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**April**

**2025**

**Turning the Tide – steering a new course towards hope and recovery**

**A report from the Western Bay Drugs Commission**

**PART TWO – SUPPORTING APPENDICES**

**Presented to the Western Bay Area Planning Board**

|  |  |
| --- | --- |
| **CURRENT COMMISSION MEMBERS** | |
| **Dr Sara Hayes** (Co-Chair, Former Public Health Consultant)  **Julian Williams** (Co-Chair, Former Chief Constable, Gwent Police)  **Dr Mel Bagshaw** (Clinical Lead GP Shared Care Cardiff & Vale CAU)  **Dr Kerry Bailey** (Consultant in Public Health Medicine, Primary Care Division, PHW; and GP providing primary care for people experiencing homelessness)  **Dr Sam Clutton** (Family Member and Carer Representative)  **Dr Lindsay Cordery-Bruce** (Chief Executive, Wales Council for Voluntary Action; and former Chief Executive, The Wallich)  **Katie Dalton** (Director, Cymorth Cymru)  **Dr Aled Davies** (General Practitioner with a specialist interest in addiction)  **Dr Amira Guirguis** (Professor [Pharmacy] and MPharm Programme Director, Swansea University Medical School) | **Rachel Henderson** (Participation and Engagement Officer, Western Bay APB)  **Prof Katy Holloway** (Professor of Criminology, University of South Wales)  **Stuart Johnson** (Chief Inspector, South Wales Police)  **Cllr Alun Llewelyn** (Deputy Leader, NPT Council [Plaid Cymru] and Cabinet Member for Housing and Community Safety)  **Dr Julia Lewis** (Consultant Addiction Psychiatrist, Visiting Professor, University of South Wales, Clinical Lead, Aneurin Bevan Specialist Drug and Alcohol Service)  **Prof Rob Poole** (Professor of Social Psychiatry, Bangor University)  **Cllr Alyson Anthony** (Cabinet Member for Wellbeing [Labour & Cooperative Party], Swansea Council)  **Joanne Stephens** (Senior Operational Support Manager; Deputy Head of Swansea and Neath Port Talbot Probation Delivery Unit) |
| **PREVIOUS MEMBERS OF THE COMMISSION** | |
| The following individuals were members of the Commission at the time of the launch of the Commission, but all had to step down from the Commission during 2023 due to the demands of other commitments: **Ifor Glyn** (Director, Swansea Carers Centre), **Professor Rick Lines** (Head of Substance Misuse and Vulnerable Populations, Public Health Wales), **Ellis Owen** (Service User Involvement Officer, Project ADDER, Western Bay APB), and **Caitlyn Williams** (Intern, Project ADDER, Office for the South Wales Police and Crime Commissioner). | |
| **COMMISSION FACILITATORS AND LEAD CONTACTS FOR REPORT** | |
| **Andy Perkins**,Director (Figure 8 Consultancy) – c/o The Signpost Centre, Lothian Crescent, Dundee, DD4 0HU. 🖂 [andyperkins@f8c.co.uk](mailto:andyperkins@f8c.co.uk) 🖳 [www.f8c.co.uk](http://www.f8c.co.uk)  **Prof Wulf Livingston**, Professor in Alcohol Studies (Wrexham University) – c/o Mold Road, Wrexham, LL11 2AW. 🖂 [wulf.livingston@wrexham.ac.uk](mailto:wulf.livingston@wrexham.ac.uk) 🖳 [www.wrexham.ac.uk](http://www.wrexham.ac.uk/) | |
| **FIGURE 8 RESEARCH AND SUPPORT TEAM MEMBERS** | |
| **Josh Dumbrell** (Researcher)  **Sophie McCluskey** (Researcher)  **Sam Steele** (Researcher) | **Beth Cairns** (Senior Researcher) – left Figure 8 in September 2023 |

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## Reports

This **Part 2** report of the Western Bay Drugs Commission provides background and contextual supporting documents to the main findings of the Commission that are presented in the **Part 1** report. The documents are presented in a series of **nine** Appendices. This document provides additional information and evidence to support the findings and recommendations in the **Part 1** main report.

## Disclaimer

This report reflects the views of the members of the Western Bay Drugs Commission. These views are based on the evidence, data, and opinions collected from invited participants and experts, as well as from **more than** **250** people who responded to the Commission’s calls for evidence. The Commission members express their own conclusions and do not speak for any organisation. This report does not cover everything discussed over the past 18 months but summarises the key contributions.

This report is presented based on the evidence at the time it was collected. The Commission recognises that a lot of work has been completed by local services and commissioners during the last 18 months, which may not be fully captured here.

This report does not intend to blame individuals but rather seeks to identify where systems and services are failing, so we can find realistic and workable solutions. All identifying information has been removed to protect people’s privacy. Everyone who contributed evidence to the Commission gave permission for their responses to be anonymised.

For details of the Commission members, see **Appendix I**. For a list of those who attended and contributed to the discussions, see **Appendix II**.

## Acknowledgments

The Commission would like to sincerely thank all the individuals and organisations who gave generously of their time in providing evidence that we found to be both detailed and honest. Many shared difficult and painful experiences, which took great courage.

We also thank the many speakers who took the time to prepare and present at the public meetings of the Commission. Their input provided valuable information and insight, which was essential for this report.

A special thanks goes to Cerys Thomas and Matthew Rafferty at the Western Bay Area Planning Board (APB) for promptly and thoroughly responding to numerous requests for data and clarifications.

Finally, we acknowledge the support from the Transformation Programme Board (formerly the Senior Reference Group Western Bay APB), who consistently supported the Commission’s facilitators.

# Appendix I: COMMISSIONER MEMBERS – BIOGRAPHIES

**This appendix provides short biographies/profiles of all the professional members of the Dundee Drugs Commission. These professional members were also joined by three members with lived experience and/or family experience of a person who experiences problems with drugs.**

**Dr Sara Hayes (Co-Chair)**

Dr Sara Hayes is a retired Public Health Consultant with experience in general practice, strategic development and governance in the areas of child health, mental health, communicable disease control and vaccination. She spent five years as Senior Medical Officer (Health Protection) in Welsh Government until 2012 when she took up the post of Executive Director of Public Health in Abertawe Bro Morgannwg University Health Board. She chaired the Western Bay Area Planning Board and the Welsh Government Together For Health Liver Disease Group for several years until her retirement in 2017. She returned to Welsh Government to support the response to the COVID 19 pandemic until June 2021 and in 2022 she assisted Prof David Heymann in the review of Welsh health protection system.

**Julian Williams QPM (Co-Chair)**

Photograph of Julian Williamd QPM

Julian joined South Wales police in 1989 and throughout his 25 years with the force worked within uniform and detective roles, eventually becoming Divisional Commander of Western Division, with responsibility for Swansea and Neath/Port Talbot. As an Assistant Chief Constable with South Wales Police, he led the specialist operations portfolio and in June 2014 transferred to Gwent Police as an Assistant Chief Constable. He later became the Deputy Chief Constable and in 2017 became the Chief Constable of Gwent Police. Julian retired from the Police service in 2019. During his career, Julian led a number of high-profile events in Wales such as the Great Britain Olympic football matches in 2012. He was the strategic lead for the Joint Firearms Unit in the South Wales region from 2015 to 2017. Julian chaired the Gwent Local Resilience Forum (LRF) from 2017 until 2019 and was chair of the LRF chairs group in Wales. He was the Human trafficking/Modern slavery policing lead for Wales from 2014 to 2019 and National Police Chiefs Council lead on ethics and sexual harassment between 2017 and 2019. He was also a member of the Welsh Modern Slavery Leadership group and co-chair of the Welsh Academic group. Following retirement from policing he became a Professor of Practice at the University of Wales Trinity Saint David and is part of a team developing and enhancing  the role of the University’s Blue Light Academy. Julian was awarded the Queens Police Medal in the 2020 New Year’s Honours list.

**Dr Mel Bagshaw**

Mel has worked in addiction services in Cardiff & Vale for over 30 years. She set up the GP Shared Care service in Cardiff in 2001. This continues to provide care to more patients than any other prescriber within drug treatment services in Cardiff & Vale. She also set up the first injectable buprenorphine GP shared care service in the UK in 2021. She has worked as a GP for over 30 years and recently retired as a GP partner.

**Dr Kerry Bailey**

Kerry trained as a GP in Swansea and now works clinically in a service providing primary care for people experiencing homelessness. She provides holistic treatment and support for people using substances as part of this. She is also a Fellow of the Faculty of Public Health and works for Public Health Wales as a Consultant in Public Health Medicine in the Primary Care Division leading nationally on reducing Health Inequalities and Inclusion Health. Previously she was the national lead on reducing harm from substances in the Health Improvement division. She was the Chair of the Supporting People National Advisory Board for Welsh Government and currently sits on several Welsh Government strategic groups. In her 30 year career as a Doctor she has worked locally, nationally and internationally, clinically and strategically, in a range of settings including in public, private, third, academic and governmental sectors and in seven countries.

**Dr Sam Clutton (Family member)**

Sam is a proud mother to two sons and Mamgu to two grandsons. Sam’s eldest son is in recovery and now has a career and a happy young family.

Sam completed her PhD on youth homelessness in 2001 and worked as an academic at Swansea University. She then worked in policy and research at Barnardo’s Cymru and the Children’s Commissioner for Wales office.  Sam works on Tackling Poverty in the Welsh Government, after five years working on Children’s Safeguarding in the Welsh Government. Sam is committed to promoting children’s rights and evidence-based policy and practice for disadvantaged people.

Sam did not find any of her extensive policy or practice knowledge very useful in her role as a carer for her son during his drug dependency. However, the mutual support of a carers group at Swansea Drugs Project was invaluable. Through the friendships made in that group, Sam has seen the devastating impact the sudden death of a loved one has on families.

**Dr Lindsay Cordery-Bruce**

Lindsay is originally from Middlesbrough in the North East of England, but came to Wales in 2011. Following a lengthy career, with particular expertise in the substance misuse field, Lindsay has spent the last six years as Chief Executive of The Wallich tackling homelessness.

Lindsay started her career as a volunteer after experiencing homelessness. She spent some time at the Probation Service delivering group work programmes in prisons and community settings before setting up the first alcohol arrest referral service in the UK. Lindsay has also worked in a Community Safety Partnership, commissioning and monitoring services. Her career has led her to this point: an experienced Chief Executive with a professional doctorate in Applied Psychology. For her thesis Lindsay developed a program for addressing addiction through beekeeping.

Lindsay served on the board of WCVA for eight years and stepped down in November 2023. She continues to serve on the board of Tai Pawb, promoting equality in housing settings and is also on the Board of Cynnal Cymru/Sustain Wales, promoting sustainable development in Wales. Lindsay volunteers with Hedgehog Helpline, operating the phone line and rehabilitating hedgehogs.

Lindsay is happily married to Lisa, with two step children, three dogs, four chickens and about 200,000 bees. In her spare time she lifts weights, enjoys boxing and is a DIY enthusiast.

**Katie Dalton**

Katie Dalton is Director of Cymorth Cymru, the representative body for homelessness, housing and support services in Wales. Katie provides strategic leadership and a strong national voice on behalf of her members and the people they support, campaigning for policy, practice and legislation to end homelessness and enable people to live independently and thrive in their communities. Katie is a member of several Welsh Government groups on housing, VAWDASV, mental health, substance use and is a member of the Ending Homelessness National Advisory Board. She has recently led successful campaigns to increase funding for housing support services, and helped shape the response to the pandemic in Wales, contributing to key guidance and successfully campaigning for people with experience of homelessness to be prioritised for the vaccine. Prior to this, Katie was Policy and Public Affairs Manager for mental health charity Gofal, where she influenced health, housing and criminal justice policy. Katie was also NUS Wales President, where she successfully campaigned to increase financial support and protect students from higher tuition fees. She was a member of the ‘Yes for Wales’ steering group for the 2011 referendum on primary law making powers and led the ‘Students Say Yes’ campaign. Katie has also been a Board member of Coleg Cymraeg Cenedlaethol, Cymru Yfory, Cadwyn Housing Association and Cardiff City FC Foundation.

**Dr Aled Davies**

Aled is a GP with a particular interest in substance use and addiction. He is the clinical lead for the Rhondda Urgent Primary Care Centre and works for Swansea Bay UHB Community Drug and Alcohol team in Neath Port Talbot. Aled has also worked in the substance use field in the criminal justice setting. Other current roles include clinical research fellow at Cardiff University and GP Lead for the NHS Wales App with Digital Health Care Wales.

**Rachel Henderson**

With over two decades of dedicated service Rachel has always been at the coalface working with vulnerable, disadvantaged, and underrepresented communities throughout the Rhondda Valleys and Western Bay.  Her extensive experience spans various sectors, including work with children, young people and their families, homelessness, VAWDASV, substance use prescribing services, and criminal justice.

Throughout her early years and career within The Department for Work and Pensions Rachel witnessed first-hand the hidden barriers people faced, a lack of understanding of the effects of mental ill health, trauma, drug and alcohol use and multiple deprivation.

This ignited a desire to change her career towards Community Development, where she has since been an advocate for the core values and principles of this field. Her drive to work alongside the most isolated and judged individuals in society has never faltered.

Rachel has never lost her passion or determination to seek out, listen to and support the most isolated, vulnerable, people hidden in our communities, encouraging them to recognise their own skills, abilities, and identity to improve their quality of life.  She also has valuable experience helping communities and agencies to work collaboratively to improve support services including the way that decisions are made.

In 2013 while manager of “The Retreat Project,” Rachel’s collaborative efforts with Swansea University were instrumental in amplifying the voices of the local community of sex workers, leading to recognition in research and government reports (Sex Work Research Wales 2014) and again (Welsh Government Sex Work, Drug and Alcohol Use 2015). Under her leadership, the project was presented with the Cymorth Cymru Capturing Creativity and Innovation Award and a Comic Relief Impact Award.

From 2020 until 2023 Rachel was the coordinator for a new innovative commissioned service, Rapid Access to Prescribing Services (RAPS) which is part of the ADDER portfolio.  This demonstrated how important an outreach and welfare focussed approach was in meeting the needs of and helping people with multiple disadvantages to access and maintain substance use treatment and support services.

