There is a belief that laws in place are not conducive to the addict's reality as they are punitive and not preventative. This has led to a culture of fear and mistrust amongst substance users.

"Most people are fearful and angry at the police, and don't trust them. But I think that's a misunderstanding of the police. What I've seen through recovery, the police have to work within the laws, uphold them, and there's good reason for that. It's turned into a cat and mouse game – there's more that have had bad experience than good"

Most service users are of the opinion that law enforcement have negative perception of substance users and it reflects in the way they treat, or address issues related to substance use.

"Every time I've overdosed / fitted in front of them they've thrown me in a cell. It happened so often they left me in a cell".

Effective and positive approach of enforcement

There were also some positives around the approach of the police to drugs and alcohol, and there were examples of the effectiveness of this approach. The police have a good relationship with treatment services and associated organisations such as housing and often signpost substance users to the appropriate support and treatment service.

"I was put on a DRR and it got me clean for 18 months. It was really effective – I either went to prison or got treatment. I was very young and scared, so I obviously took the treatment".

Experience of interactions with treatment service, police, and related organisation.

Service users felt various emotions following interactions with various public services. Frustration, stigmatisation, stereotyping, apprehension was some of the experiences identified by them. These emotions are deep-rooted and stemmed from perceptions, experiences and attitude during encounters and interactions with members or staffs of public services. Approaches and attitudes of services play a long way to how receptive service users will be of their services.

"Individuals makes the difference. I had some people that were really supported and lovely. I felt understood, I felt heard. That helped me be engaged and authentic – I could tell them the real issues. I had some that weren't like that and then the addict mentality came in – I'd lie, I'd try to hide, I'd try to get out of it"

There were also differences in expectations from the service users. Most substance users are chaotic and do not deal well with structure. And most public services have structured services which might not work well for everyone. One of the service users stated:

" Addicts are chaotic. When people try to impose structure to chaos, it doesn't work. It causes a lot of conflict. I've missed an appointment, so they've stopped my meds. So people think 'what's the point' and stop treatment."

Health services (Hospitals and mental health services)

Experience with health services varied amongst the service user, while some have had good experience other experiences have been quite negative. A lot of the contention was around mental health service and how disjointed they were to other services especially around dual diagnosis. There was no community mental health support or signposting to treatment support following discharge from hospital.

"Once I left hospital, they didn't support me with mental health and there was no link up with mental health from the Cottage or Turning Point. On loads of depression and anxiety medication".

Some service users expressed their dilemma around deciding to lie about their substance use in order to access mental health support. Many of them felt they have been bounced around the system for too long and expressed genuine frustration at not been able to access mental health support.

"Do I need to lie and tell Suffolk Wellbeing Service that I don't drink to access mental health services? As I reduce my drink intake, my mental health gets worse. It's a lose lose situation".

Some service users experience some form of stereotyping and stigmatisation from health professional during their hospital admission for substance use. They stated they felt the hospital staff were judgemental once they become aware of the service users' reason for hospitalisation. They suggested providing an intensive training on issues and implication of substance use and the important role they play in the recovery of those struggling with substance use.

"They weren't very nice – nurses made me feel it was all my fault 'people have got real problems, you shouldn't be here".

What works well

Q: How has treatment service worked well for you and if any what more can be done in their recovery journey?

Access to treatment and aftercare support

Service users had varied opinion of what have worked well for them based on their experiences with services. Some of the recovery and aftercare offer were one of the positives from their treatment experience. Of note was the Suffolk Recovery's Got Talent which provides an opportunity for them to express and share their talents and boost their confidence.

To enhance the recovery process, service users advocated for more work to be done around recovery and aftercare. They emphasized the need to create important foundations for recovery by building community and healthy connections including opportunities to attend workshops within the community to enhance integration and reduce stigma around substance use.

Stability and consistency

Stability and consistency were also highlighted as a major factor in their recovery journey. For example, having a dedicated support or key worker creates a sense of trust and reduced the chance for relapse.

"A stable key worker – I had one for 2 years and built a real relationship with him. Prior to that, I had a key worker every 2 months and relapsed several times".

