Confidential Document

‘**Turning the Tide – Steering a new course towards hope and recovery.**

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

**April**

**2025**

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

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

**PART ONE – THE REPORT**

**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). | |
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| **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 is the main report of the Western Bay Drugs Commission. There is also a supporting report (**Part 2**) that provides background and contextual supporting documents to the main findings of the Commission that are presented in this 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 various 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 apportion blame but rather seeks to identify where systems and services have shortcomings, 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** in the **Part 2 – Supporting Evidence** report. For a list of those who attended and contributed to the discussions, see **Appendix II** in the **Part 2 – Supporting Evidence** report.

## 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.

# A picture of Julian Williams1. FOREWORD – by the CO-chairS of the commission

**Julian Williams, Co-Chair**

**Sara Hayes, Co-Chair**

We are pleased to present the independent Western Bay Drugs Commission 2025 report on deaths associated with the use of drugs in this locality.

This Commission was established in response to the rates of drug-related deaths reported in the area of Western Bay, which appeared high compared to the rest of Wales and amongst the very highest in England and Wales. Local statutory services, voluntary organisations and community representatives recognised the problem and, in discussion with Welsh Government, looked for ways to reduce the number of people at risk of sadly losing their lives to drugs. Part of their response was to set up our Commission.

Our aim was to explore why Western Bay (Neath Port Talbot and Swansea) has consistently experienced the highest reported rates of drug-related deaths in Wales in recent years.

Our approach, informed by the experience of the independent Dundee Drugs Commission, included:

* Research to identify and investigate the key causes and consequences of drug use and drug deaths for individuals, families, and communities and to consider evidence of what has worked elsewhere to combat problematic substance use and drug deaths.
* Community engagement to seek the views and involvement of all relevant community stakeholders.
* Seeking the perspective of individuals and families with lived and living experience, of drug use and services supporting those who use drugs.
* Taking a partnership approach, assessing the effectiveness of the strategic planning and delivery of services co-ordinated across key partners as relevant, and
* Focussing on practical recommendations for action.

From the outset we have been guided by the principle that all voices have an important contribution to make and to be heard. We were particularly keen to hear the perspectives of individuals with lived experience and their families. We wanted to listen with empathy and work with transparency. In our collaborative journey, which lasted over a period of five years, we aimed to support the development of trust and to develop positive messages that instil hope.

The evidence presented in this report was gathered within a two-year time window from reviews of the literature, including published papers and surveys, interviews with individuals and groups and from workshops. We have also submitted questions to national and international experts in this field. We discussed our findings within the Commission and considered how we can help the local communities turn the tide in the risks and adverse outcomes facing those affected by problematic drug use in any way.

This report is a collaborative effort and contains forthright and challenging content. Much thought has gone into presenting it in a representative way. We have translated this into a set of recommendations which we hope will be practical and helpful. They are grouped around the three themes of:

* People’s lives (outcomes and impact)
* Principles (values and culture)
* Practice and processes (service configuration).

We recognise our recommendations will be stretching. They have been crafted to be practical and give hope to all in the community, including those with lived or living experience, their families and friends, and those who are policy leaders and service providers in the statutory and voluntary services.

We are clear that cultural transformation will be needed alongside any transformation in service configuration and that people need to see that change as it happens.

On behalf of the Commission, we wish to express our gratitude to all who responded in any way in giving evidence and in supporting the work of the Commission. We are greatly indebted to Andy Perkins and Wulf Livingston for their expert knowledge in this field, and their rigour and commitment in serving the Commission.

It has been an honour for us both to serve the Commission and we commend this report to Western Bay Area Planning Board and all its partner bodies.

# 2. EXECUTIVE NARRATIVE – ‘Turning the tide’

## Introduction [Why have a commission]

* The Western Bay Drugs Commission was created as one of five responses to a ‘critical incident’ declared in Western Bay (an area covering Neath Port Talbot and Swansea local authorities). This five-point plan was outlined in a document called the ‘Public Health Model for Substance Misuse’, issued by the Joint Public Services Boards for both areas. The plan is now referred to as the ‘Transformation Programme’. The critical incident was declared in response to serious drug-related harms, with Western Bay consistently recording the highest number of drug-related deaths in Wales and the second highest across both England and Wales.
* The Commission was set up as an independent body, supported by Figure 8, a specialist consultancy company based in Dundee, Scotland, and Professor Wulf Livingston of Wrexham University. Figure 8 is an independent research organisation that previously supported the Dundee Drugs Commission from 2018 to 2022 [[Dundee Drugs Commission | Dundee City Council](https://www.dundeecity.gov.uk/dundee-partnership/dundee-drugs-commission)].
* The Commission consists of 17 members, with two serving as co-Chairs (Dr Sara Hayes and Julian Williams). Members were recruited from various backgrounds, including academia, healthcare, familial, lived experience, policing, political, probation, and social care. They provide expertise in areas related to drug use and its impact on health and social issues, such as housing, mental health, and the criminal justice system. The group brings together local, national, and international knowledge and experience.
* The Commission gathered information through a variety of methods, including data analysis, interviews, public meetings, and site visits. Its work focused primarily on adult use of illegal and illicit drugs. Where possible, and within available resources, the Commission also considered legal drug use (alcohol and prescription medication) and issues affecting children and young people under 18.
* The Commission organised the large amount of information it collected into key messages and recommendations. These cover a range of topics and have varying implications. To ensure the voices of all contributors were respected, the recommendations are deliberately numerous and detailed. This summary document brings together the main points into one clear narrative.