Rachels current post as the Participation and Engagement Officer within the Western Bay Area Planning Board Support Team has enabled her to continue this work with the same values, principles, and integrity.  Part of this role focusses on engaging, listening, and empowering people with lived and living experience of substance use to be part of plans relating to the future Commissioned Substance Use Service Model.

Since being in post Rachel has encouraged people throughout Western Bay with lived and living experience of substance use and its services to set up their own service involvement group this is going from strength to strength. This group’s members are actively participating in the Alliance Planning and have contributed to the Western Bay Drugs Commission Findings, ensuring their voices are integral to shaping the future of substance use services.

**Dr Amira Guirguis**

Dr Guirguis is a trained pharmacist independent prescriber with a specialty in Substance Use Disorders. Amira gained her PhD in the in-field detection of Novel Psychoactive Substances (NPS). Amira pioneered the initiative of develop a ‘new’ concept for providing insight among pharmacists, other healthcare professionals and service providers of the completely new area of NPS which cumulated undergraduate and postgraduate pharmacy education modules and was the subject of recent Swansea University Podcast series. Amira was the 2014 winner of the JPAG’s Geoffrey Phillips award and the Principal Investigator of the first Home Office-licensed, Pharmacist-led, drug checking service in the UK. Amira is now the MPharm Programme Director at [Swansea University Medical School](https://www.swansea.ac.uk/medicine/) and Professor (Pharmacy). She is the Chair of the Royal Pharmaceutical Society’s Science and Research Committee and is a known international expert in the field of substance use.

**Professor Katy Holloway**

Katy Holloway is a Professor of Criminology at the University of South Wales, where she has been based since 2002. Previously, Katy worked as a data analyst in the Institute of Criminology at the University of Cambridge after completing her PhD there in 2000.  Katy has been researching issues related to substance use and misuse for nearly 25 years. She has conducted systematic reviews, evaluations and many empirical research studies using both qualitative and quantitative methodologies.  Recently, Katy has collaborated with colleagues from the University of Manchester on an NIHR funded evaluation of the Staying Safe Programme, an online course about drugs, alcohol and related issues designed specifically for university students.  Currently, Katy is working on Welsh Government funded evaluations of Minimum Pricing for Alcohol and Buvidal (a long-acting form of opioid substitute treatment). She is also evaluating the organisational impact of Substance Use Officers for Wales Probation Service and undertaking a qualitative study on heroin-using lifestyles funded by the Knowledge Exchange and Innovation Fund. On 1st October Katy began a Health Care Research Wales funded project in partnership with Public Health Wales examining substance use in prisons and in the period immediately following release. The philosophy of harm reduction underpins Katy’s research, and she is a member of a range of advisory boards and panels across the UK including Welsh Government's National Implementation Board for Drug Poisoning Prevention.

**Stuart Johnson**

Chief Inspector Stuart Johnson is a police officer with 24 years’ experience. For the last 18 months he has been attached to Project ADDER, which is a Home Office funded project with several aims, one of which is to prevent fatal drug poisonings. This project is focused to the Swansea, Neath and Port Talbot Basic Command Unit of South Wales Police. Prior to ADDER, he spent 6 years as the Intelligence manager for the basic command unit and assisted the force in understanding the nature and scale of the associated issues linked to County Lines and other forms of drug trafficking. Chief Inspector Johnson is from Swansea himself and is a fluent Welsh speaker.

**Dr Julia Lewis**

Julia qualified from University College London School of Medicine in 1992 and trained initially as a GP, transferring to psychiatry due to a growing interest in human behaviour. She became a Consultant Addiction Psychiatrist at the Aneurin Bevan University Health Board in 2005 and is the Clinical Lead for Addiction Services there. She is a Visiting Professor at the University of South Wales linked to her research interest in Alcohol Related Brain Damage. She was a member of the working group that updated the UK Drug Misuse and Dependence guidelines as well as the working group that developed the soon to be published UK Alcohol Use Disorders guidelines. She was an author for both Welsh Government's Substance Misuse Treatment Frameworks for Co-occurring Substance Misuse and Mental Health Problems and the framework for Alcohol Related Brain Damage.  She is a member of the executive committee of the addiction's faculty within the Royal College of Psychiatrists and is one of the founders and directors of the UK Alcohol Related Brain Damage Network. She is a member of the Substance Misuse National Partnership Board (Welsh Government) and the National Implementation Board for Drug Poisoning Prevention (Wales). She is a published playwright and frustrated amateur actor.

**Cllr Alun Llewelyn**

Alun was elected as Deputy Leader of Neath Port Talbot County Borough Council in June 2022 and is also Cabinet member for Housing and Community Safety. He is Leader of the Plaid Cymru group, within the Council’s “Rainbow Coalition” and a former Chair of the Regeneration Scrutiny Committee and Social Services and Housing Scrutiny Committee.

Alun is a member of Ystalyfera Community Council and supports many local organisations in his ward in the Swansea Valley, including being a school Governor.

Professionally, Alun had a 30-year career in the housing and supported-housing association field with Gwalia and Tai Trothwy housing associations.

**Professor Rob Poole**

Rob Poole is Professor of Social Psychiatry at Bangor University, where he co-directs the Centre for Mental Health and Society with Professor Peter Huxley. He is Honorary Consultant in Liaison Psychiatry at Wrexham Maelor Hospital.

After training at St George’s, London and in Oxford, he worked as an NHS community psychiatrist in inner-city Liverpool for 16 years and in North Wales for five years. He became a full-time clinical academic in 2009. He has extensive experience of service development.

His clinical and research interests centre on marginalised populations and the social determinants of mental health. He has a long standing interest in substance misuse and its interaction with mental illness. His current research activities concern dysfunctional high-dose opioid use in people with chronic pain, the care of people with persistent psychosis and self-harm in South Asia.

He has written extensively, including scientific papers, book chapters and several books, including Mental Health and Poverty (with Catherine Robinson and Robert Higgo, 2014). He is a former chair of the Royal College of Psychiatrists in Wales, and he established the RCPsych Invited Review Service. He received the Royal College of Psychiatrists’ Lifetime Achievement Award in 2017.

**Cllr Alyson Anthony**

Alyson is a current Councillor representing the Labour and Cooperative Party for the Llansamlet ward. She is the Cabinet Member for Wellbeing with responsibility for poverty reduction, financial inclusion, welfare rights, community cohesion, VAWDASV and Substance Use.

Prior to this Alyson has 35 years’ experience as a nurse and Health Visitor. A career starting with Paediatrics, district nursing, GUM medicine and the Poison’s unit. An MSc in Community Health and a change back to children. Working in areas of high deprivation and need managing Sure Start, Alyson seen the devastating effects of substance use and poverty on families and the need for change led her to the political field.

**Joanne Stephens**

Joanne is the Deputy Head of Swansea and Neath Port Talbot Probation Delivery Unit.

The Drugs Commission was facilitated and supported by Figure 8 Consultancy (Dundee).

**Andy Perkins (Director)**

Andy has over 29 years’ experience in the alcohol and drug, criminal justice and homelessness sectors and is an expert in the evaluation and review of a wide range of policies, services, and systems – at local and national levels. As the founding Director of Figure 8, Andy has project managed more than 170 contracts over the last seventeen years for a range of clients including health, social care, and criminal justice providers. Andy’s relevant recent experience to demonstrate his extensive contribution to leading and managing drug and alcohol evaluation, research, and consultancy contracts at a national and international level, includes:

* Leading a four-year evaluation of the WHO/EU Evidence into Action on Alcohol Project, funded by the European Commission (due for completion October 2026).
* Leading (in collaboration with Prof Jo Neale, Kings College London) a longitudinal qualitative research study evaluating the Individual Placement and Support (IPS) programme across English drug and alcohol services, on behalf of the Office for Health Improvement and Disparities, London (due for completion end of 2025).
* Co-leading an evaluation of £6.1m Scottish Government Drug Deaths Taskforce funding for test of change projects (via the DDTF Innovation Fund) on behalf of Corra/Scottish Government (due for completion end of 2024).
* Principal Investigator on one, and Co-Investigator on two, five-year research studies in relation to the impact of Minimum Pricing for Alcohol implementation in Wales on behalf of the Welsh Government (due for completion November 2024).
* Principal Investigator on an evaluation of additional £10m funding for inpatient detoxification programmes across England (NIHR/OHID funded study) – in collaboration with Professor Jo Neale and colleagues, Kings College London (due for completion November 2024).
* Co-leading a comprehensive review of alcohol services in acute hospitals in Scotland to support the development of an improvement toolkit, on behalf of SHAAP (January 2024).
* Principal Investigator on an ‘Exploring demand for, and perceptions of, residential rehabilitation among people who use drugs across Scotland’ study on behalf of Public Health Scotland (2022-23) [[online](https://publichealthscotland.scot/media/26889/figure-8-final-report-3-may-2024.pdf)].
* Co-Investigator on the five years ‘Evaluation of the impact of Minimum Unit Pricing of Alcohol on Scotland’s Harmful Drinkers’ study (2022), on behalf of Public Health Scotland – in collaboration with Professor John Holmes and colleagues, University of Sheffield. [[online](https://www.publichealthscotland.scot/media/13486/evaluating-the-impact-of-minimum-unit-pricing-in-scotland-on-people-who-are-drinking-at-harmful-levels-report.pdf)] This included the design, delivery, and resulting analysis of a comprehensive quantitative survey for use in the study with 706 ‘harmful’ drinkers and a detailed qualitative survey with 55 service providers across Scotland and the north of England.
* Principle Investigator on an ‘*Understanding substance use (alcohol, drugs and tobacco) and the wider support needs of Scotland’s prison population*’ study (2022) on behalf of the Scottish Government. [[online](https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2022/09/understanding-substance-use-wider-support-needs-scotlands-prison-population/documents/understanding-substance-use-wider-support-needs-scotlands-prison-population/understanding-substance-use-wider-support-needs-scotlands-prison-population/govscot%3Adocument/understanding-substance-use-wider-support-needs-scotlands-prison-population.pdf)]
* Facilitation and support of the four year (2018-2022) Independent Dundee Drug Commission [[online](https://www.dundeecity.gov.uk/dundee-partnership/dundee-drugs-commission?msclkid=64f3e616c04b11ec9417cd749a2e9c84)]
* Consultancy support to the Scottish Government’s Drug Deaths Taskforce (Multiple and Complex Needs workstream), (2020-2021).
* Co-investigator of a Scottish Government Drug Deaths Taskforce funded research study exploring the perceptions and attitudes of senior decision makers across Scotland in regard to the implementation of drug consumption rooms (2020-21) – in collaboration with Professor Tessa Parkes and colleagues, University of Stirling. [[online](https://doi.org/10.3390/ijerph19116575)]
* Provided analytical support to Welsh Government as their Minimum Unit Pricing Bill passed through various stages in the Welsh Assembly (2018).
* Project management of 29 Health Needs Assessment projects across the UK (Scotland, Wales, England, and Northern Ireland) at national, regional, and local levels, mainly covering alcohol, drugs, tobacco, mental health, co-occurring conditions (2008 – present day).
* Co-lead of a review of the Welsh Government’s national alcohol and drug strategy in partnership with Glyndŵr University in Wrexham (2018). [[online](https://gov.wales/sites/default/files/statistics-and-research/2019-06/180419-review-working-together-reduce-harm-en.pdf)]

As a practitioner, Andy spent 10 years managing residential and in-prison alcohol and drug treatment programmes, including registered residential services for men, women and children, and in-prison services for young offenders.

**Professor Wulf Livingston**

Wulf has over 30 years of practice and research experience in the alcohol and other drugs field. Wulf is a registered and practising social worker. His practice experience has been spent in a range community and residential settings. He is currently an external consultant and supervisor to a residential recovery community. His practice role prior to this was an Area Manager for the Probation service.

Through an extensive research history he has developed an expertise in the evaluation of a wide range of policies, services, and systems, notably within the two devolved nations of Scotland and Wales. This work includes a number of national policy evaluations for Governments. Current projects include regard for; inpatient detoxication, drug deaths, minimum pricing for alcohol and recovery. Much of this work has adopted rich mixed methodological approaches and as such Wulf has extensively developed skills in the synthesis and interpretation of qualitative and quantitative data. Wulf has worked as an Associate Consultant for Figure 8 over the last 10 years, as well as co-leading collaborative projects between Figure 8 and his University (Wrexham University). He is the current Chair of the British Association of Social Worker’s Special Interest Group (Alcohol and other Drugs).

**Josh Dumbrell (Researcher)**

Josh splits his time between a role as senior researcher with Figure 8 Consultancy and a part-time PhD student at the University of Stirling, funded by The Salvation Army. Josh’s research expertise lies in the intersection of substance use, mental health, and homelessness, with a particular focus on leveraging lived experience to inform meaningful research outcomes.

In his role at Figure 8, Josh supports the design and implementation of mixed-methods research projects, conducts needs assessments and contributes to strategic evaluations. He is committed to integrating the voices of those with lived experience, ensuring that research is both inclusive and impactful. At the Salvation Army Centre for Addiction Services and Research (SACASR), he has managed and facilitated Patient and Public Involvement (PPI) groups, across a range of projects with individuals with lived experience and affected family members, using his extensive networks within recovery communities within which he is trusted for supporting meaningful engagement.

# APPENDIX II – PUBLIC EVIDENCE SESSIONS

## Introduction

Between March 2023 and March 2024, the Drugs Commission has held **five** public evidence sessions where a range of experts were invited to either present to the Commission or discuss certain topics as part of a panel-based question and answer session with the Commission. Additionally, a further closed evidence session was held with individuals with lived/living experience of problematic drug use and family members/significant others.

All of these sessions were open to staff from local services, individuals with lived/living experience, family members, and anyone else with an interest in attending.