The consistent changes the treatment services have gone through and uncertainty around funding as a result of the commissioning cycle and the COVID 19 pandemic have been reflective in the quality of treatment in the past years. Some interventions have had to be cut due constraint around funding with priorities given to treatment element and lapse in the recovery and aftercare aspect of treatment services.

Sense of community

Most of the service users reported having positive experiences from their support groups as they felt less shame knowing their challenges were not isolated to them. Being around other people with similar experiences and supporting each other in their treatment and recovery journey have given them a sense of community and assurance they can overcome their various addictions.

"It is good to be around other people that know what we're going through – used to hide my addiction. Real sense of community".

For those not assessing treatment

Negative past experiences and perception of the treatment service is a major barrier to accessing treatment and support services by those with substance use problem. Some people are anxious, depressed, apprehensive about been treated negatively and this hinders them from seeking help.

"Anxiety has stopped a lot of my friends from getting help. It's hard for some people to get dressed"

Engagement and Harm reduction

Q: How would you promote access to drug and alcohol services among people who are drug and alcohol dependant?

Most people are unaware of the implication of substance use, available treatment and support offers. Service users intimated promoting available service more widely within community and across the county through increased awareness and broadening understanding around substance use using various approaches including creating or attending local events. These events give them a glimpse of the reality of substance use and that recovery and integration back to the society is possible. Also, most service users felt use of words of mouth by health professionals especially doctors and mental health workers and advertising treatment and support offer available locally through a Turning Point Suffolk dedicated leaflet or website could increase awareness and access[vi]. Also, they suggested promoting existing services through social media and within other services using posters.

"Word of mouth, signs. Any advertising possible. Mental health workers, doctors, etc. They expect us to ask ourselves. That's not good enough".

Adopting a compassionate and trauma informed approach to care and service provision.

Service users felt embedding this model in the treatment and recovery process and interrelation between all services will provide better outcomes.

"Trauma informed care – really looking forward with a more compassionate care. What is the root cause of the addiction? Not why are you using these drugs? What is the cause of the pain? I imagine this will take a while to embed into the services, but it's a much more humanistic, holistic approach."

Treatment services could partner with community groups or services (like Sam's Café in Lowestoft where free meals are provided) as part of social integration and networking, recovery approach and ways of introducing treatment service offer to members of the community.

Service users advocated that treatment models and messages be geared towards harm reduction not abstinence, as abstinence will not be achieved for every service user in their recovery journey. Needle exchange and Naloxone was seen as a good example of an effective harm reduction intervention as they are readily available and accessible. They however recommended increasing the number of places to access both to maximise harm reduction amongst drug users.

"Not always easy to get. More places should have them".

[vi] Please note that Turning Point have a dedicated website landing page for Suffolk; https://www.turning-point.co.uk/services/suffolk-recovery-network

Recommendations

The recommendations from this report encompass a wide range of services and populations. Therefore, recommendations have been distilled into five categories:

1. Reducing harm from substance use;
2. Meeting the needs of underserved populations;
3. Working together to address complex needs;
4. Developing services; and
5. Supporting children and young people.

Please note that the recommendations included in this report may reflect some of the ongoing substance use work across Suffolk, such as the Drug Strategy Funding awarded in 2022.

Reducing harm from substance use

Recommendation 1: A creation of a multiagency, targeted prevention strategy

Many stakeholders work with individuals that have low levels of problematic substance use and do not meet the threshold for level 2 or 3 specialist substance use treatment.

Suffolk Public Health and Communities should look to create a prevention strategy that reduces harm associated with substance use that targets groups with additional vulnerabilities (i.e., unemployed, those with mental health issues, poor housing or homeless).

Recommendation 2: Continued emphasis on a holistic approach to treatment

There was consensus that the system should maintain the aim of abstinence but acknowledge that many clients require multiple courses of treatment to achieve recovery and may never achieve abstinence. Therefore, there is a need to adopt a model of long-term, active care management for problematic substance use that is holistic.

A long-term, holistic model of care would require both strengthened recovery services and an increase in harm reduction approaches. Existing schemes such as supervised consumption and needle exchange schemes would require further development and expansion. New commissioning approaches are required to engage more community pharmacists and GPs to undertake holistic care. Greater GP involvement would assist in the management also of any physical/mental health co-morbidities.