## Messages [What we heard]

* As an independent commission we heard and saw how many people face very difficult life experiences. It also noted how complex drug use, services, and untimely deaths are linked.
* Although there are some mixed messages about the specifics of the drug death data for Western Bay compared to other areas of Wales, what is clear to us is that too many people are dying unnecessarily because of drug use. Many others struggle to access the services they need, where and when they need them.
* Overall, we found a system that is struggling to respond to a changing and complex set of needs. We believe that it is held back by some unhelpful historical legacies and is also too slow to adopt new approaches.
* The solution does not lie in another revised set of plans or performance measures. Instead, it requires a major cultural shift led by strong and visible public leadership.
* There is also a need for a shift to understanding drug use as a logical response to the circumstances people face. The problems and solutions lie in areas such as access to services, education, finances, housing, social inclusion, and addressing trauma.
* Some outdated practices – such as reliance on appointments and office-based services, passing responsibility to other parties, excluding living and lived experience voices, and focusing too much on opioid substitute medication – are limiting the development of more effective services.
* We found many gaps in the system, many of which were surprising. The most striking was the lack of active involvement from people with lived experience, their families, and their communities in local strategies and services.
* Services appear to be designed to suit providers rather than meeting people where they are. This was characterised by our observation that there is simply no ‘open door’ for people to walk into and be met in a large welcoming space. It was also reflected in a severe lack of outreach and out-of-hours support.
* We found minimal evidence of any meaningful involvement from primary care services (such as shared care prescribing, pharmacies, and dental care), which undermines efforts to meet the basic needs of people who use drugs.
* All too often, we heard how mental health has been treated as a separate issue, rather than as an integral part of people’s experiences that requires an inclusive response.
* Many of these issues led to us hearing and feeling fatigue. People struggle to navigate complex care pathways and inclusion criteria. Workers, though committed, are exhausted by talk of change they often feel excluded from. Commissioners and partners also contribute to, as well as experience, frustration with slow processes and delays.
* We did hear an acknowledgment of the need for transformation and a willingness to embrace change. This is welcome, however, much of this felt aspirational, or tentative in its beginnings, rather than firmly active.
* Through all of this though, we have observed that there are some examples of excellent practice, hardworking and passionate individuals, and enthusiasm for change.
* These positive foundations must now be used to build an inclusive future.

## Recommendations [What we think needs to happen next]

* Our recommendations focus on the need to make significant changes, start afresh, and take new approaches. We are calling for genuine transformation, not just commissioning reconfiguration. More than an alliance is required here.
* Many of these changes will require a new level of openness. There is a need to recognise and address the fact that these deaths are happening. It will take a willingness to let go of fixed positions and consider different alternatives. There should also be a desire to share experiences and power amongst everyone involved.
* The recommendations call for joined-up approaches. Firstly, between professionals and the individuals and families directly affected by drug use. Secondly, between statutory services, the health board, and other relevant agencies and sectors. Thirdly, across budgets. Finally, involving shared resources, such as buildings, communities, and staff.
* Most of these changes are within the reach of wider partnerships and should not be left solely to the Area Planning Board. A smaller number of considerations need action at the national level.

## In summary [The headline]

For too long, Western Bay has consistently reported the highest numbers of drug-related deaths in Wales. Individuals and families affected by this are struggling to get the responsive and inclusive support they need within the current system. People within the system consistently expressed feeling worn out. Now that the issues are being discussed more openly, there is an opportunity to create new and better services with a radical and fresh approach.

# 3. language, Terminology and GLOSSARY

## Language

The Commission took great care in choosing the language used in this report. We understand that the words we use can shape how people think about drug use and those affected by it. Language can influence attitudes, behaviours, and even the type of support people receive.

We have made a conscious effort to reduce the volume of jargon in this report and to write using the principles of ‘Plain English’ [[Online](http://www.plainenglish.co.uk/files/howto.pdf)].

To avoid reinforcing negative stereotypes, we chose not to use words that judge or label people, such as "addict" or "substance abuser." These terms can be dehumanising and do not reflect the complexity of a person's situation. Instead, we use phrases like "people who use drugs" or "individuals affected by drug use." This approach puts the focus on the person rather than defining them by their drug use.

We also made sure to use language that is respectful and accurate. Our aim was to avoid words that might create stigma or lead to misunderstanding. By being mindful of our language, we hope to encourage greater compassion and better support for those affected by drug use.

Throughout the report, we have been consistent in our language choices. This helps ensure that the report is clear and that our respect for the people and communities involved is evident in every section.

At our first meeting, we held a detailed discussion regarding the original title for the Commission (i.e. ‘Western Bay Substance Misuse Truth Commission’). Commissioners experienced the most difficulty with the term ‘substance misuse’ in the title. It was agreed that terminology such as ‘misuse’ or ‘abuse’ is stigmatising and should not be used, in line with guidance from the Global Commission on Drug Policy [[Online](http://www.globalcommissionondrugs.org/wp-content/uploads/2018/01/GCDP-Report-2017_Perceptions-ENGLISH.pdf)]. We had the sense that the current conversation and priority in the drug treatment field is about whole populations and wellbeing (i.e. a continuum of people who use drugs and people who do not use). We also had the sense that whilst ‘substance misuse’ maybe a term that is understood by professionals, it is not a term that is commonly understood or used by the wider public. Given that the Commission was set-up to explore the high rates of drug related deaths and harms, we felt it important to use the word ‘drugs’ in the title. By so doing, our hope is that everyone would immediately understand what the Commission was focused on.

With this in mind, we have not overlooked the impact of alcohol. In fact, we recognise that alcohol often plays a significant role for people affected by their own or someone else’s drug use. Considering the high levels of harm and deaths linked to alcohol, it would have been entirely reasonable to conduct a separate commission focused solely on alcohol. As a result, we sometimes refer to ‘alcohol and other drugs’ in this report to make it clear that alcohol is also a drug that causes harm.

Following our deliberations, we agreed to remove the terms ‘misuse’ and ‘truth’[[1]](#footnote-2) from the title and agreed that we would be called the ‘Western Bay Drugs Commission’.

When thinking about how language shapes important discussions, we also considered other terms commonly used that need attention due to their past usage. One of the most common is ‘service user’, a limited term used for those who access treatment services. This term does not reflect the wider group of people who use drugs (whether legal or illegal), regardless of whether they are in treatment. We prefer using ‘individual’ (who uses services) or ‘a person who experiences problems with drugs’ instead. This approach aims to:

* Reduce the stigma linked to labelling.
* Acknowledge the complexities of identities and boundaries; and
* Promote a more inclusive and person-centred perspective.

We recommend that all relevant stakeholders carefully consider using language that truly focuses on people and reduces stigma. Services across Western Bay should adopt titles that avoid stigmatising language. There are several helpful resources available to support this effort, and we especially suggest looking at the Scottish Drug Forum’s report ‘Moving Beyond People-First Language’ (2020) [[Online](https://www.sdf.org.uk/wp-content/uploads/2024/05/Moving-Beyond-People-First-Language-A-glossary-of-contested-terms-in-substance-use.pdf)].

## Terminology

When quoting individuals or citing literature sources we will use the terms they have chosen for accuracy of representation. Where the Commission has paraphrased and summarised its analysis into a particular phrase, this will be identified using italics and should not be misconstrued as a direct quote from an individual.

## Glossary

To aid anyone reading this report, we have included a ‘glossary of terms’ below to identify any abbreviations used within the report. We have written the full term in the report for the first time each abbreviation is used.