Meetings were held on the following dates and the names/titles of speakers and topics covered were as follows:

| Date | Speaker(s) | Titles |
| --- | --- | --- |
| 8th March 2023 | **Keith Reid** (Executive Director of Public Health, SBUHB)  **Angharad Metcalfe** (All Wales Substance Misuse Strategy Lead, Police and Crime Commissioner and Chair of Western Bay APB Commissioning, Finance and Performance Sub-Group)  **Jamie Harris** (Chair of Western Bay APB Harm Reduction Group)  **Julia Jenkins** (Commissioning and Development Manager, Western Bay APB)  **Matthew Rafferty** (Harm Reduction Lead, Western Bay APB) | **Presentation:** ‘The aspirations and progress of the Western Bay APB Transformation Programme’ |
| 26th April 2023 | **Matthew Rafferty** (Harm Reduction Lead, Western Bay APB)  **Cerys Thomas** (Case Review Coordinator for Drug Related Deaths, Western Bay APB)  **Prof Rick Lines** (Head of Substance Misuse and Vulnerable Populations, Public Health Wales)  **Dr Andrew McAuley** (Consultant Healthcare Scientist (Epidemiology), Public Health Scotland) | **Presentation:** ‘Local data systems’  **Presentation:** ‘National data systems’  **Presentation:** ‘Lessons from international data/evidence’ |
| 27th June 2023 | **Dermot Nolan** (Associate Service Group Director for Mental Health and Learning Disabilities, SBUHB)  **Richard Maggs** (Medical Director, Service Group for Mental Health and Learning Disabilities, SBUHB)  **Liam Cherry** (Counsellor, Platfform) | **Panel-based discussion:** ‘Local dual diagnosis strategy’  **Panel-based discussion:** ‘Mental wellbeing perspectives from the frontline’ |
| 20th September 2023 | **Helen Arnold** (Manager, Dinas Fechan Hostel, Swansea)  **Debbie Mottley** (Area Manager, The Wallich)  **Mark Winston** (Area Manager, The Wallich), and  **Phil Stapley** (Strategic Operational Lead, The Wallich)  **Mark Edwar**ds (Rapid Rehousing Coordinator, NPT Council)  **Emma O’Brien** (Homelessness and Housing Options Manager, NPT Council), and  **Hayley Short** (Po-Commissioning/Housing/ Homelessness Strategy and Supporting People, NPT Council). | **Panel-based discussion:** ‘Experiences of a local housing provider’  **Panel-based discussion:** ‘Strategic considerations regarding intersection between housing and substance use’ |
| 6th December 2023 | **Lived/living experience and family member representatives** | **Panel-based discussion:** ‘The experiences of those with lived/living experience and family members.’ |
| 13th March 2024 | **Claire Jones** (NPT Council)  **Matthew Rafferty** (Western Bay APB)  **CI James Ratti** (South Wales Police)  **Paul Thomas** (Swansea Council)  **Elinor Wellington** (NPT Council)  **Jessica Williams** (South Wales Police)  **Sarah Williams** | **Q&A discussion:**   1. Can you start by explaining the background and purpose of the Community Safety Partnerships across Swansea and NPT? Could you also comment on the current lines of reporting and accountability between the APB and the CSP – and whether this works well in practice (i.e. are any improvements needed?)? 2. What are the current priorities for the CSPs? 3. What are the main challenges that you are presented with in the CSPs when considering drug harms and drug deaths? 4. What successes have you experienced in responding to these challenges – whether direct or indirect? 5. Looking forward, what are the next set of challenges (on the horizon) and what planning needs to be in place for these? |

# APPENDIX III – INITIAL CALL FOR EVIDENCE

**Q1. What are the key issues that the Western Bay Drugs Commission need to be concerned with?**

Based on the survey responses, a number of themes emerged in relation to respondents’ perspectives on the key issues of concern for the Western Bay Drugs Commission. These highlight both positive aspects of existing services and areas that require improvement, such as reducing waiting times, enhancing outreach efforts, improving coordination and communication, and addressing specific gaps in support.

* **Lack of access to services**: Several respondents, both staff and people with lived experience highlighted the difficulties in accessing substance use treatment and other related services. The commission should focus on improving accessibility and removing barriers to entry for individuals seeking support.
* **Dual diagnosis and mental health**: The survey responses highlight the need for better integration and holistic approaches to addressing dual diagnosis (co-occurring substance use and mental health issues). The commission should work towards improving coordination between substance misuse services and mental health services.
* **Housing and homelessness**: Homelessness and lack of housing options are mentioned as significant concerns. The commission should address the lack of housing support, drop-in centres, and community facilities for individuals struggling with substance use.
* **Early intervention and prevention**: The survey responses emphasise the importance of early intervention, prevention, and education programs, especially for vulnerable populations such as young people. The commission should focus on developing universal messaging and outreach programs to raise awareness and prevent substance misuse.
* **Coordination with criminal justice**: The links between substance use and criminal justice are mentioned as an important area of focus. The commission should work on improving coordination and collaboration between substance misuse services and the criminal justice system to address substance-related offenses and provide appropriate support.
* **Complexities of the criminal justice system**: The survey responses indicate the complexities of people involved in the criminal justice system and the need for better coordination across prisons, probation, and approved premises. The commission should address the challenges posed by the spread of these services across different areas and districts.
* **Stigma and public perception**: Stigma surrounding substance use and the negative public perception are identified as key issues. The commission should work on reducing stigma, promoting understanding, and changing public attitudes towards individuals with substance use disorders.
* **Funding and service provision**: Funding allocation, location of services, and the need for co-working between substance use agencies and other support services are mentioned as concerns. The commission should ensure appropriate funding and effective allocation of resources, as well as promote collaboration between different agencies involved in supporting individuals with substance use issues.
* **Harm reduction and safety**: The survey responses highlight the need for safe injection places, needle exchange programs, and harm reduction strategies. The commission should prioritise implementing harm reduction measures to minimise the risks associated with substance use.
* **Staff training and suppor**t: The survey responses mention the importance of staff training, support, and quality care in substance use services. The commission should address concerns regarding the quality of care provided by staff and ensure proper training and support systems are in place.

These key issues should guide the Western Bay Drugs Commission in formulating strategies, policies, and interventions to address the challenges related to substance use in their area.

**Q2. For those affected by drug and/or alcohol use across the Western Bay area (whether individuals, families, or communities), do you think that there are currently:(i) sufficient types of appropriate services and support available;(ii) in the right places; and(iii) at the right time?**

Based on the responses provided, the high-level themes that emerge regarding the sufficiency, placement, and timeliness of services and support for drug and alcohol use in the Western Bay area are as follows:

**(i) Sufficient types of appropriate services and support available**:

* Some respondents mentioned that there are good quality services available in the Western Bay area.
* However, there were also concerns about the limited range of services, lack of options for certain substances other than heroin, and inadequate support for specific groups, such as family members and those in the criminal justice system.
* Recruitment and retention of staff have been identified as a challenge, affecting the capacity and waiting times for treatment.

**(ii) Services in the right places**:

* There were positive examples mentioned where services and staff were located in the right places, such as substance use liaison nurses in general hospitals, drop-in and outreach services in hostels, and young person's workers in schools.
* However, accessing services in rural areas was identified as a challenge due to factors like travel costs, limited public transport, and mobility issues.
* More effective support available for transitions between hospitals, prisons, from homelessness

**(iii) Services at the right time**:

* Waiting lists for accessing OST and alcohol treatment are variable, experienced as too long, with pathways to support dependent on personal circumstances and confusing and frustrating for patients and staff.
* Flexibility in accessing and re-accessing services was highlighted as a need, along with reducing barriers during the transition between services.
* Several respondents mentioned the importance of services being available outside of regular office hours, including evenings and weekends.

Overall, while some positive aspects were mentioned, there are several areas for improvement in terms of the range, accessibility, and timeliness of services and support for drug and alcohol use in the Western Bay area.

# APPENDIX IV – Service user and family member consultations

Invitations were extended through the Commission’s Calls for Evidence and by word of mouth through services and via meetings for individuals with lived experience and family members to speak directly to the Commission. This has been added as an extra layer of informal evidence gathering to the initial planned methods of the Commission.

Over **20** individuals and family members have come forward across the period of the Commission to speak of their experiences of the treatment and support that is across Western Bay and to discuss the changes they would like to see to improve the local situation. These meetings were all conducted in confidence and no names will be reported in this document.

The meetings included a wide range of discussions ranging from very positive experiences to one’s that have been very difficult to listen to. The balance of views are reflected in the key themes that the Commission have heard about through their formal evidence gathering methods.

# APPENDIX V – service visits

Commission members visited a range of alcohol and drug service across Swansea on 16th August 2023, and also across Neath Port Talbot on 25th October 2023. In total, the following six services were visited, with an opportunity for Commission members to meet with staff and service users or family members:

Swansea – 16th August 2023

* Adferiad
* Barod
* CDAT
* Dyfodol

Neath Port Talbot – 25th October 2023

* Adferiad
* CDAT
* Dyfodol

Following each set of visits, Commission members reconvened for debrief sessions on all the visits. Details of these discussions have been analysed as part of the Commission’s key findings, but the details are not presented here to protect anonymity of all those who participated in the visits.

# APPENDIX VI – evidence submissions from services

Towards the end of the Commission’s process a structured survey was designed and distributed to all the alcohol and drug services that currently receive funding from the APB. Detailed responses were received back from the following services:

* Adferiad (NPT)
* Adferiad (Swansea)
* Barod (Swansea)
* CDAT
* Dyfodol Criminal Justice Service
* PSALT
* Rapid Access Prescribing Service (Dyfodol)

The responses were analysed, and the results are presented below.

## Nature of Services

### Services/interventions that services provide

A graph showing the services/interventions that service people.
Detoxification Community 14.3%
Detoxification Inpatient 14.3%
Groupwork 71.4%
Harm Reduction eg needle exchange / advice 100%
Individual counselling 57.1%
Prescribing services - opiate substitute 57.1%
Self help 42.9%
Support for recovery 57.1%
Other 42.9%


100% of services included in the survey offer harm reduction, whereas only one service offers detox (both inpatient and in the community).

### Others:

**Total number of responses: 3**

As well as the above services/interventions, organisations also provide the following:

|  |  |
| --- | --- |
| Services | Projects |
| * ‘Outreach, support for Tier 4 rehab applications.’ * ‘Support with justice issues and mechanisms including liaison with agencies, adherence to specified levels of contact to satisfy court orders and licence conditions, specific reporting routes and mechanisms. Co-work with probation, police and prisons.’ * ‘Gaining Employment and qualifications.’ * Pabrinex clinics. * ‘Rapid Access Prescribing Service that focuses on vulnerable, non-prescribed class A users.’ | * Early intervention and stimulant projects whereby the service will specifically work with those who use stimulants, but ‘may not identify as someone who needs traditional drug services.’ * ‘Helping End Homelessness NPT 360 Project which is partnership with a variety of partners.’ * ‘Peer to Peer projects - for a mix of people who still or are still using substances.’ |

## Commissioning

### Pattern of commissioning

**A graph showing the pattern of commissioning.
Area Planning Board 100%
Local Authority NPT 28.6%
Local Authority Swansea 28.6%
Police and Crime Commissioner 42.9%
Swansea Bay Uniersity Health Board 42.9%
other 28.6%**

The APB fund every service that respondents represent. Most services are jointly funded by the APB and other commissioners, except for one service where the APB is the sole funder.

### Other:

**Total number of responses: 2**

Those who selected ‘other’ gave the following answers:

* ‘HMPPS.’
* ‘National Lottery Funding.’

### Comments or observations about the commissioning process, arrangements, or relationships

**Total number of responses: 5**

|  |  |
| --- | --- |
| Comments or observations | Concerns |
| * One service is collectively funded by OPCC and HMPPS, and they state they ‘have a very strong relationship with our commissioners with clear accountability against outcomes.’ One of their services is a 'whole justice system service', where they also work with third sector partners. * One respondent noted different agencies working together to deliver different services, such as community-based help with ‘community caseworkers’, ‘clinical services’ and the provision of ‘Prison caseworkers’. * The APB and the MOJ offer joint funding to one service contract. * Project Adder funds services such as ‘Early Interventions’ and ‘Recovery Plus’. * ‘We find this reach across the justice settings and mechanisms provides a continuous and consistent level of provision for a service user group, many of whom faced barriers to having their needs met, leading to the difficulties that triggered their offending and substance use.’ * It is suggested that services can make improvements regardless of any systemic changes as ‘the commissioning team [are] responsive to new ideas and developments.’ | * One respondent says the APB ‘feels far removed from operational services to really understand operational needs and pressures.’ * An example is provided of the disconnect between commissioners and the health board as one service were advised to ‘progress things, such as delivering Buvidal and then after 18 months of work, the health board said we couldn't offer it.’ * ‘The area planning board was set up to allow all services within the area to receive funding without going against each other. That (sic) way services that are delivered are holistic across the area. The recent commissioning has now negated this.’ * ‘There has (sic) been times when some great collaborative worked (sic) has occurred and other times where professional working practices have become extremely fractured, this is at the detriment to the people who access services, almost creating a state of structural inequity.’ |

### Financial worth of commissioning

Not all services were able to provide details on their financial worth of commissioning, however some answers were as follows:

| Service | Financial worth of commissioning |
| --- | --- |
| Dyfodol CJ Service | ‘Our Western Bay service is part of a much bigger Dyfodol service so its (sic) difficult to extrapolate (sic) the information. However a working estimate is roughly £350,000pa.’ |
| Dyfodol CJ Service | ‘It is difficult to dis-aggregate the Western Bay element from our main contract. We receive £3.85m per year for the entire contract. RAPS and ADDER are additional.’ |
| CDAT | ‘We do not commission services, funding is via APB and Welsh Government.’ |
| PSALT | ‘I am not authorised to provide commercially sensitive information.’ |
| Adferiad (Swansea) | ‘As with any charitable service providing a service the aim is to reduce costs to public funded services. With funding the aim is to deliver a support package that can support individuals to reduce harm or to remain abstinent from substances. Adferiad cover this whole area through our support which has been generously funded the APB.’  Swansea Financial Profile Tier 2 & 3 adult services:  Budget: £570, 553.90 |
| Adferiad (NPT) | Neath Port Talbot Alcohol & Drug Housing Support Service quarterly contract sum between 01/04/2023-31/03/2024:   * Q1 - £24,643.50 * Q2 - £24,643.50 * Q3 - £21,905.34 * Q4 - £16,429.02   HSOP - Rough Sleeper scheme annual contract sum between 01/04/2023-31/03/2024:   * £34,632   Mental Health Engagement scheme annual contract sum between 01/04/2023-31/03/2024:   * £34,000 |
| Barod (Swansea) | Tier 2 & 3 - Adult Services (Swansea) £215,971.00 Tier 2 - Children young people service (Swansea)CYP £13,972.00 Tier 2 - Family Service (Swansea) CYP £121,489.00 Total Barod:- £369,646.28 |