Recommendation 3: Continue to develop dedicated recovery support and communities that support long term recovery

Develop and expand recovery services, including 12 Steps and Smart Recovery, which strengthen support from the community and address the complex socio-economic issues with the aim of securing a sustained recovery. This could include expanding the length of time that a person receives recovery support to reflect client need with the objective of reducing the high number of re-presentations within six months.

Many stakeholders and service users mentioned that community-based assets for aftercare had diminished during the pandemic and there was a need for these to be reinstated.

Recommendation 4: Undertake review of drug related deaths in East Suffolk

Highest number and rate for deaths from drug misuse are in East Suffolk. In previous years, the highest incidence was in Waveney which has now been incorporated into the East Suffolk area.

Understanding the profile and contributing factors of these deaths will inform harm reduction interventions and facilitate ongoing partnership collaboration in addressing the issue.

Recommendation 5: Review admission profile of people admitted to Ipswich Hospital for alcohol-related conditions to inform harm reduction approaches

Those aged 40 to 64 in Ipswich, both male and female, were the only age banding across all of Suffolk's LTLAs to show a significantly higher rate of admission for alcohol-related conditions compared to England.

Suffolk Public Health and Communities and system partners should make a concerted effort to tackle problematic drinking in Ipswich residents aged 40 to 64.

Recommendation 6: Improved vaccination uptake and screening for Hepatitis B and Hepatitis C

Suffolk's continued low uptake and incomplete vaccination for Hepatitis B and low testing for Hepatitis C requires continued commitment.

Although NHSE have commissioned an external partner to boost testing, there needs to be more joined up and co-ordinated action across the Suffolk system to increase vaccination and testing rates for Hep B and Hep C.

Recommendation 7: Review impact of current system to support people using substances to maintain housing tenancy

Stakeholders acknowledge importance of coordinated action across agencies to support this cohort.

Acknowledging the need to support housing providers to effectively help clients sustain their tenancies in the light of relapse, difficult circumstances etc.

Meeting the needs of underserved populations

Recommendation 8: Increase numbers in treatment for problematic alcohol use

Data indicates unmet need for those with problematic alcohol use.

Maximise opportunities across primary and secondary care and community-based services to engage with people requiring support for dependency on alcohol, supporting entry into specialist treatment.

Recommendation 9: Increasing access and treatment uptake by delivering specialist treatment for substance use at place

At present, the specialist drug and alcohol treatment service have three main Hubs in Suffolk making service provision largely confined to Ipswich, Bury St Edmunds, and Lowestoft[vii]. Delivering at a 'place' level, whether co-locating and partnering with INTs and PCNs, in areas of rurality and/or areas where there are higher prevalence of alcohol and substance use was a priority for stakeholders and service users alike.

[vii] Please note that Turning Point also have satellites in the Newmarket, Sudbury, Haverhill and Mildenhall, and Leiston

Recommendation 10: Review current access to services methods to identify and implement ways to increase accessibility and uptake of specialist drug and alcohol treatment services by women

Stakeholders acknowledge that women using substances, have different needs and vulnerabilities and may have barriers to accessing services for example impact of exploitation, child-care responsibilities.

Recommendation 11: Embed consideration of substance use issues into services that support older people

Many stakeholders raised concerns about problematic substance use in the older population. Suffolk Public Health and Communities should raise awareness /education about substance use amongst older people with statutory and voluntary sector older people's services.

Working together to address complex needs

Recommendation 12: Review, develop and implement a clear pathway / service offer between substance use services and mental health services

Currently individuals experiencing substance use and mental health issues are too complex for commissioned service that address mild to moderate mental health needs. A statutory service that these individuals can access to address their mental health needs should be explored. The service pathway and options for addressing this gap also need consideration.

There is an on-going need to build collaboration and overcome the organisational challenges between services.

Recommendation 13: Specialist treatment services for homeless individuals, including assertive outreach

Many stakeholders commented that the structured format for recovery does not work effectively for the most chaotic individuals and communities, such as rough sleepers.

The option of an integrated pathway for rough sleepers that is separated from conventional pathways should be explored.