Table 3.1: Glossary of terms used in the report

|  |  |  |
| --- | --- | --- |
| Abbreviation, Acronym or Key word | Definition and meaning |  |
| APB(s) | Area Planning Board(s) | Local partnership arrangements to support alcohol and drug commissioning and service provision. |
| CDAT(s) | Community Drug and Alcohol team(s) | Statutory Health led alcohol and drug service providers. |
| HMPPS | His Majesty Prison and Probation Service |  |
| NHS | National Health service |  |
| OPCC | Office of Police and Crime Commissioner |  |
| OST(s) | Opioid Substitute Therapy/ies | Prescription drugs to help opioid maintenance, withdrawal etc -e.g. Buvidal, Methadone. |
| PSB | Public Service Boards |  |
| RPB | Regional Planning Board |  |
| SBHUB | Swansea Bay University Health Board |  |
| SMAF | Substance Misue Action Fund |  |
| StEPS | Support through Engagement with Prescribing Services | Local (APB) programme of delivery for reorganising provision of OST. |
| WBAPB | Western Bay Area Planning Board |  |
| Western Bay |  | An area covering both Neath Port Talbot and Swansea local authorities. |

# 4. what we were asked to do AND WHAT WE SET OUT TO DO

## Background

Members of the Western Bay Area Planning Board [WBAPB] have been aware over a number of years of increasing public interest and media coverage in relation to a range of issues associated primarily with the impact of drug use and the response of services across Western Bay (an area covering both Neath Port Talbot and Swansea local authorities). These include, but are not limited to, public concerns regarding disturbing images of the impact of drug use on individuals, families and communities; individuals’ access to and experience of, treatment and support services; and the reported rises in drug-related deaths across Western Bay to the highest (population) rate of drug-related deaths in Wales.

In 2019, a ‘critical incident’ [[Online](https://assets.publishing.service.gov.uk/media/668d303c4a94d44125d9cf6d/Critical+incident+management__1_.pdf)] was declared in Western Bay regarding the high rates of drug-related deaths. These concerns with drug-related deaths and near fatal overdoses led to a local search for ways to improve outcomes and reduce risk to those using drugs. As part of the response to this announcement the joint Public Service Boards [PSBs] for Neath Port Talbot and Swansea developed and agreed a new ‘Public Health Model for Substance Misuse’ which included a five-point plan that has subsequently been called the ‘Transformation Programme’.

The five-point plan included:

1. That a co-operative Public Health model for Substance Misuse is developed in the Swansea and Neath Port Talbot area incorporating a comprehensive and robust evaluation.
2. Initiate work required to establish a joint funding agreement between all relevant partners including, but not limited to, the APBs, the University Health Boards, the South Wales Police and Crime Commissioner, the Probation Service, local authorities, allied health and social services and Welsh Government.
3. Establish the governance framework and processes for this business change programme, as there will need to be dedicated resources to enable the detailed implementation and delivery planning required to support development of a co-operative commissioning model of ‘alliance contracting.’
4. Establish an **expert advisory panel** to support the development, implementation, monitoring and evaluation and act as a critical friend to Western Bay APB and any other pilot APB areas.
5. Development of a robust and sustained campaign of community engagement.

In February 2020 the Welsh Government facilitated discussions between the facilitators of the independent Dundee Drugs Commission (Figure 8 Consultancy) and leaders of the WBAPB. Following detailed discussions, the WBAPB decided to convene an independent Drugs Commission as its ‘expert panel’ (as per point 4 above), incorporating the strengths and good practice of the Dundee Commission [[Online](https://www.dundeecity.gov.uk/dundee-partnership/dundee-drugs-commission)], including research, community engagement, user perspective, a partnership approach, and a focus on practical recommendations for action.

In June 2022 Figure 8 Consultancy, a specialist alcohol and other drugs consultancy company based in Dundee, was commissioned by WBAPB to set-up and facilitate an independent commission on the same basis as the Dundee Drugs Commission.

Between July-November 2022, Figure 8 recruited twenty members to the Commission, including members with lived experience of substance use and family members affected by a loved one’s use of substances. Full details of the Commission members are provided in **Appendix I** in the **Part 2** report.

The Western Bay APB announced that the Commission would be commencing at a launch event on 7th December 2022 at the Swansea.com stadium.[[2]](#footnote-3)

## Our aim and objectives

Our aim was to explore why Western Bay (Neath Port Talbot and Swansea) has consistently experienced the highest rates of drug-related deaths in Wales.

The Commission was provided with a draft set of objectives from the Western Bay Area Planning Board, and at our first full meeting in January 2023, we refined them slightly to the following final set of objectives.

The Western Bay Drugs Commission will:

* Consider the nature, extent, and impact of substance use across the region.
* Specifically explore drug-related harms and deaths (inclusive of illegal, illicit, prescription and alcohol use).
* Have active regard for the wider (cultural, economic, familial, psychological, and social) determinants and influences of problematic substance use.
* Be a critical friend to all stakeholders (local commissioners, communities, leaders, and providers).
* Use and adapt learning, where necessary, from the Swansea Poverty Truth Commission Model.
* Use and adapt, where necessary, the independent Dundee Drugs Commission Model.
* Ensure that our final report includes recommendations on additional priorities for practical and achievable action.

In this regard, the activities and report of the Commission has a focus on adult illegal and illicit drug use. In doing so we have where appropriate, and resources permitted, also taken account of issues of legal drug use (alcohol and prescription medication) and children/young people (under 18 years of age).

## Our guiding principle

At our first formal Commission meeting in January 2023 the members were unanimous in their view that a values-based guiding principle should be agreed and held at the forefront of all deliberations. The following statement was developed and agreed.

‘**All voices** have an important contribution to make and will be heard. Whilst the starting position of high drug deaths is known, we are here to listen with **transparency** and **empathy**. Whilst the conclusion is unknown, we will focus on positive messages that instil **hope**. In undertaking a collaborative journey, we will support the development of **trust** between everyone.’

## Ethics and safeguarding

The nature of this work as a facilitated commission rather than a research project meant that no prior ethical approval was required. This said, the work was facilitated by Figure 8 Consultancy, at all times in a manner consistent with the company’s principles, outlined in its ‘ethics’ and ‘safeguarding/disclosure’ policies.

During the course of our evidence gathering we identified one matter of a safeguarding concern. In line with our safeguarding policy, this was immediately referred to the relevant authorities who responded promptly and appropriately to these concerns.