### The nature/extent of performance monitoring for services and how this differs between each commissioner/funder. How effective/beneficial the performance monitoring arrangements are

All respondents advised that their services are monitored on a quarterly basis, albeit by varying means:

| Service | Performance monitoring |
| --- | --- |
| Dyfodol CJ Service | ‘Any reporting is done through G4S as we are a subcontracted service of Dyfodol. we meet quarterly for G4S meetings as well as quarterly with OPCC commissioning team>kaleidoscope doesnt (sic) have any specific performance monitoring responsibilities.’ |
| Dyfodol CJ Service | ‘Our data is largely captured and stored on Palbase, a system controlled by the OPCC in our contract. We report to the OPCC on Dyfodol on a quarterly basis on their 'flexigrant' system. That system is a bit rigid and restrictive, so we also provide our own 'impact reports' to provide more colour and to convey more meaning.’ |
| CDAT | ‘We provide quarterly monitoring reports in line with WG KPIs to the APB. The APB monitoring worker meets with the team managers and directorate managers to go through previous actions, information provided in the report and discuss issues raised. Since COVID these meeting are always on MS Teams. Only once has the monitoring worker been out to a service (detox ward). They are fairly effective as in it is the only opportunity the team managers have to meet to go through data and operational issues. Within the HB there are various reporting mechanisms e.g. care metrics, monthly service scorecard, quality & safety assurance, compliments/complaints, medication audits, clinical audits, staff data for training, PADR compliance.’  ‘The Monitoring and Performance Management Officer will report issues of concern arising from monitoring activity to the Commissioning, Finance and Performance (CFP) Sub-Group of the APB, which, in turn, reports issues of concern to the APB.’  Other performance monitoring activities that are not monitored through the Monitoring and Performance Management Officer include:   * BBV Testing, Needle Exchange and Take-Home Naloxone; ‘monitored by the WB APB Team’s Harm Reduction Lead, who reports to the Harm Reduction Sub-Group (HRSG) of the APB.’ * Drug Related Deaths and Non-Fatal Drug Poisoning; ‘monitored by the APB Team’s Case Review Coordinator, who provides information to the Drug Poisoning Task Force and the Independent Case Review Panel, which present recommendations to the HRSG.’ * Service User Involvement; ‘mapped out and supported to be developed by the Service User Involvement Officer.’ |
| PSALT | ‘We submit quarterly monitoring information to the APB. We have an annual quality assurance visit by the health board (this was established in 2023 and we had not been monitored previously since 2014) The contract monitoring process does not hold any value for us as a service. It has not existed for 23/24 as roles within the ABP changed and we were required only email figures. Prior to the change in roles, it was more engaging, and it felt like the ABP listened to concerns raised and responded.’ |
| Adferiad (Swansea) | 'The performance for the service in Swansea requires a quarterly report to higher management that covers not only the numbers required for funding purposes. but also includes the staff opinions on how the service is going and what could be improved. Case studies are also collated and added to the report.’ |
| Barod (Swansea) | ‘From a data retrieval standpoint, WCCIS does not allow us to pull off data with ease. But it does allow us to get data for monitoring purposes. The quarterly monitoring has tended to be online (Teams), which does take away the ability to bring a real-time person-centred approach. However, this doesn't restrict us from discussions. The long-standing challenges have been the obvious split between two services that deliver the tier 2/3 interventions and the differing approaches and the way in which this has been managed over the years as this has been difficult at times. Historically it has felt that when funding came available it was 50/50 split. This has improved slightly over time.’ |
| Adferiad (Newport) | ‘Performance monitoring is conducted by the APB performance monitoring officer at quarterly intervals, and by the local authority HSG at quarterly intervals.’ |

## People we work with

### Brief profiles of individuals that services are working with (i.e. The patterns/trends that services are dealing with and whether these are changing over time

| Theme/key message | Examples |
| --- | --- |
| Varying dependence, poly-substance use and changing patterns of substance use | * One service stated that *all* of their service users usually have an ‘extensive history of opiate dependence.’ One service supports those who are opiate dependent who are considered low intensity. * Nitizine use is becoming more common across South Wales, as well as substances that ‘do not have a prescribing treatment route e.g ketamine, crack cocaine, novel benzos, uncertainty of substances being used with synthetic opioids.’ * Poly-substance use including alcohol is becoming more common, as well as referrals for prescription opioids, which ‘complicates treatment’. ‘Less binge pattern benzo use’ is noted, with those who are dependent upon benzodiazepines managing their addiction with ‘illicit benzos due to having prescriptions stopped.’ * Across the services, it is reported that there is more alcohol dependency and increasing stimulant use presenting. |
| Criminal justice | * Services report that many individuals they support have links to the criminal justice system, with one service reporting that this is typical of ‘most’ of their service users. Some of these individuals may present to services following their release from prison, to continue treatment in the community after starting treatment during their sentence. * ‘Some [service users] will go through Court and receive a community sentence with some treatment (DRR / ATR) as a part of their Order. Some will be referred directly from Probation.’ * **‘**Our services accross (sic) South Wales are facing an unprecedented number of unplanned, early release prisoners from the prison estate which is diverting staff from planned work.’ * ‘Programs often collaborate with probation and prison services to support rehabilitation and reintegration.’ |
| Complex and co-occurring needs | * A general increase in people presenting with complex needs is reported, with many service users having both substance use and mental health treatment needs. * It is recognised that there are unmet needs regarding dual diagnosis, as ‘there are many issues with capacity and thresholds within these services.’ * ‘Chronic conditions such as liver disease, respiratory issues (COPD), and infectious diseases (e.g., hepatitis C, HIV) are common. Poor general health and neglect of medical care.’ |
| People experiencing homelessness/ housing insecurity | * There is an understanding that homeless service users ‘need more bespoke arrangements’, as ‘access to stable housing is a critical component of recovery.’ * It is noted that ‘many clients face unemployment, unstable housing, or homelessness.’ |
| Employment and socioeconomic status | * It is highlighted that there is a small population of service users who are ‘sex working’. * Services see a mixture ‘of unemployed and employed people’, however it is also noted that ‘individuals from lower socioeconomic backgrounds are disproportionately represented among our service users’, with some facing barriers due to their ‘limited educational attainment.’ |
| Demographics | * Respondents report an over-representation of male service users, however one service noted that ‘since lockdown there has been a rise in the number of women accessing the agency.’ * ‘Most are aged 34 to 50.’ * ‘Our services support people of all ages, but there is a notable concentration among younger adults (11-25) and middle-aged individuals (35-54). [Service] do also work with older people as well. Adolescents and elderly individuals also seek help, though they represent smaller proportions.’ |
| Families and support networks | * ‘Strained family relationships and social isolation are common. Some individuals have supportive networks, while others are largely disconnected from family and community.’ * Services see young people that either need support for their own substance use or someone else’s. |

### The number of individuals open to and engaging with services

| Service | How many individuals are ‘open to you service(s)? | And how many of these ‘open’ cases are currently actively engaging with your service(s)? | How many individuals worked with over the last 12 months |
| --- | --- | --- | --- |
| Dyfodol CJ Service (Overall) | 'Roughly 210.’  Respondent followed up with an email stating there are an estimated 750 individuals open to the service in ‘23/’24. | ‘210’ |  |
| Dyfodol CJ Service (RAPS) | ‘Dyfodol: 330. RAPS: 45. Adder: 85.’ | ‘All of those who are open are engaged.’ | ‘Dyfodol 953. RAPS 65. Adder 170.’ |
| CDAT | ‘Swansea 481 NPT 446’  In CDAT NPT, there were 243 Service Provisions open between 1st Jan – 31st March 2023. | ‘Swansea 387 NPT 380’  In CDAT NPT, there were 8 Service Provisions started between 1st Jan – 31st March 2023. | ‘WCCIS will not provide this information.’ |
| PSALT | ‘340’ | ‘336’ | ‘350.’ |
| Adferiad (Swansea) | ‘100’ (adult service)  Complete figures, including adult, CYP and family service:  Financial year - 2023/2024  Swansea:820  Currently open  Swansea:258 | ‘On average about 75% will actively engage.’ It is recognised that these numbers can fluctuate. | Unable to provide figures due to being new into the role. |
| Adferiad (NPT) | ‘314 (NPT Adults)’  Complete figures, including adult, CYP and family service:  Financial year - 2023/2024  NPT:1179  Currently Open:  NPT: 472 | ‘Unable to retrieve this data, an audit would need to be completed.’ | ‘801 (NPT Adults).’ |
| Barod (Swansea) | ‘507 Open Referrals currently, 40 on the waiting list. We have 609 active and unique individuals accessing the Needle and Syringe Programme.’  In the adult service, there were 577 Service Provisions open during ‘23-’24.  In the CYP service, there were 577 Service Provisions open during the period ‘23-’24.  In the family service, there were 115 Service Provisions open during the period ‘23-’24. | ‘We identify those that are being actively worked with as having a service provision (care plan) out of the current 507 + 40 on Barod waiting list, we have currently active 381. However, some cases are engaging and have multiple overlapping unmet needs and are seen only on an assertive outreach basis.’  In the adult service, there were 359 Service Provisions started during ‘23-’24.  In the CYP service, there were 391 Service Provisions started during the period ‘23-’24.  In the family service, there were 55 Service Provisions open during the period ‘23-’24. | ‘In the last year we have 862 Received referrals for specific Barod services this is broken down into the specific fields (Adults service 439), (Families 75), (CYP services 348). This potential doesn't capture the full picture due to teething problems with the First Point of Contact.’ |

### How services involve family members/significant others when working with individuals

All respondents reported that their services involve family members to some degree, with an emphasis on confidentiality:

| Degree of involvement | Examples |
| --- | --- |
| Service user-led family support | * ‘We are led by patients in regards to involving their families as we are a medical service, therefore bound by their confidentiality. We do not offer any direct support to family members.’ * Services may involve family members, and they may be present at appointments (particularly with younger services users, ‘with consent and when appropriate.’ * ‘We work mainly with the individual. While we do a lot of work with family / significant others, it isn't in a format that is captured.’ |
| Specific family support | * ‘Family support is offered through outreach, 1-1 or group work. we have an accredited counsellor on project who offers 1-1 counselling and conducts group sessions weekly. and an outreach worker who will offer support to anyone who is unable to or would rather support in their own homes.’ * One service involves families and loved ones in ‘developing and reviewing’ treatment plans, through educating loved ones ‘on the nature of dependency, how to provide effective support, and how to establish healthy boundaries.’ ‘Healthy, substance-free activities together’ are also encouraged ‘to strengthen their relationship and support recovery.’ * ‘We offer a separate package of support to family members/significant others comprising of group and 1-2-1 sessions.’ * One service helps to ‘prepare significant others to handle crisis situations and provide them with resources and contacts for immediate help.’ |

### How numbers of service users are changing over time, including the nature of presentations (including details of complexity, presenting substance use, etc.)

Multiple respondents advised that the numbers of people presenting to treatment have been increasing. Additional presentations have been due in part to the following themes:

| Theme/key message | Examples |
| --- | --- |
| New and increasing substance use, and poly-substance use | * ‘Increasing complexity’ and poly-substance use has become extremely common amongst services. * The rising use of crack is ‘causing concerns around overdose and long term lung damage.’ * ‘We are seeing more people who have never used illicit drugs, but have become dependent on OTC or prescribed opioids (..) Most street heroin use is accompanied by crack and benzo use. We have seen an increase in the misuse of gabapentinoids and alcohol among our street drug using patients. We see little use of ketamine, MDMA or hallucinogens.’ * The number of service users is increasing, with more people using ‘stimulants, benzodiazepines and alcohol.’ * ‘There has been a noticeable increase in the use of crack cocaine and benzodiazepines. More service users that were historic opiate users are receiving substitute prescriptions, and many of these have become reliant on crack cocaine and benzodiazepines.’ |
| Increase in alcohol use | * Four out of seven responses cited alcohol use and alcohol dependency as being an increasing issue amongst service users. |
| Complex and co-occurring needs | * Services are seeing more individuals with ‘comorbidity problems’ and ‘complex needs’ as mental health issues are becoming more prominent. * One service states that there is ‘an emphasis on abstinence for the most complex cases.’ |
| Age | * ‘Individuals accessing services are ageing and this brings a great deal of comorbidity problems.’ |
| Accessibility | * ‘The numbers can depend on how easily accessible the service is for people.’ * ‘Accessibility to primary care’ presents an issue for some service users, creating a hidden population for those in need of treatment. |

Although all respondents noted a rise in either the numbers of people accessing support, or a rise in particular presentations, one service stated:

*‘We are seeing our numbers stay reasonably stable.’*

### Appropriateness and effectiveness of available support for people with diagnosed or undiagnosed mental health problems presenting to services, including protocols for referring individuals to specialist mental health services and the thresholds/criteria they must meet in order get a referral

| Theme/key message | Examples |
| --- | --- |
| Referrals to mental health services and how effective this is | * Although referrals are made by one service to the ‘NHS SM team’, it is recognised that NHS services are under great pressure and therefore may not respond in a timely manner. ‘Our Service users also, as stated earlier, find it difficult to access statutory services due to behaviours that challenge and so it can feel that they aren’t getting the help they need.’ Other services cited the issue of long waiting lists, as by the time they are seen by mental health services, they may no longer need the substance use service. * One respondent noted that they may also refer to CMHT as well as to primary mental health services. Conversely, one respondent advised that they support people in attending ‘outpatient appointments when they are not care managed by CMHT. The medics will sometimes prescribe if needed psychotropic medication.’ * Although one service says getting ‘people accepted for MH support’ is ‘improving’, it is still commonly described as ‘difficult’ due to constraints within mental health services themselves. The improvement is explained as being ‘slow particularly when there are barriers for people using substances, complex - risk they will get lost in the system or who are not able to e.g. respond to letters/opt in questionnaire on line (sic).’ * One service stated they do not have a formal referral pathway to ‘specialist mental health support via SBUHB, for example CMHT.’ Instead, ‘patients are directed back to their own GP or are asked to contact 111, option 2.’ They are also ‘able to refer directly to third sector services for example Mind and Platform who are able to offer talking therapies and other non-medical interventions. Patients who present with complex or declining mental health that is affecting their substance use can be referred to CDAT via JAM meetings. This process is well established and effective. However, there are always a handful of patients that sit in a grey area.’ * There is the option from one service to be ‘sign posted to other services within Adferiad or other organisations dependant on need.’ * ‘Any service users suspected of having, or with a diagnoses of a mental health condition are supported to access their GP for referral to mental health services. We are able to refer directly via the professionals line but this is taken on a case by case basis, and is usually in the event of a mental health crisis.’ * One of the barriers to accessing specialist mental health support is that ‘CMHT [require] a level of stability with their substance use before they will be considered for treatment’, which can make it difficult for individuals accessing substance use services. * ‘There are many issues in referring, we can only use primary care to refer or use section 136, when police attend and deem the person vulnerable and then they will intervene, but this is not reliable.’ |
| In-house specific mental health workers | * A need for an on-site mental health worker was identified by one respondent, however other services are able to offer this support. One respondent advised that ‘1 co-occurring link worker has recently started in post (1 to start in June).’ It is inferred however, that this is not enough, as they explain that ‘this is for the whole MH&SU service in SBUHB.’ * Another service employs ‘two Assistant Psychologists to work with those who struggle with low level or diagnosed mental health difficulties.’ It is explained that ‘these practitioners are given training and clinical supervision by a forensic psychology consultancy service. They focus on light touch assessments, psycho education, distress tolerance and coping with the impact of trauma. They help people understand themselves so that they can manage their own particular challenges in a more positive way. This is effective.’ * One respondent noted that they have ‘a mental health outreach worker, funded by the HSG, working with those who require mental health support that are homeless or vulnerably housed, and have substance use that affects their daily life.’ |
| In-house mental health support provided by substance use staff | * One respondent states that substance use staff can identify those who ‘are mentally frail or need further mental health support’, however they do not assess individuals’ mental capacity in-house, nor do they ‘provide mental health interventions.’ They sometimes ‘have to refuse treatment’ if a person’s needs are so complex in relation to their mental health, as they ‘are not commissioned to work with this complexity and do not have any of the wrap around support to reduce risks.’ * It is noted that some services do not offer formal mental health treatment. Instead, they offer support by ‘actively listen[ing] to patients and provide[ing] flexibility to access the service as much as possible.’ This support also includes ‘promoting long-term recovery and well-being' which, it is suggested, ‘will be enhanced further more (sic) in collaboration with mental health services.’ * One service ‘ran a pilot project providing therapy to support the Mental Health Treatment Requirement over the last three years and have now won the contract to roll out the substantive service. The support we offered enabled around 200 people access the requirement where single figures per annum would previously be able to engage with the previous provision. In the new service we will be emphasising the need for the Courts to make dual Orders featuring ATRs / DRRs and MHTRs so we can provide that holistic treatment. We will also be using this AP resource to bring their approach to our main practitioner grade to spread their knowledge and some universal resources across our whole staff group.’ |
| Family support | * One service stated that they involve loved ones by offering ‘family sessions to address family dynamics and improve support systems’, as well as providing education on how best to support their loved one. |

### Direct work with families/significant others (if any) with their own support needs

Most respondents advise that their service do not formally offer support to families/significant others, and instead, with consent from the service user, will refer loved ones out to relevant services and/or provide informal assistance:

| Theme/key message | Examples |
| --- | --- |
| Signposting | * One respondent advised that loved ones are signposted to a ‘family worker in [service]. MIND, carers centre, referrals to Social services for support for family members.’ |
| Advocacy | * ‘We act as an advocate and support to reduce tension in the family. Submit information to family court and offer advice and support to adult and children's teams to help them better understand addiction and behaviours. Attend child protection, safeguarding, conferences.’ |
| Education | * ‘The main approach is to educate family members about drug and alcohol use and how [service] can support their loved ones.’ |
| In-house support specifically for families/ loved ones | * One service will ‘offer group and 1-2-1 sessions for family members/significant others.’ |

### Individuals, family members and significant others’ involvement in services (e.g. Board Members, volunteers, staff, peer-led provision, etc.)

| Theme/key message | Examples |
| --- | --- |
| Peer-led activities and staff with lived experience | * Employment opportunities for people with lived experience are ‘welcomed’ in most services, with many staff members starting out in a voluntary position or as a peer mentor. One respondent explains that employing workers with lived experience ‘has been done to enrich provision, their experiences feeding directly into our work. But also to provide extended opportunities for people to progress from being in treatment, to being involved with rehabilitation as a practitioner, with work comes dignity and economic viability and greater personal opportunity.’ * One service however, advised that ‘restrictions with vetting and CRB requirements’ act as a barrier to employing lived-experience workers, and therefore they have ‘historically’ not done so. * ‘Family members are seen as Key Stakeholders: this will include individuals with lived experience of substance use.’ * One respondent advises that their service supports ‘peer-led initiatives and projects that can offer unique perspectives and solutions.’ * For one service it is important that ‘individuals (...) have had a period of abstinence in order to be considered [for employment] but can be found amongst our board members, volunteers, staff and peer led services.’ |
| Feedback from service users, family members and loved ones | * Within services, clients may offer feedback, compliments and/or complaints, with responses and suggestions being ‘recorded and reviewed’. They may also provide feedback through the Health Board Patient Experience, which one respondent says has ‘been positive’. * Feedback may also be gathered via ‘advisory committees that include a diverse group of stakeholders (...) Surveys and Questionnaires (...) Focus groups and Workshops (...) [and] Suggestion Boxes..’ * One respondent gives an example of how ongoing feedback affects their service provision, as they develop ‘pilot programs based on stakeholder input and refine them through iterative feedback.’ |
| Collaborative service design | * Services are ‘working towards having a co-produced strategic vision.’ * One provider organises ‘workshops where participants can actively engage in designing and refining service models for ever changing needs.’ They also involve stakeholders in ‘co-design sessions where they can collaborate on creating or improving services.’ |

## Prescribing services

N=4 (57.1%) out of the seven services included in the responses provide a prescribing service, whereas n=3 (42.9%) services do not.

A graph N=4 (57.1%) out of the seven services included in the responses provide a prescribing service, whereas n=3 (42.9%) services do not.

The data throughout the following section, ‘prescribing services’, is retrieved from responses of those who answered ‘yes’ to the above (n=4).

### The current total numbers in services for prescribing drug treatment

| Service | Current total number of individuals receiving prescribing drug treatment | |
| --- | --- | --- |
| Dyfodol CJ Service (Overall) | * ‘Methadone 37 Espranor 17 buvidal 156 total 210 (this is subject to change)’ | |
| Dyfodol (RAPS) | * Q1 ‘23/’24 - 26 * Q2 ‘23/’24 - 29 * Q3 ‘23/’24 - 35 * Q4 ‘23/’24 - 41 | |
| CDAT | **NPT Total number of patients prescribed:** 298 (265 on OST and 33 on other medications)  **OST**  Buvidal: 32  Methadone/Physeptone: 162  Suboxone: 5  Subutex: 14  Buprenorphine: 52 | **Swansea Total number of patients prescribed:** 334 (299 on OST and 35 on other medications)  **OST**  Buvidal: 87  Methadone/Physeptone: 136  Suboxone: 0  Subutex: 6  Buprenorphine: 70 |
| PSALT | * ‘339 - on script as of 14/05/24 110 SBL Buprenorphine, 229 on buprenorphine. We have a further 8 people due to be titrated onto px in the next 2 weeks. Meds unconfirmed as yet.’ | |

### Current capacity of prescribers in the service (e.g. numbers working and number of sessions offered and delivered)

Based on responses, there are 10 prescribers across the area:

| Service | Current total number of individuals receiving prescribing drug treatment |
| --- | --- |
| Dyfodol CJ Service | * ‘1 medical prescriber offering 8-10 hours per week hybrid virtual/in person model this prescriber is at full capacity’ |
| CDAT | * ‘NPT CDAT 1.0 WTE Consultant This includes a total of 2 sessions to cover ward and 3 sessions Outpatient clinic. .6 WTE GP - 2 sessions for outpatient clinics Pharmacist - works .4 WTE as part of the low threshold service based in NPT. He delivers 3 sessions as clinics * Swansea CDAT 1.2 consultant - total of 4 sessions for clinics GP .3 WTE - 2 sessions for outpatient clinics CNS - works 4 sessions in Swansea CDAT - 3 sessions delivered for clinics.’ |
| PSALT | * ‘We currently have 2 prescribers who offer a total of 4 sessions a week. This is a mixture of clinical appointments (usually 10 a week), case management and prescription signing. We also have Monday - Friday 9am to 6pm remote clinical support for immediate matters.’ |

### Current caseloads by types of clinical/nursing/social work staff. Respondents were also asked if there are agreed 'optimal' caseload numbers

| Service | Current caseloads by types of clinical/nursing/social work staff |
| --- | --- |
| Dyfodol CJ Service | * ‘Rough caseloads for RAPS and ADDER nurses are 30 service users per nurse.’ |
| CDAT | * ‘This depends on complexity, staff experience, hours they work. average 28 - across nurses and social workers monitoring workers have up to 100 on their caseload.’ |
| PSALT | * ‘In our service only keyworkers carry caseloads. These range between 70-100 people per working, depending on caseload type and experience.’ |

### Current numbers of staff with prescribing competencies and whether they are sufficient to meet current/future demand, including any workforce plans that are in place to ensure sufficient prescribing capacity

| Service | Current numbers of staff with prescribing competencies | Workforce plans |
| --- | --- | --- |
| Dyfodol CJ Service | * ‘We would like to have an NMP to support our prescriber but find it very difficult to recruit as a non-NHS organisation.’ | * ‘We have a strategy to ensure a grow your own model in any new contracts.’ |
| CDAT | * ‘There are not enough prescribers in the service. We would like to offer a quicker route (hot clinics) for people to start OST but do not have prescribers to do this. Medics will provide cross cover to the other CDAT team and ward for e.g. annual leave We had funding to increase nursing capacity but money was not provided to increase prescribers. Medical staff has been difficult to recruit to (sic). We were unable to recruit a 1.0 WTE specialty doctor and have instead used the money for .6 WTE Consultant. There is reluctance with medics to use money for other prescribers.’ | * ‘ANP or Pharmacist are included in workforce plans for the service to increase prescribing capacity. This would also enable the consultant to see the most complex clients.’ |
| PSALT | * ‘We currently only have 2 prescribers, both of whom are nearing retirement. We currently have a GP who undertaken the RCGP part 1 training, however the RCGP part 2 qualification in the management of substance use (which clinicians who wish practice in their area should undertake) is not currently being delivered in Wales due to a lack of funding.’ | * ‘We have no other option but to send clinicians to England to undertake the qualification if we are to future proof the service.’ |

### Services using a 'treatment contract' for those who are being prescribed, or not

**A graph (75%) prescribing services use a ‘treatment contract’ for those who are being prescribed, and n=1 (25%) service does not.**

n=3 (75%) prescribing services use a ‘treatment contract’ for those who are being prescribed, and n=1 (25%) service does not.

### Clinical processes from first assessment to determine treatment suitability and pathway (e.g. how many urines to be positive, and whether a person need to be in withdrawal objectively before RX, including tolerance testing

| Clinical Processes | Examples |
| --- | --- |
| First assessment | * One service noted a lack of weekly meetings to discuss all referrals, and instead stated how they ‘discuss referrals dynamically’. They explain that this means if an individual is not suitable for their service, it can be ‘fed back as soon as possible to prevent delay.’ * Prison leavers continue with their existing prescriptions ‘once evidence of treatment is verified with the prison’, meaning they do not need a formal assessment. * Within one service, a key worker will carry out the initial assessment. * One respondent provided details of their referral pathway: ‘People who are not in treatment - Once a person is referred to the service they are offered an initial appointment with a senior keyworker. If they are known to the service they will be asked to provide a brief history of their drug use and previous treatment, and an update on their current issues and circumstances. If they are not known to the service, they may be asked to provide more detail about their history, as well as their current circumstances. All patients are then offered a GP appointment within 7 days.’ |
| How many urines to be positive | * Services advised they require ‘2-3’ positive urine tests, however one respondent advised ‘the number of urine tests required are generally tailored to the person ie if they have recently been in treatment we might only carry out one but if there has been a significant time since last treatment we might require 2-3.’ |
| Prescribing and withdrawals | * Services require individuals to be in ‘mild to moderate withdrawal ahead of starting treatment’, ‘by abstaining from opiates for 12 hours prior to they're (sic) first dose of medication’, however it ‘depends on treatment they are on whether objective evidence of withdrawal is required.’ * One respondent advised that individuals are ‘monitored weekly whilst titrating’. |
| Transfers of care | * One respondent illustrated the journey when an individual’s care is transferred: ‘patients who are already prescribed by another [name of service] service are offered an initial appointment with a senior keyworker. If possible their current keyworker will also attend the appointment. Records from current prescriber are shared prior to appointment so just an overview of current circumstances are obtained. The cases are then discussed with [service] prescriber in case management and if no concerns are raised prescriptions are transferred. The patients (sic) is then offered a GP appointment post transfer.’ |

### Clinical processes if an individual is off RX by 4 days, up to a few months, including the length of wait

| Clinical Processes | Examples |
| --- | --- |
| What happens when an individual has been off RX | * ‘For service users who miss 3 consecutive days of dosing at the dispensary or pharmacy we discuss with medical staff and usually restart them on 30mgs methadone for instance without further need for an assessment/medical review however they do receive a medical review quickly after that.’ Conversely, other services advise that a medical review needs to take place in the first instance, to assess whether it is appropriate for the individual to ‘go back on prescription’, as the ‘rate of titration to therapeutic dose’ needs to be agreed upon. If possible, one service will conduct a ‘joint assessment with partner agencies.’ * Once they have discussed the reasons for the missing prescriptions with the service user, and how they can avoid this in future, one service may explain ‘that the only option available is Buvidal if they are unable to attend pharmacies for instance for weekend dosing.’ * Another service will have a similar discussion as above with the service user who has missed 3 consecutive days of their prescription, followed by a urine sample, to which they are ‘then offered a restart at the earliest possible opportunity providing it is safe to do so. This usually happens within 7 days. The person is usually titrated up to their previous dose between 3 and 14 days depending on the previous dose.’ |
| Length of wait | * No services reported a length of wait: ‘we do not have a time to wait to return to treatment.’ |
| Individual needs | * ‘This is dependent on the person, our knowledge of them, their general health, drug use and reason for disruption.’ * One service said the protocol for restarting individuals on medication is dependent upon their presentation and individual needs. |