Developing services

Recommendations 14: Review options for funding interventions beyond commissioned specialist drug and alcohol treatment providers, optimising opportunities to align resources across the wider Suffolk system

There was a consensus across all stakeholders that there is a need for brief and extended interventions beyond traditional commissioned services, in areas where they are most effective and have the greatest cost benefits. For example, interventions at a population level through PCNs or GP Practices and preventative programmes through specialist nurses in acute hospitals when service users present with substance use issues.

Recommendations 15: Increasing community detoxification, exploring supportive role of primary care and community and third sector organisations

Community detoxification can have good outcomes when delivered alongside a structured psychosocial intervention. It is also cost effective.

Recommendation 16: Increase accessibility of specialist drug and alcohol services

Both service users and stakeholders representing service users' voices noted that the current treatment services do not work well for people who are employed. The 9 - 5 nature of the commissioned services limit access for those who are employed. It's understood that telephone consultations are offered to those in employment, but some service users said that this did not work for them.

Service provision specifically aimed at those in employment, such as evening sessions, should be explored.

Recommendation 17: Continued development of hospital liaison services for alcohol detoxification

Alcohol Specialist Nurses continue to provide great support and treatment, and there is a clear cost benefit provided by the liaison service. Learning from Alcohol Care Teams demonstrates the benefits of acute hospitals proactively focusing on alcohol to identify problematic use and developing pathways of care into the community.

Recommendation 18: Continued development of hospital liaison services for wider substance use

At present, Suffolk hospitals do not have any formalised system for supporting those who are using substances (non-alcohol) who present at the hospital. Some preliminary discussions indicates that there is a cohort of people who present on numerous occasions (i.e., 'frequent flyers'). More investigation is required to identify who these are and the most appropriate intervention.

Suffolk Public Health and Communities, commissioned outreach services, and secondary care should build on current pathways between outreach drug and alcohol services and A&E teams to ensure that substance use patients are not overlooked. Additionally, thought should be given to establishing / re-establishing multiagency meetings concerning frequent flyers using multiple services – many of these were in place prior to the pandemic and have subsequently changed or have been suspended indefinitely.

Recommendation 19: Develop a Suffolk drug and alcohol workforce development plan

Stakeholders acknowledged ongoing issues regarding recruitment and retention of staff. Issues regarding continuity of staff, staff turnover, and staff training was also expressed by many stakeholders and service users.

Stakeholders acknowledged the key role of non-drug and alcohol services and the need therefore, to increase skills and knowledge amongst the wider workforces.

Recommendation 20: Co-ordinated multi-agency interventions for those people who use substances and are in the criminal justice/community safety arenas

Stakeholders acknowledged the key role specialist drug and alcohol treatment services have in criminal justice settings, including within the courts.

Supporting children and young people

Recommendation 21: Increased support and embedding of drugs and alcohol universal offer to all educational settings, children's homes, youth services and CYPS teams

Although Suffolk compares well in terms of substance use in children and young people there are still substantial numbers who use substances.

Stakeholders acknowledged the negative impact of funding constraints on prevention and engagement approaches aimed at children and young people and those that work with this cohort. This is reflected in lower numbers of children and young people in drug and alcohol treatment services than in previous years.

Recommendation 22: Targeted and co-ordinated population-level outreach in high-risk areas and/or with high-risk groups, building on pockets of good practice

Many of the children and young people in the treatment services have different vulnerabilities. Looked after children, those with mental ill-health or who are self-harming are examples of common vulnerabilities. There is evidence for targeted, early interventions for these groups.

Recommendation 23: Co-ordinated, multi-agency specialist support to children and young people with complex need, building on pockets of good practice. Include wrap around support by including VCS youth support organisations

Stakeholders report increasing complexity of need amongst children and young people, exacerbated by the impact of Covid-19.

Recommendation 24: Embed coproduction and principles of resilience and managing risk into services that work with children and young people

Stakeholders recognise the impact of wider determinants such as deprivation and exploitation as risk factors for children and young people.

Recommendation 25: Improved interagency working for children and young people who have parents or carers misusing substances

Children living with parents who have problematic substance use are at high risk of poorer health and wellbeing outcomes.

Suffolk's Local Safeguarding Children Board (LSCB) and the Suffolk Safeguarding Partnership continue to positively impact children and young people who have parents or carers with problematic substances. However, stakeholders have said that the lessons learned from these cases should be used more explicitly to improve interagency working across the Suffolk system.

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