# 5. what we have done

## Introduction

The Western Bay Drugs Commission, referred to as ‘the Commission’, held its first official meeting in January 2023. Since then, we have had twelve more formal meetings up until May 2024. Six of these meetings included public evidence sessions, where members of the public and professionals were invited to observe the discussions. More details on these public sessions and the speakers can be found in **Appendix II** of the **Part 2** report.

## Evidence gathering

A wide variety of quantitative (data and statistics), qualitative (expressed views) activities and observations (Commission members and facilitators visits) have been used to capture as broad and balanced a set of evidence as possible over the last 18 months. In total, we have grouped these activities into twelve different categories of evidence, as detailed below.

|  |  |  |  |
| --- | --- | --- | --- |
| **No.** |  | **Evidence source** | **Notes** |
| 1 |  | Initial Call for Evidence | An initial call for evidence was distributed through various networks across Western Bay during 24th February 2023. The call for evidence consisted of three key questions, focused on understanding how the work of professionals across Western Bay in supporting those who have problematic drug use can make a positive difference to their outcomes. In total **63** responses to this initial call were received. Full analysis is provided in **Appendix III** in the **Part 2** report. |
| 2 |  | Evidence submissions from the WBAPB | Across the lifespan of the Drugs Commission, a wide range of communications (meetings, phone calls and email exchanges) have taken place with officers from the WBAPB and partner agencies. Numerous documents were sent to the Commission, and subsequently reviewed, in response to a variety of information requests from the Commission. |
| 3 |  | Deeper Dive of Drug Death Data | Various meetings were held and email communications exchanged across the lifespan of the Commission with Cerys Thomas (Case Review Coordinator) and Matthew Rafferty (Harm Reduction Lead) from the WBAPB. A range of documents and information were received from Cerys and Matthew in response to the Commission’s requests for information regarding drug death data. |
| 4 |  | Public Evidence Sessions | Over the course of the last year, the Drugs Commission has held **six** 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. Full details of evidence speakers are provided at **Appendix II** in the **Part 2** report. |
| 5 |  | Service user / family member consultations | Focus groups and interviews were conducted by Figure 8 Consultancy with a range of individuals and groups affected by their own, or someone else’s, drug use. The majority of these consultations took place through advertisement and support from local drug and alcohol services. A smaller number of interviews and communications took place with individuals who made contact directly with the Commission, mainly through its Calls for Evidence. Further details are provided in **Appendix IV** in the **Part 2** report. |
| 6 |  | Service visits (conversations and observations) | A range of visits to commissioned services across Western Bay were undertaken by groups of Commission members on [insert dates]. In total, **seven** services were visited, with an opportunity for Commission members to meet with staff and service users or family members. Full details are provided in **Appendix V** in the **Part 2** report. |
| 7 |  | Evidence submissions from services commissioned in the locality (i.e. by WBAPB, HMPSS, South Wales OPCC, Local Authority etc) | Across the lifespan of the Drugs Commission, a wide range of communications (meetings, phone calls and email exchanges) have taken place with commissioned services across Western Bay. In the final stage of evidence gathering the Commission requested detailed information (via an online survey) from all commissioned services on the services they provide, and detailed responses were received from all.  Full details are provided in **Appendix VI** in the **Part 2** report. |
| 8 |  | Consultations with staff members from local services | Numerous consultations took place across the 18-month period of the Commission with all services funded by the WBAPB and/or their partner organisations. A number of ancillary support services and non-specialist drug and alcohol services were also consulted. Consultations took a variety of forms, whether through face-to-face conversations or staff focus groups, to online meetings and email communications. Further details are provided in **Appendix VII** in the **Part 2** report. |
| 9 |  | Key stakeholder meetings and interviews | A wide range of ad hoc key stakeholder meetings and interviews with professionals took place over the course of the evidence gathering period, on a whole range of themes. Although it has not been possible to write all of these up for the purposes of this report, the discussions that have taken place have consistently helped to shape the findings of the Commission’s work. |
| 10 |  | Service user, family and members of the public – meetings and correspondence | 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 (via discussions with Andy Perkins and/or Wulf Livingston). This has been added as an extra layer of informal evidence gathering to the initial planned methods of the Commission. |
| 11 |  | 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 timeframe allocated. There were six consistent themes that were identified, over and above any others: Culture and Governance; Data; Housing; Mental Wellbeing; Prescribing; and Primary Care/Shared Care. The Commission set-up sub-groups to explore and report upon these core themes. Further details of each sub-group’s composition and work is provided in **Appendix VIII** in the **Part 2** report. |
| 12 |  | Final Call for Evidence | A final call for evidence was distributed online through various networks across Western Bay between 25th April 2024 and 24th May 2024. There were **43** responses to this final survey – a mixture of individual and corporate responses. Full analysis is provided in **Appendix IX** in the **Part 2** report. |

## What we haven’t done – the limitations

Despite our best efforts, there are some areas that the Commission couldn’t explore as fully as others. It should be noted that the Commission was not tasked with undertaking either a Health Needs Assessment study, conducting a wholesale epidemiological study, or employing data statisticians.

Early on, we decided to focus on the key themes identified in the Initial Call for Evidence, such as culture and governance, drug-related deaths and harms data, housing, mental wellbeing, prescribing, and primary care/shared care. This allowed us to conduct a thorough review within the time and resources available. In this context there are several important areas that we could not fully explore, which will need further attention in the future to enable a comprehensive review across the entire system.

The main areas we couldn’t investigate as deeply as we would have liked are:

1. The impact of drug use on children and young people – whether their own use or that of family members or others close to them.

Although we have included some evidence and conducted key interviews on this topic, this area requires a much more detailed review. We encourage the WBAPB to prioritise this issue in its future work. We were mindful of the work and report of Kinbee, who were commissioned by the WBAPB during the course of our work to explore the needs of children and young people (up to the age of 25) across Western Bay in relation to drug use.

1. The role of alcohol, both in relation to drug-related harms and deaths, and as a significant issue in its own right.

Alcohol is the most commonly reported substance at initial assessment[[3]](#footnote-4). However, the focus of most APB activity, resources, service providers, and transformation efforts has been on drugs, particularly opioids. The Commission, as per its remit, concentrated on drugs, not alcohol, even though alcohol is the larger issue. We recommend that the WBAPB addresses this imbalance going forward.

1. The role of justice services (Courts, Police, Prison and Probation), the availability of drugs in Western Bay, and drug law enforcement.