### How RX is continued for those discharged from Prison, and whether it differs depending upon which Prison the individual is released from, including the pathway for receiving prescribing information for Prison releases

| Route | Pathway | Concerns |  |
| --- | --- | --- | --- |
| * ‘The majority of cases go via Dyfodol. where cases are to be taken over by CDAT links and plans would have been made beforehand.’ * ‘People who are remanded in custody for more than 84 consecutive days are automatically discharged to Dyfodol.’ | * One service is alerted to planned releases via their healthcare teams and G4S, so that medication can be arranged ‘via dispensary or community pharmacy from the day after release once we have confirmation of final dosing whilst in prison.’ This respondent advises that ‘this is the same for all prisons.’ * Conversely, another respondent states that the process ‘will depend on the prison’, however ‘normally people are given their OST dose prior to release and their community px is commenced the following day.’ Treatment services will ‘usually request a minimum of 7 days’ notice to ensure that suitable prescriptions are available in the community pharmacy.’ | * One response states that ‘information from police isn't always shared in a timely fashion’, and therefore there may be delays in transfers of care. * There may arise potential difficulties if individuals are released on a Friday, ‘as it is usually very difficult to organise a last minute prescription.’ | |

### Retoxing

Only one response advised that they may retox if required:

*‘Very rare occasion we will do. it is not routine and it needs clinical rationale to do so.’*

### Situations where services won't take on someone until they have enacted some lifestyle change or given a person a timescale (e.g. won't take back for 6 months or however long)

Only 2 respondents reported that they would advise an individual to move away from their care until they have enacted some lifestyle change:

* ‘Occasions where we ask clients to work with other agencies - no medical rationale/motivated - this tends to be more with alcohol clients rather than OST.’
* ‘Occasionally we may ask patients to undertake a therapeutic time out (for context, this has happened 3 times in the last year). This is usually done as a very last resort when a patient continues to engage in high risk behaviour where a prescription is no longer seen as protective. The purpose is to allow the person to have a break from structured treatment to assess if they are ready to engage in a medically assisted programme. The person is invited to attend regular appointments over the 6 week period and then is offered a review at the end of the period to discuss returning to treatment. This is usually with [service] but may be with another service. If that is he case, a referral and a (...) discussion is usually undertaken during the therapeutic time out.’

### The number of planned and unplanned discharges (and how these are defined by the service) - over the last 12 months, and trends over time

Only 2 respondents were able to provide figures for planned and unplanned discharges over the last 12 months:

| Service | Total number of planned discharges over the last 12 months | Total number of unplanned discharges over the last 12 months | Trends over time |
| --- | --- | --- | --- |
| CDAT | * NPT– 60 * Swansea – 89 * CDAT defines a planned discharge as ‘treatment complete- substance free, referred on to another service.’ | * NPT – 97 * Swansea – 180 * CDAT defines an unplanned discharge as ‘in prison, deceased, declined treatment, DNA/no contact, moved.’ | * Unable to provide information on trends over time, however they do advise that ‘prescribing services in this area have been stable for quite some time.’ |
| PSALT | * ‘7 people have completed treatment problematic drug free - this is when people have maintained and (sic) opioid free status and have weaned off their OST in a planned manner.’ * ‘12 people have completed treatment. This means they have undertaken a successful period of OST prescribing but have now left the service.’ * This respondent states that ‘14 people were referred onto a different prescribing service.’ | * ‘4 people were remanded in custody (for longer than 84 days)’ | * There is a trend of individuals disengaging with the service for a variety of different reasons, including; ‘no longer looking for structured treatment, working full time so no longer want the hassle of a pharmacy collection, relapse, moving area.’ |

### Unplanned discharges in the last year (i.e. quick reduction of RX and then discharged), and for what reason(s)

Only anecdotal responses were provided:

* ‘Patients may not pick up prescription and drop out of treatment rather than an active decision to rapid reduction and discharge.’
* ‘We have only had one patient who was given a reduction that was directed by us. This was due to the fact that he would not attend any appointments following his initial assessment.’

### Individuals who did not attend their first appointment with the drugs service over the last 12 months, and the process for responding to DNAs

Only 1 respondent was able to say how many individuals did not attend their first appointment with the drugs service:

* ‘Over the last 12 months 9 people who were offered an initial appointment to commence treatment did not engage with the service.’ The process of responding to DNAs in this service is that individuals are sent an appointment letter which they are required to respond to within 7 days, to confirm their attendance. If they are unable to do this, they receive a phone call to confirm. ‘If they do not attend they are called again and a further appointment is sent. If they miss 2 initial assessments they are discharged.’
* One respondent explained that usually when people do not attend their appointment, it is because ‘they have been transferred from a different prescribing service.’

### The point at which an individual will go on a treatment waiting list, and how long it takes for them to receive a prescription

* One respondent advised they ‘do not operate a waiting list.’
* Two respondents state that individuals are added to a waiting list after the first point of contact.
* Within one service, 'the actual wait from referral to initial appointment is on average 6 weeks’, however they ‘should be on px within 12 days’, following their first appointment.

### Treatment (both prescribing and/or other support) provided by service for individuals who present with issues pertaining to (a) prescribed opiates, (b) street benzos, (c) crack cocaine, and/or (d) gabapentinoids

| Prescribed opiates | Street benzos | Crack cocaine | Gabapentinoids |
| --- | --- | --- | --- |
| * OST * ‘Psychosocial support.’ | * ‘Occasional reducing scripts, where it is the last option available.’ * Harm reduction. * ‘Psychosocial support.’ * Detox. | * Detox. * Harm reduction. * ‘Psychosocial support.’ | * ‘No standard treatment route, not often problematic drug, sometimes present in poly substance use.’ * Harm reduction. * ‘Psychosocial support.’ |

One respondent detailed the non-medical support that their service offers to all clients:

* A model ‘based on connection, support and review.’ This includes;
  + ‘Developing a rapport and developing a picture of substance use and lifestyle including consideration of offences, vulnerabilities and strengths, creating a lifestyle plan (care plan) with the person. By support, we would focus on bringing about stability by meeting or helping meet immediate needs (helping with housing, health, justice structures, relationships).’
  + ‘Motivational interviewing to create dissonance, elicit change talk, using a range of models to encourage change (positive psychology and perma, 5 ways to wellbeing encompassing loads of potential for developing good habits and making a contribution), using the justice frameworks of RNR, Desistance, Hazel Kemshall's ongoing assessment and management approaches), the Good Lives Model, CHIME, CBT, ACT, Adversity and Trauma based approaches.’
  + ‘Work on resilience, this will be about building a life beyond substances and frameworks of support to replace / displace drug using structures. This will also involve exit planning either with a move on to another agency or exit services with safety nets available.’
  + Regular reviews that can last up to 12 months.

## Partnership working

### How partnership working across Western Bay has been embedded at (a) the system level, (b) service level, and (c) individual practitioner level

*System level*

A graph showing how partnership working across western bay is embeded
Fully 14.3%
Mostly 0%
Often 14.3%
Somewhat 42.9%
A little 28.6%
Not at all 0%

*Service level*

commissioning at service level

Fully 14.3%
Mostly 0%
often 28.6%
somewhat 57.1%
A little 0%
Not at all 0%

*Individual practitioner level*

Commissioning at Individual practitioner level
Fully 14.3%
Mostly 28.6%
Often 42.9%
Somewhat 0%
a little 14.3%
Not at all 0%

| System level | Service level | Individual practitioner level |
| --- | --- | --- |
| * Lack of trust between services. * Not enough input from medical personnel. * ‘The current set of services have been commissioned bit by bit over many years and seemingly without a strategic plan. I do not believe there has been a strong strategic review undertaken until now.’ * It was noted that partnership working has been a vital element in the smooth running of services in order to provide service users with positive experiences, and therefore is being embedded across Western Bay. However, it was also highlighted that this requires hard work. * Conversely, a lack of cohesion between Swansea and Newport was illustrated and it was suggested that there was, in fact, no partnership across Western Bay due to ‘historical commissioning’. * It was suggested that the system is ‘under-developed’. | * It was suggested that services are inflexible due to structural issues * There are positive interpersonal relationships between some services, however it was also suggested that there may be some degree of rivalry between some 3rd sector and prescribing services. * It was noted that harm-reduction services are not acknowledged enough. * The importance of working together was highlighted as way to offer the best services to people in need. | * Positive communication between staff members is reported, however there may be some issues with staff dynamics. It has also been noted that some services experience poor communication within their staff team. * There are also both positive and negative comments about communication between services themselves, with one respondent stating that service relationships are ‘very much person led’, as some individuals have ‘worked closely for a number of years’. * The dedication of staff members is important to recognise, as one respondent advised that it is these who ‘often find a way to forge a pathway for their clients.’ * One respondent doesn’t ‘believe there has been a strong strategic review undertaken until now.’ |

### Observations and reflections regarding the role of the APB in supporting partnership working across Western Bay

Observations and reflections regarding the role of the APB in supporting partnership working are mixed:

| Observations and reflections | Concerns |
| --- | --- |
| * Partnership working, which the APB have championed, is described as ‘successful’. It has ‘highlighted the importance of partnership working’, which has in turn helped to support service users in accessing various services. * There is hope that this review will support partnership working, with the suggestion that ‘an alliance of open access provision can be piloted.’ * It is noted that in commissioning a new service, there can be a fresh start in order to ‘develop and respond to needs’, rather than dealing with issues within current services. * ‘The ABP (sic) have been very supportive of [service] historically. The problem is they are somewhat of a toothless tiger.’ | * There is a worry that the APB’s approach is both ideologically and resource driven. * ‘It can seem like the APB team is "herding cats" in that they are trying to get partners to work collegiately when not all the partners want to do this.’ * It is noted that the APB and commissioning team are not visible enough amongst services, leading to a lack of awareness amongst staff members of who they actually are. * There is a concern that information sharing is not up to standard, and that there is a lack of democracy when it comes to decision making. * There is the suggestion that the APB do not live up to expectation, as they ‘talk a good talk’ but struggle to make any real change within services. This could be due to the relationship between the APB and the health board and ‘internal information governance issues.’ * It is recognised that partnership working historically has not been wholly successful as some services are not willing to work with others. |

### Observations and reflections regarding the nature of partnership working across Western Bay substance use services

The observations and reflections offered regarding partnership working across Western Bay substance use services are mixed:

| Observations and reflections | Concerns |
| --- | --- |
| * Co-operation between services has been described as ‘good’, with staff members feeling enthusiastic about working with other agencies. * It is recognised that partnership working will enable services to deliver better support for individuals accessing treatment. | * A lack of trust has been cited as an issue, causing tension between services. It is suggested that this could be due to ‘potential (un)conscious bias towards models of working.’ * It is noted that there are issues ‘between the operational aspects and the APB service group and APB’, creating barriers for services. |

## Observations and reflections regarding the APB's Transformation Programme

The observations and reflections offered regarding the APB’s Transformation Programme are mixed:

| Observations and reflections | Recommendations |
| --- | --- |
| * Some respondents think the APB’s Transformation Programme is optimistic but are not confident in its implementation. * There is a concern about the programme’s effect on the range of available services. There is also worry about whether limited resources will make it difficult for health-led services to accept service users from drug and alcohol treatment. It is stated that due to restricted resources, ‘acceptance criteria tightens and access becomes unreliable.’ * There is a lack of awareness of what the programme actually is, and what effect staff investments will have. There is limited information on what services need to do to prepare for the programme’s integration, as they have been advised to ‘form their alliances ahead of the tender being released later in the year’, without knowing what it is going to look like. * There is a worry that the Transformation Model may not be able to overcome existing problems, and it may be too ambitious to go from the current way of working to ‘full alliance’. It is proposed that the programme may actually create a disconnect between services due to geographical location and differing ways of working and communicating. * There is concern regarding current joined up working which allows criminal justice services to track the justice journey, allowing for a smooth transition from prison to the community with continuous treatment. It is suggested that ‘alliances would make these services difficult to resource and prioritise.’ * There is scepticism regarding the alliance as one respondent thinks it may damage their service if the health services are not addressed. * Missed opportunities for stakeholder engagement are highlighted. * The programme is described as a ‘golden opportunity to drive significant positive changes if it is well-planned and well executed with a focus on vision, leadership, stakeholder engagement, and the adaptability.’ | * ‘Change has to be meaningful.’ * One respondent suggested ‘setting up an alliance for the open access section of the services’ to create wholesale success. * There are considerations as to how potential findings of the review may affect services, in that it could lead to further investment in particular areas, wholesale redesign, ‘or it could lead to a conclusion that services outside of the clutch of those commissioned (NHS run services) need significant restructuring to support the wider service scene.’ * A need for strong leadership is highlighted, as well as creating a framework for such governance, to ensure ‘accountability, oversight, and proper resource allocation.’ * The importance of clear communication is identified, with the suggestion of implementing a ‘consistent platform for communication.’ * A need for a ‘robust Change Management model’ is identified to support the planning and implementation of the Transformation Programme. It is also suggested that an iterative approach is required so that progress can be tracked, and practices refined. |

## Other comments

### Additional information about services

| Theme/key message | Examples |
| --- | --- |
| Limitations from commissioners | * Service providers unfortunately can feel ‘frustrated by working within organisational structures’ that are under strain. One respondent advised they ‘would like to see commissioning which allows us to be risk aware rather than risk averse.’ This frustration is echoed as one service says they ‘are hammered with artificial barriers from the health board.’ It is noted however, that the APB ‘are much more open to innovation’, however ‘there is always a veto by senior managers in the HB.’ * Complex cases lead to growing caseloads and ‘additional tasks’ which one respondent says requires recognition by commissioners.’ |
| Lack of flexibility within services | * Restricted opening hours create a barrier for certain populations such as sex workers, however they are necessary ‘based on affordability as well as service user demand.' * It is highlighted that services need to be adaptable, in order to respond to ‘trends in crime and the changing priorities of government, changing policies on treatment and rehabilitation in sentencing and pressure from the public.’ * It is stated however, that one area has ‘been poor at continuously adapting approaches to meet the evolving needs of our communities, as it requires flexibility and creativity, this is lacking from services due to concern and worry of opening the flood gates.’ |
| Staff overworked and services underfunded | * There is a common theme that staff within services ‘go above and beyond’ for their clients, providing ‘over and above for the service we are commissioned for.’ * It is stressed that services feel they have little support, are ' underfunded given the caseloads in volume’, and ‘feel that teams are working hard to provide services under strain.’ * One service advised they ‘have not had a financial uplift to our core funding since 2012.’ |
| Inadequate resources, not enough staff and a lack of staff training | * Services state that issues with resources include;   + ‘Inadequate accommodation’   + An ‘inadequate IT system’   + ‘Not (...) enough medic resource’   + ‘No formalised training for staff’   + ‘No psychology input into the service when we know that service users have experience complex trauma.’   + ‘Not enough social workers across the service.’ * One respondent stated that they have ‘recently appointed a physio and OT to the detox ward’, however ‘due to some services not returning to pre covid arrangements issues to access GPs and pharmacy services is difficult for service users. This depends on geography and means key workers pick up the pieces and has also caused service users to relapse as they cannot get their medication.’ |

# Appendix vii – consultations with staff from local services

Throughout the course of the Commission’s work, a range of informal one-to-one interviews and focus groups were conducted by Figure 8 Consultancy with staff from across all funded alcohol and drug services across Western Bay.