Whilst this area is mostly outside the local remit (i.e. is policy and practice controlled and directed from UK Government); we did gather substantial evidence on the experience of criminal justice provision in supporting people who use drugs. We received positive feedback on the effective work of justice services in Western Bay. The recurring key theme was of the challenges posed to accessing good quality treatment pre- and post-prison release. We noted challenges, such as the misalignment between UK, Welsh, Regional, Health and Local Authority commissioning remits and timescales. Often, Home Office or OPPC projects, are introduced first and then aligned locally, rather than being genuinely devolved local commissioning arrangements. As for drug availability and enforcement, this area was beyond the scope of our work.

# 6. CONTEXT

## National, UK and Welsh contexts

Over the past 40 years, drug and alcohol policy in the UK has shifted through several key phases (paradigm shifts), each influencing how services are provided. We identify these as:

1. Criminal Justice Focus:

This approach was prominent from the late 1980s to the early 2000s, especially under the Blairite Labour government, with policies like the introduction of a ‘Drug Tsar’ and the ‘tough on crime, tough on the causes of crime’ stance. Drug policy was often implemented through local Community Safety Partnerships, with a strong emphasis on criminal justice-led interventions. APBs in Wales still show traces of these origins.

1. Health-Oriented Approach:

This phase has dominated much of the 21st century so far, with a shift towards treating drug problems as a health issue. Significant funding has been directed towards treatment services, especially those focused on opioid substitution therapy. In Wales, most drug treatment funding, whether from the Welsh Government, Health Boards, or Criminal Justice, has gone to statutory health providers.

1. Socially Oriented Approach:

In the last decade, there has been growing recognition of the need for a broader approach, addressing the social and economic factors that influence health. This approach also considers complex needs, including trauma. Although there is increasing evidence to support this paradigm, it has not yet been sufficiently reflected in strategies and service delivery.

In Western Bay, we have heard that many of the challenges are best understood through this third, socially oriented approach. However, much of the current commissioning and service delivery remains stuck in the health-focused second phase.

## Key Policy Developments

More broadly there have been a number of important policy developments. These are:

1. Co-Production:

There is now widespread recognition that policy, practice, and research should involve those with lived experience of drug use, as well as their families and communities. Whilst this approach is embedded in the Social Services and Well-being Act (Wales) 2014, it has been difficult to fully implement in the core statutory and health-led services for drug and alcohol treatment in Wales.

1. Recovery provision:

There is growing recognition of the need for recovery support and communities, including those led by peers. However, in Wales, these groups and organisations are only well-established in a few areas.

1. Impact of Westminster Policies:

The UK government has pursued a mix of semi-privatisation of services and austerity, leading to cuts in provision. Whilst the Welsh Government has resisted some of the privatisation, the wider impact of budget cuts on health and social care has still been felt. For drug service provision in Wales this has not necessarily been felt in the APB or Criminal Justice budgets, but rather in those of the benefit systems, local authorities, third sector providers and the overall NHS budget.

1. COVID-19 Pandemic:

The pandemic has significantly altered service provision, diverting attention from core issues and hindering the development of new strategies. It has also had economic, health, and psychological impacts on individuals and families.

This report reflects these contexts, which should be kept in mind when considering its findings. As one of our respondents put it, *‘the drugs are changing, but the services are not’*, highlighting the persistent focus on outdated approaches and the slow shift towards more socially oriented solutions.

## Local context

It is clear that the challenges facing Western Bay in relation to drug harms are as current today as they were when the Commission started its work back in December 2022. The recent headline from the South Wales Evening Post, 11th July 2024 [[Online](https://www.pressreader.com/uk/south-wales-evening-post/20240711/281560886012583)].

This media coverage was in response to the latest national ‘drug related mortality’ annual report from Public Health Wales [[Online](https://phw.nhs.wales/news/opioids-the-leading-factor-in-drug-related-deaths-in-wales/harm-reduction-database-wales-drug-related-mortality/)] which indicates Swansea Bay as being the Health Board that experiences the highest rates of drug-related deaths across the country. Swansea Bay has consistently reported the highest levels of drug misuse deaths for six of the last seven years and only fell slightly behind Cwm Taf Morgannwg in 2019. During the Commission’s work it became clear that different definitions of drug-related deaths are used in different contexts and by different organisations. The need for consistency in this area is highlighted within the remainder of the report and our recommendations.

Figure 7.1: European Age Standardised Rates of Drug Misuse Deaths per 100,000 population of Health Board, 2018-2022, with national rates for Wales (**black**) and England (**red**)

A graph showing Swansea has the highest number of drug related deaths in Wales

Wales

England

Figure 7.2: European Age Standardised Rates of Drug Misuse Deaths per 100,000 populationin Wales by local authority, 2022, with national rates for Wales (**black**) and England (**red**)

A graph showing that Swansea has the largest number of drug related deaths out of all the other counties.

Wales

England

It is important to note the time lags that are experienced in the publication of drug death statistics for Wales, which means that the graphs above, which show the most recent data (2022), are over now two years old. It is therefore difficult to establish an accurate real-time picture.

# 7. what we have heard AND FOUND – OUR DOMINANT KEY MESSAGES

## Development of key findings

Our review has led the identification of a number of key messages – all of which have been used to form an ambitious set of recommendations. These key messages are a combination of:

* **early messaging** that arose from our initial call for evidence and the resulting exploratory evidence gathering; and
* a set of more evolved messages resulting from a set of **layered experiences** that we heard across the multiple consultations and evidence sessions we have held over the last 18 months.

**To be clear, the phrases below that are set in *italics* are the words of the Commission rather than direct quotes from individuals.** We have paraphrased in order to summarise the consistent and strong messages that we have heard whilst taking necessary steps to protect the anonymity of those we have spoken to.

## Early messaging

Analysis of our initial call for evidence (see **Appendix III** in the **Part 2** report) identified a number of issues that we used to develop our work programme of evidence gathering. We set-up small working groups of Commission members, each of whom were tasked with conducting a deeper dive of the identified issues, and who then helped form the following set of early messages.

### Culture and governance

In terms of investigating the role of leadership in the drugs field in Western Bay, we have taken evidence from multiple sources, with particular focus on the roles of all local drug services, the WBAPB, the Joint Public Services Board, the executive leadership from Neath Port Talbot Council, the Office of the South Wales Police and Crime Commissioner, Swansea Council, and Swansea Bay University Health Board.

Much of the evidence we have come across has reflected a story that offers some long historical footprints (boundaries, services, providers, relationships etc.). These have led to what has felt like a culture of conservatism, risk aversion, defensiveness, and shifting of responsibility rather than one that embraces the culture of transformation (i.e. radical change and thinking afresh). We have concluded that if the aspiration of transformation is to become reality across Western Bay, then this needs to begin with real cultural change, and an adoption of some new mindsets.

We would suggest this cultural change needs to start with that of leadership. It also wants to consider who might be the necessary actors. This will also require the adoption of some fresh approaches and identity. We think this is reflected in one of our core straplines, that ***reconfiguration is not transformation***.

The evidence we have received has led us to conclude that leadership (related to the drugs problem) over recent years, at all levels, has been ***disjointed*** at best, with decision-making being slow and often bogged down between several partnership forums and overly complicated governance arrangements. We have evidenced this via:

1. An inability and/or lack of accountability mechanisms to follow through timeously on improvement plans and promises; and
2. At times, limited ambition, whatever it takes, in some areas to act to prevent harm and drug-related deaths.

We do want to acknowledge recent improvements that have been achieved through the establishment, chairing, and project management of the Transformation Programme Board. This has brought a good degree of oversight, accountability, and energy to the Transformation Programme, which was severely lacking in the early stages of the Commission’s work. However, despite recent improvements, we do still feel the need to highlight these issues, as we are aware that it would be all too easy, given ever-increasing competing demands, to reduce the level of input and oversight provided through the Transformation Programme Board.

The slow pace of change does not suggest a lack of desire, rather that all too often the different frameworks, governance and structures of the various partners become the obstacle and cause of delay. Multi-organisational partnership working has its challenges but these need to be overcome rather than permitted to be the brakes on change taking place.

We have also observed and experienced varying degrees of input and cognisance of the issues related to drug harms from executive leadership across the statutory partner agencies, as well as from third sector organisations

In terms of who the key, and necessary, ‘actors’ are in the drug treatment sector, we came to a clear conclusion regarding the role of the WBAPB. The APB should be an integrated partnership activity that develops a shared strategic plan, with responsibility for commissioning services and governing the sector.

We found that the WBAPB was more often than not referred to as an **‘*other’***. In the main, stakeholders did not express ownership of the WBAPB but rather viewed it as being the members of the WBAPB support team. Most notable in this view were health services and the Community Drug and Alcohol Team [CDAT] in particular.

APBs in Wales have, and Western Bay is no different in this regard, drifted into becoming commissioning and performance management bodies rather than strategic partnership boards. Our review of the minutes of WBAPB meetings and our experience of attending a variety of APB meetings has evidenced this for us. APBs have been overtaken by other developments, notably the enhanced role of Public Service Boards [PSB] and Regional Partnership Boards [RPB].

APBs develop holistic plans but in reality they only direct a given percentage of the total monies that are spent on alcohol and drug related intervention/services in their locality. Primarily, this is the Substance Misuse Action Funds [SMAF] that are provided directly to the APB from the Welsh Government. The SMAF funds are usually given to a single Local Authority acting as the banker on behalf of the APB. In the case of Western Bay, this is Neath Port Talbot Council. Health Board monies usually consist of two parts: ring-fenced alcohol and drug spend and wider other consultant, prescription, primary, and secondary health care costs. Ring-fenced Health Board monies often appear within APB financial statements. More generally though, Health Board monies, as well as those of the Office of Police and Crime Commissioner [OPCC] and HMPSS are commissioned (and spent) independently of the APB.

The problems and deficits outlined in this report highlight multiple complex, overlapping, and integrated sets of needs which require a broader spectrum of *actors*.

Given the above, we have questioned senior leaders across Western Bay regarding whether it is even possible for the APB to effectively lead and govern the responses to drug harms. For example, we heard and considered on multiple occasions the dominance of both housing insecurity and mental health issues for those affected by drug use. Towards the end of our evidence gathering period, it became clear that the spectre of the TATA steelworks closure and significant local job cuts loomed and could be yet another catalyst for potentially economic and socially driven rises in alcohol and drug use [[Online](https://www.bbc.co.uk/news/articles/c70zxjldqnxo)]. These issues lie outside the exclusive responsibilities of the APB and are controlled in other partnership settings. It is pertinent to note too that, to a large degree, crisis responses to drug harms are often provided by frontline third sector housing and homelessness services, most of whom are not funded or governed through the APB. The rest of the report narrative and certain recommendations highlight these challenges and indicate the need for drug use, because of economic, health and social determinants, to be actively responded to by a range of bodies and leaders (elected councils, health boards, regional partnerships etc.).

The question of how this needs to change is not just a matter for local leaders but also has implications for the Welsh Government. We will come back to this at the end of our report.

### Approaches and identity

Our experience and understanding of the history of the WBAPB has been one of continual reconfiguration of services – a moving around the (chess) board of the same pieces so to speak, rather than anything new and/or aligned with today’s challenges. Having said this, the recent moves towards the WBAPBs Transformation Programme has demonstrated the early signs of greater ambition and new thinking. We welcome the plans and work of the Transformation Programme, but we would also continue to challenge whether the foundations of the Programme are sufficient to deliver the aspired to transformation. For example, with the Transformation Programme being set-up through the existing structure and partnerships of the WBAPB, there is a danger that the Transformation Programme will be a ***siloed response*** – that is to say, due to the WBAPBs remit being drug and alcohol services, that it will struggle to affect change across the multiple sectors, particularly housing and mental health, that will be required for transformation to truly happen.

We would argue that transformation will only occur when we recognise and respond to drug use through a ***‘social determinants of health’*** and ***‘trauma-based’*** lens rather than simply through the lens of focusing on drug use itself as the problem. The recognition of such requires the need for a fresh approach.

We found that Western Bay lacks any real sense of consistency in providing outreach, recovery, or substantive co-production. In fact, we are not sure that it is indeed possible within the existing APB structure. We are referring to a need for a significant cultural shift regarding what is at the very heart, or purpose, of how you go about designing effective drug services. For example, time and time again we heard about the need to move away from the provision of urban-centric, Monday-Friday, 9-5, services. The starkest observation for us was, that for those adults who require help from specialist drug services, there is currently *no open door* for them to walk through, without being faced with a locked door, buzzer entry, or glass partition once inside the front door. It should not be a surprise to anyone to know that this experience for many is one of stigmatisation and one that deters individuals from accessing services.

In terms of identity, the Transformation Programme provides the opportunity for services to consider some fresh names for services to aid departure from historic provisions towards a new future.