* Adferiad (NPT)
* Adferiad (Swansea)
* Barod (Swansea)
* CDAT
* Dyfodol Criminal Justice Service
* Platfform
* PSALT
* Rapid Access Prescribing Service (Dyfodol)

Although it has not been possible to write up all of these up for the purposes of this report, the Commission members were briefed by Figure 8 on the discussions and they consistently helped to shape the findings of the Commission’s work. Those individuals who spoke to the Commission were also guaranteed anonymity in their participation, which is an important reason why detailed findings are not presented here.

# appendix viii – commission sub-groups

Following analysis of its Initial Call for Evidence and other early evidence gathering activities, the Commission considered the main themes that it needed to prioritise in the timeframe allocated. There were six consistent themes that were identified, over and above any others. A decision was made to set-up sub-groups of the Commission, who would be tasked with collating all relevant evidence and take the lead in reporting thematic findings.

The six key themes, and the membership of the sub-groups is detailed below:

|  |  |
| --- | --- |
| Key Theme | Membership of Sub-Group |
| Culture and governance | Katie Dalton (Chair)  Dr Sara Hayes  Prof Julian Williams  Prof Wulf Livingston  Andy Perkins |
| Data | Prof Wulf Livingston  Andy Perkins |
| Housing | Prof Katy Holloway (Chair)  Dr Lindsay Cordery-Bruce  Katie Dalton  Prof Wulf Livingston |
| Mental wellbeing | Prof Rob Poole (Chair)  Andy Perkins |
| Prescribing | Dr Julia Lewis (Chair)  Andy Perkins |
| Primary care/shared care | Dr Kerry Bailey (Chair)  Dr Mel Bagshaw  Dr Aled Davies  Dr Sara Hayes  Prof Wulf Livingston |

# appendix ix – final call for evidence

A final call for evidence was distributed through various networks across Western Bay during May 2024. The call for evidence consisted of one main question focused on understanding why there are consistently high numbers of drug-related deaths and serious harms across the Western Bay area.

In total, there were forty-three (43) respondents to the survey, although some people skipped questions.

A summary of all consistent messages noted, with example quotes, is provided below, under each question heading.

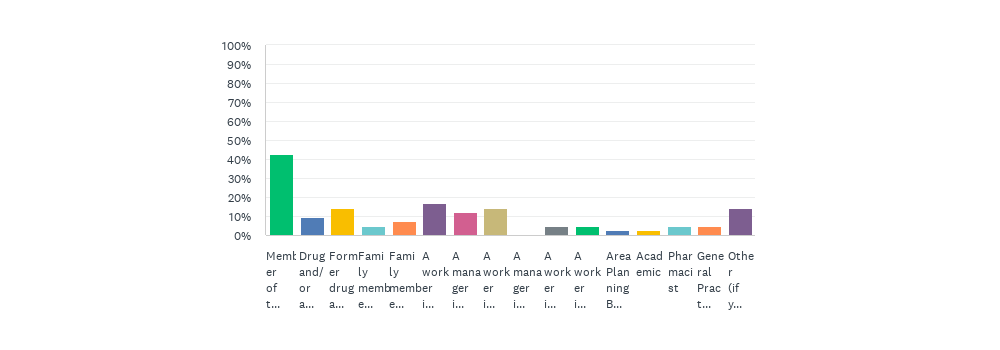
1. **From the basis of your experience, is there anything that you would like to say or share with the Drugs Commission about the high-rates of drug-related deaths and harms that are experienced across the Swansea Bay/Western Bay area? We are particularly interested in what you think the solutions are to the current situation**