### Data

The initial assumption underpinning both the formation, and the work, of the Commission was that Swansea Bay is an outlier in Wales due to drug death data identifying Swansea Bay as consistently experiencing the highest numbers of drug deaths of any area of Wales. Through extensive discussions with those responsible for keeping local drug death data, along with discussions with other areas as well as those with national data responsibilities, it became clear to us that this assumption cannot necessarily be relied upon. Essentially, the nature of data collected, and possible accuracy and interpretation of the data, varies between APBs within Wales and makes comparisons unreliable.[[4]](#footnote-5)

Having said this, the statistics account for genuine concern. Swansea Bay unquestionably experiences high rates of drug-related deaths. We are only questioning the data one way; that is to say, nobody is questioning the high numbers of drug deaths, but rather that we are questioning whether other areas are potentially underreporting. Arrangements in Western Bay involve a close working relationship with the coroner. This is probably the case across Wales within each Health Board area. However, from our investigations there does appear to be data consistency issues across Welsh regions, with different data practices dependent in a significant way on the approach of the local Coroner regarding reporting. We heard from a Scottish expert how this has been tackled in Scotland. There is now one Coroner (known as a Procurator Fiscal in Scotland) who oversees the recording and reporting of all drug-related deaths across the country, hence leading to increased confidence in the quality and consistency of reporting across all areas. This kind of approach to Coroner practice is lacking in Wales.

The presence of a full-time case review coordinator employed by WBAPB, unique in Wales, does imply more thorough data collection in Western Bay than in other regions.

Despite this additional resource for Western Bay, we have regularly heard about challenges that services and commissioners face regarding data utilisation and any subsequent impact on practice.

We heard from several sources about potential impact of transient populations on data accuracy, particularly for Swansea. Current approaches to data collection and analysis are not sufficient to provide expert interpretation of any potential impact in this regard.

Importantly, we have also heard significant frustration expressed over a ***focus on minutiae*** in APB meetings rather than any substantive discussion on crucial data like drug-related deaths statistics. This should be a matter of concern regarding governance and oversight for the WBAPB.

Coupled with this is ongoing frustration regarding the time lags in the national reporting of drug-related death data reports. For example, the latest national report from Public Health Wales [PHW] was published on 11th July 2024 but provides reporting of data from 2022-2023. Understanding the frustration behind the timeliness and availability of reporting may help to explain why detailed data discussions do not take place. Given the fast pace at which drug markets and consumption trends are changing across the UK it can be no surprise to feel like the data are already out-of-date by the time they are published. Again, we heard from a Scottish expert regarding the significant steps forward in Public Health surveillance of drug deaths in Scotland in recent years, and particularly the development of the RADAR (Rapid Action Drug Alerts and Response) [[Online](https://publichealthscotland.scot/media/13618/radar-leaflet_english_june-2022.pdf)] system, hosted by Public Health Scotland. This is an early warning national system that works with communities and stakeholders to identify and assess potential drug-related risks and harms, which then informs decision making to reduce those harms and save lives. The system delivers a quarterly report that seeks to reduce drug harms using two main methods: (1) routine information sharing, and (2) identification and response to new and emerging harms. We welcomed the evidence provided from the Scottish expert. There are significant lessons to be learned from the Scottish experience of drug-related deaths, not least of which is that of data collection, analysis, expert interpretation, and implementation of lessons learned.

### Housing insecurity and homelessness

Throughout all our consultations we were repeatedly struck by the prominence of housing insecurity and homelessness being ***top of the list*** in terms of the priority need for people who experience problems with drugs. We have heard housing expressed as a consistent and unmet need by individuals in current drug treatment.

We have observed a range of housing providers (particularly Third Sector) to be one of the key agencies (often along with Police/Ambulance) picking up people in crisis. By ‘in crisis’ we are referring to individuals who are deemed to be those with the most complex and chaotic of lives, who are often rejected and turned away from drugs services because they are deemed to be unmotivated or too chaotic. It seems somewhat of a miss that the most expensive, resource dominant, services who have the highest paid and qualified staff, are those that are least likely to work with this group (by discharging them from their service for being too complex and chaotic).

When people fall between the gaps, which they do all too often, we have heard numerous reports of how they get picked up by other organisations and agencies, usually housing providers. We would suggest that, at the very least, these service providers, in the current delivery context, be regarded and treated as key drug and alcohol services. Our observations have been that these services are providing a much needed and person-first response. They are keeping people alive, ensuring where they can, that individuals are accessing, or being supported to access/re-engage with, drug treatment services. These services have hugely skilled staff, who are some of the least paid in the workforce and they are left alone to support individuals who are turned away from specialist services. If these are the places where people are at then we would suggest that drug services should be going to them, providing services from there, rather than expecting individuals to attend where the drug services are at.

We heard significant evidence of local authority plans and strategies, particularly from NPT Council, to address some of these housing issues. However, we also heard that any plans can be hugely restricted by outside considerations, such as a severe lack of available stock, prices, suitability of landlords, austerity, etc. We have noted that the new Labour Government in Westminster have indicated this area as a priority. It will require strong leadership and political literacy of the issues to commit to a prioritisation of this across Western Bay.

### Mental Wellbeing

Similar to the prominence of housing insecurity and homelessness throughout our consultations, we have also heard a similar prominence given by all stakeholders to the importance of mental wellbeing and an expressed lack of mental health support for individuals who experience problems with drugs. We have consistently heard about the narrow and (too) high threshold currently in place for those who take drugs to be seen by mental health services. More worryingly, we have heard numerous reports of individuals being refused assessment for their mental health until they can stop using drugs. This goes against all the accepted best practice and evidence around co-occurring mental health and substance use, where the two conditions should be dealt with in tandem, rather than sequentially. We can only conclude that this is ***discriminatory*** in nature and should be of significant concern to commissioners and leaders of mental health services across Western Bay.

Drug treatment is viewed by many in Western Bay as a ‘specialism’. This allows disciplines, such as mental health services, to be distant or not fully engaged with those who are currently using illicit substances as indicated above, by asserting that the drug problem needs to be tackled before other help can be offered. Additionally, this ‘specialism’ view allows services to take the position that they are the only ones skilled to deal with people who experience problems with drugs and is a possible reason why there are so few planned discharges from drug services. The clearest example of this is how CDAT over many years have not engaged with primary care or been even welcoming of shared care opportunities with local GPs. This will require concerted efforts towards normalisation over the long-term. That is, there should be **‘*no wrong door*’** for people who need help to get the help they need, no matter which service they present at. A form of mandating of **‘*it’s everyone’s responsibility*’** may be required nationally to deal with the massive challenges of stigma faced by those who use drugs.