**Total number of respondents: 35**

| Theme | No. of respondents | Examples |
| --- | --- | --- |
| Whole systems approach/ joined up working | **13 (37.14%)** | * ‘Joint action with our partners in these areas include the need for us to work in partnership to address risk factors for harmful substance use.’ * ‘More progress is needed on integration of mental health and substance misuse services and psychosocial support across pathways.’ * ‘If people have mental health issues associated with their addiction or are using substances because of a mental health issue then services should work in a joined up way to holistically support. Not pushing people back and forth between services with neither dealing with the presenting issues.’ * ‘I am very concerned about the lack of join up between services.’ * ‘Poor communication between CDAT and CMHT.’ * ‘Some GPS in area are continuing to send to us and prescribe until they are seen by us, diazepam, we are not a prescribing service we are psychosocial and this is creating dangerous situations and further addictions for our clients.’ * ‘It would be beneficial to have a mental health support worker on project to work alongside Our support staff to ensure that the service user is not on a waiting list for mental health services before they are able to access our services.’ * ‘There is a disconnect between services in terms of the police, health service and council with not enough direct contact between all of them and no Co-Located Working to join things up and provide a better wrap around service.’ * ‘A collaborative approach to educate people with new invoative (sic) marketing campaigns and videos.’ * ‘If only the communication between the staff on the ward and the drug & alcohol team was improved then I would hope that my daughter would have received the help she deserved.’ * ‘Delays in prescribing in community, relates to - lack of shared care with GPs.’ * ‘Appropriate leadership at different organisations working towards to same goal and taking advice and involving senior clinicians such as consultants in decision making or planning.’ * ‘As we are aware, substance misuse and poor mental health is greatly intertwined, and so these services need to be joined up and accessible. They are not.’ * ‘Substance misuse services in Western Bay have been commissioned in a very traditional and reactive way and taking a piecemeal approach to allocating resources instead of looking at the whole system will continue to deliver a disjointed service.’ * ‘Lack of GP shared care models of service delivery -High reliance on Community Drug and Alcohol services.’ * ‘We are blessed with a close working relationship with the community drug and alcohol team who actively listen and expedite when we have concerns.’ * ‘Substance misuse and poor mental health is greatly intertwined, and so these services need to be joined up and accessible. They are not.’ |
| Service provision | **10 (28.57%)** | * ‘I believe there should be more focus on psychosocial support, mental health support, and support towards addressing the underlying issues enabling users to move towards recovery.’ * ‘Not enough psychosocial support to address the underlying issues resulting in their substance use.’ * ‘People need the right advice, guidance and support to tackle the root causes of their addiction, trauma informed provision, with supportive and knowledgeable workers.’ * ‘In the arena of substance use it is important that the solutions we develop are long term, systemic, preventative and developed with involvement and collaboration.’ * ‘Services need to be psychologically safe environments and trauma informed.’ * ‘Need more rehabilitation centres and more focus on hard drugs.’ * ‘Rather than (sic) give them pip you should be give them a funded scheme for rehabilitation course which they have to stick to an (sic) rejoin Society.’ * ‘Traditional health care services do not work for those who are seeking help with their addictions. Appointment based, structured appointments with DNA policies, strict eligibility (sic) criteria, long waiting lists and contact by letter do not promote a recovery environment.’ * ‘Provide services to people when they need them, how they need them and without stigma. People need the right advice, guidance and support to tackle the root causes of their addiction, trauma informed provision, with supportive and knowledgeable workers.’ * ‘Ensuring that interventions and services meet the needs of different groups e.g. based on age, gender, race and ethnicity, geography, income.’ * ‘It would be beneficial to have a drop in service in the more hard to access areas within the borough.’ * ‘While the chats with other addicts and recovering/recovered addicts were helpful in the sense that I was not in isolation, they were not enough to get me well. I needed a cage and time to dry out properly.’ * ‘I was literally begging for a hospital detox(…)there was no real support after.’ * ‘Possibly introduce ONE accessible centre that provides advice, needle exchange, safety, treatment referrals, prescribing (sic) pharmacist.’ * ‘We need a whole different approach. Detox beds are in short supply, and so if people do come forward for treatment, its (sic) not there for them. Treatment needs to be timely which it isn't.’ * ‘Female only bases or everything is available in the community in safe places.’ * ‘Make sure services are safeguarding and protecting people and not putting them in awful situations just because its where their office or base is and see people in the community centres, cafes etc.’ * ‘There are still levels of drug related deaths that we should be aiming to eliminate across the region by making changes to service provision. Our concerns across our region is that we are very reactive to a situation at a given time and do not plan or commission as effectively as we should in the medium to longer term to address some of these needs across the region.’ |
| Prescribing/ long waiting lists | **10 (28.57%)** | * ‘Lack of access to prescribing/ long waiting times continues to be noted as the main contributing factor to DRDs however, we feel that it is the whole system that needs to be improved and the prescribing is one (albeit significant) element of this.’ * ‘Prescription rates within deprived areas in Western Bay for opioids / benzodiazepines (GP, CMHT, CDAT).’ * ‘Could this be looked at based on the reality of what happens when a script is stopped or is too low and this creates a lot of wasted time in the system and is counter to what a rapid prescribing approach is aiming for.’ * ‘Issues with prison discharges (I work in healthcare in HMP Swansea) happening suddenly without warning meaning gaps in OST in community. (Relates to HMPPS changes). Delays in prescribing in community, relates to - lack of shared care with GPs, systems difficulties in CDAT (prescribing process).’ * ‘Access to rapid prescribing is a challenge.’ * ‘People are turned off entering services due to long waiting times and then to much supervision around pharmacy pick ups. People are not given enough confidentiality at the pharmacies and when they miss a day or two they are basically punished with the service withdrawing there (sic) prescription and closing the case to quickly due to pressures on there (sic) service.’ * ‘Prescribing regimes by NHS services are still based on risk and this in turn is stopping DR's risking prescribing to chaotic clients due to the risk. The very people who need it. Legislation needs to change where outreach services can use a prescriber that is not going to be held accountable if a death occurs.’ * ‘Timely prescribing for substance problems.’ * ‘Unless you have committed a crime it has always been hard to get a script for heroin use. I have been with many different agencies and have lost my script for many reasons. The solution = It is easy to get into treatment whatever your situation and it takes a few days not months. Also you are never discharged and if you cant (sic) attend for 3 days you aren't closed/loose (sic) your script.’ * ‘Longer dispensing times(…)Open on weekends(…)you can pick up your script every day or there is an emergency cover nurse or Dr to sort this out.’ * ‘The waiting lists for services such as substitute prescribing services are long and complicated, with often people who miss appointments being discharged from the services.’ |
| Prevention and early intervention | **7 (20%)** | * ‘Overall, prevention, early intervention, health and social equity require a much higher profile, priority and integration in our regional work on this agenda, alongside visible action to address the root causes of harmful substance use (alcohol and drugs). Without a greater focus on prevention, we will not reduce drug related deaths in the long term.’ * ‘If we want to prevent future drug related deaths there is a need to enhance primary prevention of ACEs and early intervention and support, as well as ensuring that our local services are psychologically safe environments and trauma informed.’ * ‘In the arena of substance use it is important that the solutions we develop are long term, systemic, preventative and developed with involvement and collaboration. It is also important that a long-term view means finding solutions for our future generations, and the children and young people of today.’ * ‘Help parents to develop safe and stable relationships with their children, develop a safe home environment for children to grow strengthen parenting skills, and (in some instances) help to address specific ACEs (e.g. parental mental illness or substance abuse).’ * ‘Local strategy on drugs needs include a consideration of how the rise in vaping in young people and resulting addictive behaviour may impact future patterns of substance use in our region and the need for co-ordinated action across these two health-harming behaviours(...)There is a need for a stronger focus on prevention and early intervention on alcohol.’ * ‘Greater investment in youth services and positive activities/prevention e.g. youth services /sports/ play/arts/culture/volunteering.  Developing an evidence-based specification and guidelines for drug and alcohol education in schools and training for teachers in this area as part of the APB strategy and collaborative work with our Regional Healthy School Programme   A robust multi agency approach to addressing school absence, supporting children and families to maintain children’s attendance at school and increase educational outcomes.’ * ‘The need to provide input at an early intervention and prevention stage.’ * ‘We tend to focus on one aspect of harm reduction or prevention in relation to rapid access to a prescribing services which undoubtable is a a factor, but not the sole factor. We tend to then not focus on the other factors such as early education, wellbeing management, employment, deprivation, community financial pressure etc.’ * ‘More effort needs to be aimed at targeting the fundamental causes of it, rather than the issue itself.’ * ‘More time needs to be spent building relationships with community members using substances, a more visible prevention model.’ * ‘Without a greater focus on prevention, we will not reduce drug related deaths in the long term.’ |
| Higher crime rates and suggestions for criminal justice relating to drug use | **8 (22.86%)** | * ‘You Never see police anywhere! It’s absolutely ridiculous. What on earth is going on?? We only ever see speed camera vans, something that makes money but never visible to call upon instead on hold to 101.’ * ‘Should there be harsher penalties? should we be criminalising drug use rather than victimising it?’ * ‘Target gangs of youth, stop and search, be aware of local meeting points.’ * ‘Nationally introduce a law for drug dealing that is the same as mass murder with jail time that carries wait (sic).’ * ‘More CCTV in these areas, More police patrols, and actually prosecuting for possession offences regardless of whether there is intent to supply... part of the prosecution should also lead to rehabilitation support provided for where they have been found in possession.’ * ‘Users should not to be made to feel like criminals - it’s for this reason people don't come forward if they have a problem and want help. You don't make smokers criminals for wanting help to quit, you give them the tools they need!! Or you at least ensure that those products are regulated and safe, like everything else in society. Prohibition does not work.’ * ‘Seem to be lots of links on county lines between Swansea and Liverpool for example. Obviously difficult to address. Also ? lots of pop up shops (vape/barbers) ?? front for drug sales ?? more police on the streets would help.’ * ‘County lines and knife crime is just increasing year on year, so whatever we are currently doing is not working.’ * ‘I am particularly concerned about the young people who get blackmailed into running drugs to different destinations.’ |
| Improved data collection and information sharing between services | **6 (17.14%)** | * ‘I believe that in the Western Bay area, there is a particular focus on the prompt reporting of all drug related deaths and harms. Without knowing the accuracy of reporting in other areas, I wonder whether this is something that should be factored in.’ * ‘The data side is extremely pertinent as the initial data published by Public Health Wales regarding DRD was not validated data.  Therefore a robust baseline needs to be set in order to not only be able to accurately measure whether improvements are being made but also to accurately say whether Western Bay is a true outlier for DRDs.’ * ‘Robust and regular information is required in order to make service improvements, ensure value for money and commission for outcomes.’ * ‘Despite the existence of an all-Wales Information Sharing Protocol, some partners are very reluctant to share, and this is hampering our ability to be proactive and provide people with the help and support they require to deal with their substance misuse. Partners need to be held to account to a greater degree and there needs to be a concerted effort to actively share this vital information.’ * ‘It was establish (sic) through one of the public meeting held by the Drug Commission at one of their professional presentations from Public Health Wales about the Drug Related Death figures, that the centralised data could not be verified that they were in fact comparing like for like data across all areas of Wales. This did bring in to question the validity of the figures that were being compared for the West Glamorgan region to other regions of Wales. In could be in fact argued that due to the variance in process and reporting that the West Glamorgan region was not in fact a (sic) outlier as initially described. We need to improve that baseline data information.’ * ‘We need to completely reviewing (sic) our current join commissioning arrangements to commission more effectively as there is no quick solution to the significant factors that result in drug related deaths.’ * ‘If only the communication between the staff on the ward and the drug & alcohol team was improved then I would hope that my daughter would have received the help she deserved.’ * ‘Better information sharing in the community is required, personally I would link this work to the community safety teams across the police and council and involve health with Engagement officers in post to act as a link as its extremely difficult to engage health on a large number of areas of work currently in terms of their face to face engagement outside strategic forums or steering groups.’ |
| Drug related deaths | **6 (17.14%)** | * ‘I have first-hand experience of dealing with drug deaths in the community, the majority of these linked to heroin or bad Valium.’ * ‘I am hearing that poly drug use is a component in the high levels of drug related deaths and non-fatal overdoses and there are examples of some of which may be struggling to maintain the very strict clinical criteria and are trying to self-medicate on top.’ * ‘Lack of the following: Affordable and secure housing. Decently paid secure employment. Future prospects. Plausible mental health services. Timely prescribing for substance problems. Honest government. Affordable food and energy. Tackle that lot and I believe there would be a massive upturn in healthy living. Less desperation. More hope. Less escapism into drugs. Less drug related deaths. A massive task.’ * ‘From my experience the only way to improve drug related deaths is to improve the quality of them, this can only be done through a regulated market.’ * ‘I believe most deaths are caused by overdose due to varying purity of illegal drugs.’ * ‘If we want to prevent future drug related deaths there is a need to invest in primary prevention of ACEs and early intervention and support, as well as ensuring that our local services are psychologically safe environments and trauma informed.’ |
| Greater availability of drugs in Swansea | **5 (14.29%)** | * ‘I have always been shocked at the level of drugs available on the street and in local communities in Swansea and surrounding areas.’ * ‘For some members of our communities, using drugs is actually normalised within their own homes as they grow up, and hence they will naturally be more predisposed to using drugs. I also notice that the use of drugs is becoming more and more normalised and acceptable within our communities.’ * ‘Young people are getting easy access to drugs and are just meeting socially every evening to do drugs. It is normal behaviour and the amount of cannabis, which leads onto stronger drugs, being used by young people is scary.’ * ‘"Key dealers" from who young people always can buy drugs!’ * ‘There are so many different strong illicit substances easily available now that we are looking at a very different landscape to that of 10 years ago.’ |
| Harm reduction | **5 (14.29%)** | * ‘We need a treatment and harm reduction system that is agile to respond to future developments and emerging “threats” e.g. synthetic opioids.’ * ‘All drugs should be treated as a matter of health.’ * ‘Safe injecting rooms such as the one in Glasgow.’ * ‘In Copenhagen people can attend clinics where they can use heroin etc with staff trained to help if they become unwell. While this could be seen as condoning the use of illegal drugs it would reduce the suffering caused by the huge illegal industry currently supplying.’ * ‘Naloxone is widely promoted in the NPT area with various initiatives but when a client is under the influence of non-prescribed medication/crack their awareness diminishes and they become more at risk and may not even think to carry naloxone.’ |
| Housing insecurity/ homelessness | **4 (11.43%)** | * ‘There is quite a significant population in inadequate housing due to the lack of affordability and availability of housing. This has resulted in a high number of people in interim accommodation, many of whom have found themselves living in close proximity to other substance users who influence and encourage each other's substance use.’ * ‘Due to despondency when living in such accommodation, they often feel that the only option they have is to resort to substance use. If and when, more permanent housing is secured, often after long periods of time in interim accommodation, they lack the ability to budget to be able to sustain this accommodation, due to the change to high rent charges, utilities etc, and quite often find themselves losing this accommodation and re-entering interim accommodation. More support in this area would be beneficial.’ * ‘More supported accommodation would be beneficial, providing an environment where they can be offered wrap around support from all angles.’ * ‘Ensuring people have a stable home in an appropriate setting with support would allow the space for people to start to tackle their issues, more custom built supported accommodation in suitable locations would enable this to happen.’ * ‘The impact on the stop start particularly those who have become homeless and in temp accommodation is more challenging when they have little diversionary activities and only have one room to occupy all day which they eat live and sleep in.’ * ‘Lack of the following: Affordable and secure housing.’ |
| Poly substance use | **4 (11.43%)** | * ‘The roll out and success of Buvidal along with other prescription opiate substitutes, has resulted in an increase in use of other substances such as benzodiazepines, crack cocaine and alcohol, as many are resorting to finding a "high" from other substances.’ * ‘Some GPS in area are continuing to send to us and prescribe until they are seen by us, diazepam, we are not a prescribing service we are psychosocial and this is creating dangerous situations and further addictions for our clients.’ * ‘I have noticed that when I speak with clients who are currently using heroin, whenever there is a shortage of supply they will seek out more non prescribed MSJ/Valium or crack to try and manage any withdrawals that they may experience.’ * ‘I have been given examples where people are driven to illicit methadone or other drugs to top up and combat the withdrawal effects still being felts (sic) and consequently this seems to drive poly use. This is in regard to people who are genuinely trying to reduce their use and are not management issues.’ * ‘I am hearing that poly drug use is a component in the high levels of drug related deaths and non-fatal overdoses.’ |
| Economic climate | **4 (11.43%)** | * ‘There is a high level of poverty in the area, relating to the high levels of substance use.’ * ‘Given the cost of living and the lack of appropriate public transport in some areas it is often impossible for service users to be able to access services within the city centre.’ * ‘Lack of the following: Affordable and secure housing. Decently paid secure employment. Future prospects. Plausible mental health services. Timely prescribing for substance problems. Honest government. Affordable food and energy. Tackle that lot and I believe there would be a massive upturn in healthy living. Less desperation. More hope. Less escapism into drugs. Less drug related deaths. A massive task.’ * ‘The current economic climate is also compounding drug use in local communities as is its effect on crime, and so numbers accessing services are only going to increase over the next few years.’ |
| Support in the community | **4 (11.43%)** | * ‘The impact on the stop start particularly those who have become homeless and in temp accommodation is more challenging when they have little diversionary activities and only have one room to occupy all day which they eat live and sleep in.’ * ‘Lacking something to do in the day leading to drug use again ?? need something more structured.’ * ‘Funding community projects, education etc. (sic) gives people opportunities to rebuild their lives.’ * ‘‘They should also provide networks of peer-based recovery support and establish communities of recovery and mutual aid groups.’ |
| Eligibility criteria | **3 (8.57%)** | * ‘Appointment based, structured appointments with DNA policies, strict eligibility (sic) criteria, long waiting lists and contact by letter do not promote a recovery environment.’ * ‘Culture of defensiveness in services - each service is defining their eligibility boundary to reduce service demand rather than proactively working with individuals impacted by drugs.’ * ‘The clinical criteria regarding apply or methadone dosing and the need for drug free blood tests seems too ridged. I hear that people struggle with the withdrawal effects on what they consider too low doses of methadone which are not increased rapidly enough or are stopping if there is not a drug free test.’ |
| Stigma | **2 (5.72%)** | * ‘Our regional work needs to include challenging and eliminating stigma towards people who experience problems with drugs and alcohol in our language, communications and models and culture of service delivery. Stigma can prevent people from accessing help, damage mental health and lead to social isolation and further exclusion of people who use drugs and their families.’ * ‘Reducing stigma and giving people a sense of purpose and belonging.’ |
| Employment and staffing levels | **1 (2.86%)** | * ‘Lack of the following: (...) Decently paid secure employment.’ * ‘We have lost many experienced workers over the years to better paid roles, so this is something that needs to be addressed if we are to retain quality staff and maintain high quality services. Recruitment is difficult due to the same reasons, and so there are never enough workers to safely support the numbers of people that need services. The roles can be demanding and so the right people are needed to fill the roles, and supporting the staff is also very important. We definitely need more investment in staff recruitment and retention.’ * ‘I've literally given up on the idea of getting decent employment at the age of 41. Despite my excellent educational background and work experience, it just seems pointless and financially detrimental.’ |
| Support for families and young people | **1 (2.86%)** | * ‘The strengthening families and relationship component includes strengthening parenting practices, encourage healthy relationships between children and parents and/or other caring adults or peers and improve the financial security of families.’ |

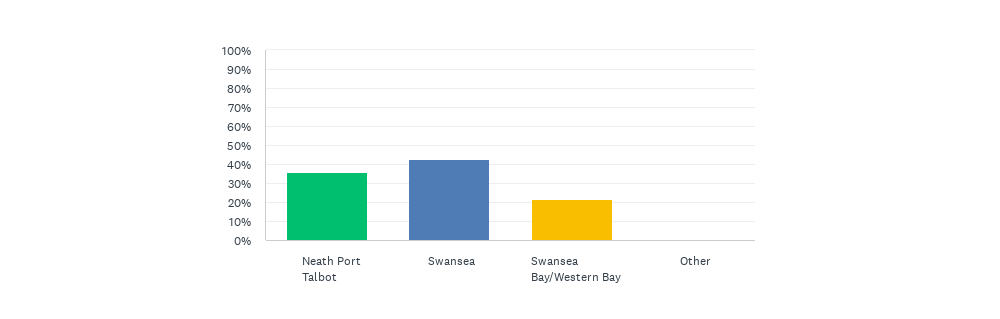
1. **Which of the following would best describe you? (Select all that apply)**

**Total number of respondents: 42**

****The majority of respondents (42.86%, n=18) stated to be members of the public, 16.67% (n=7) were workers in drug and/or alcohol services, and 14.29% (n=6) were either workers in a health and social care service (not drugs or alcohol), former drug and/or alcohol user, or identified themselves as ‘other’. 11.9% (5) of respondents were managers in a health and social care service (not drugs or alcohol), 9.52% (n=4) stated they were current drug and/or alcohol users, and 7.14% (n=3) were a family member (or carer) of a former drug and/or alcohol user. 4.76% of respondents (n=2) said they were either a family member (or carer) of a current drug and/or alcohol user, a worker in education, a worker in criminal and community justice, a pharmacist, or a GP. Only 2.38% of respondents (n=1) said they were from the Area Planning Board or an academic setting. There were no respondents who were managers in a health and social care service (not drugs or alcohol).

1. **What area do you primarily work in?**

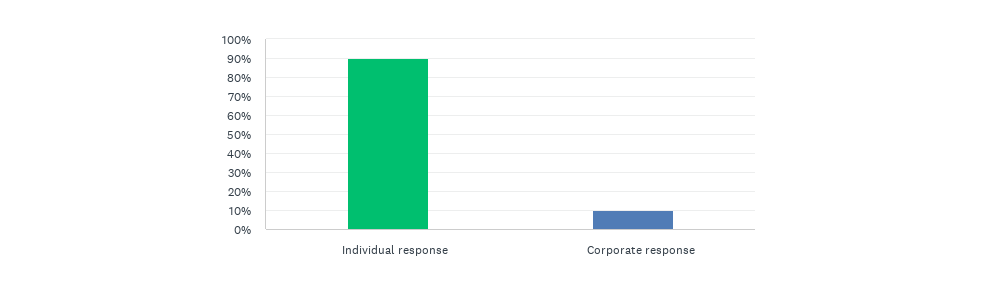
**Total number of respondents: 42**

****

The majority of respondents primarily work in the Swansea area (42.86%), whereas n=15 respondents (35.71%) work in Neath Port Talbot, and n=9 people (21.43%) work in the Swansea Bay/Western Bay area respectively. No respondents work primarily in any other area.

1. **Are you completing the survey to give your own views, or are you submitting a response on behalf of a group, organisation or service (i.e. corporate response)?**

**Total number of respondents: 40**

****

90% of respondents (n=36) completed the survey to give their own views, whereas just 10% (n=4) submitted a response on behalf of a group, organisation or service.