When we have sought details about how mental health provision is being prioritised, we have been presented with full details of the Dual Diagnosis Strategy developed by the West Glamorgan Regional Partnership Board [RPB]. Although welcome, this strategy is too narrow when focussing on those with diagnosed co-occurring mental health and substance use conditions, which the strategy refers to as ‘dual diagnosis’. We believe that this labelling is not helpful and unintentionally compounds the ability of mental health services to refuse to work with people who use drugs unless they fit the high threshold of severe and enduring mental health problems. A holistic and person-centred approach would not refer to ‘dual diagnosis’, as that fails to appreciate and acknowledge the wider social and economic determinants of health that need to be appreciated and supported for individuals to receive the highest possible standard of care and support.

### Prescribing Services

Another key theme that arose during our initial call for evidence was that of prescribing services across Western Bay. We can only summarise the extensive views shared on this subject by concluding that the current experience for those who require prescribing services is ***confused*** at best. One of the strongest senses of the confusion that exists is highlighted in the quote of one individual who asked the question, *‘Why am I required to receive my medication [OST] from [name of prescribing service] rather than from my GP? I just want to get it from my GP rather than having to keep coming here.’*

There are four primary routes for prescribing interventions across Western Bay which, other than the more recent focus on Rapid Access Prescribing, are historic arrangements that have been reconfigured over time rather than transformed.

During our work, we have been aware of the development of the StEPS [Support through Engagement with Prescribing Services] programme of service reconfiguration through dedicated support from the WBAPB. The appearance is that the StEPS programme has been developed separately to the Transformation Programme as it fits the category of reconfiguration and has involved the moving around of the existing ‘jigsaw’ pieces rather than anything new or transformational. We cannot stress enough the missed opportunity, to engage with primary care and shared care models when developing the StEPS model. We will comment more on this in the following section.

Concerningly, we have heard experiences of individuals being moved between the four prescribing services with relapse being regularly reported. Because of being taken off the medication that they were stable on when transferred, and being required to engage with another provider (where they are put on a different form of Opioid Substitution Therapy [OST] because the medication they were stable on is not an option at the new service), relapse then occurs.

### Primary Care/Shared Care

As mentioned above, there has been a complete disconnect between drug treatment services and primary care/shared care models of treatment for people who experience problems with drugs across Western Bay.

Primary Care is the first point of contact and provides accessible, community and local based, holistic care to everyone in Wales with the aim of being equitable and non-judgmental. Primary Care encompasses pharmacy, optometry, dentistry, as well as general practice and social prescribing.

So, why do primary care and shared care models matter when we consider treatment for people who experience problems with drugs across Western Bay?

GPs should provide comprehensive care, with multifaceted healthcare advantages, to people who experience problems with drugs. In addition to prescribing and monitoring of OST medications they can provide a holistic approach to physical and mental health needs. GPs support was often referred to as ‘low threshold prescribing’. In Western Bay this is done via secondary care provision and as such negates the opportunities for other primary care interventions to be provided. People who experience problems with drugs frequently have long-term conditions including respiratory and cardiovascular conditions. The general practice approach should integrate drug use treatment into routine primary care, ensuring continuity, personalised approach of prevention, early intervention, and chronic disease management, as well as psychosocial support. GPs should work with a range of health and social care professionals to ensure high quality care. GPs prioritise the fostering of a supportive environment that encourages long-term recovery, promoting patient engagement, and reducing stigma. Overall, GPs prescribing OST aligns with a patient-centred approach, emphasising accessibility, individualised care, and the de-stigmatisation of problematic drug use. The shared care collaborative model optimises the utilisation of healthcare resources, enhances accessibility, and improves overall outcomes for individuals navigating the challenging path of problematic drug use.

We were surprised and disappointed to find a dearth of primary care and/or shared care provision (between local GPs and CDAT) for those using drugs across Western Bay. With only a couple of exceptions (a particular practice or individuals), it appears that a long breakdown of working relationships and trust between GPs and CDAT across the region has resulted. Internationally, this is a highly unusual picture. GP prescribing or shared care is less common in Wales (than the wider UK-European picture). GP shared care establishes accessible provision which helps support wider health and care needs amongst individuals.

There is no observed or reported use of ‘exit pathways’ for people to return to primary care once stabilised on medication. We consider this to be a community drug service equivalent of ‘bed blocking’. It appears that only a relatively small and limited amount of the current drug use budget funding is being allocated to primary care.

The model of current prescribing provision within Western Bay is exclusively a secondary care model. More broadly, the model of care not only struggles to integrate primary and secondary care but also appears to be polarised between other considerations as outlined elsewhere in this report (i.e. that of harm reduction or abstinence, statutory or third sector provision, etc.).

The breakdown, decline, and lack of any shared care practice reflects a breakdown in relationships between CDAT and GPs. This seems to be one of blame and a lack of trust. We received evidence about several incidents in which CDAT suggested that GPs were not being safe in their practice with people who experience problems with drugs. This appears at odds with the wider nationally and internationally available evidence. We heard very early in our evidence gathering from members of the Dundee Drugs Commission who had explored and evidenced the important role of shared care for a fully functioning drug treatment system. They reported their discussions with three GPs from Edinburgh where, over many years, the shared care arrangements have been prioritised and developed to a point where roughly 3000 of the 4000 people on OST medication are held within primary care and not the statutory drug treatment system. This has freed up capacity of the statutory drug treatment service in the city to focus on the more complex and chaotic individuals who require specialist rather than generalist support. In Cardiff and the Vale, there has been a particularly strong development of a shared care model. Also, there are currently three smaller examples of shared care approaches other Health Board areas in Wales (Aneurin Bevan University Health Board, Betsi Cadwaladr University Health Board, and Cwm Taf Morgannwg University Health Board).

It was in this context disappointing to see the missed opportunity that the recent StEPS programme presented. StEPS was designed to only realign the existing secondary care prescribing services rather than transform the Western Bay experience to bring GPs back into the fold and increase the diversity and volume of potential prescribers.

Our understanding from our investigations indicates that the existing contract between GPs and Swansea Bay University Health Board [SBUHB] to support prescribing was last reviewed over 14 years ago, in 2010. Except for one practice and a small handful of individual GPs, there is essentially no GP prescribing or shared care going on within Western Bay at present. These appear as ad hoc and legacy provision and do not reflect any strategic approach from the SBUHB and WBADP to such provision.

During our work and following the sharing of our initial concerns, we have noted some improved taking up of small parts of this agenda, but there is clearly a long way to go to restore trust and healthy working relationships between local GPs and the drug treatment services.

Community pharmacies can also offer a local, non-judgemental approach to dispensing. Research has demonstrated improved accessibility and acceptability across communities as a result.

We have been informed that there are 85 pharmacies across Western Bay who are signed up to deliver observed methadone dispensing. Despite pharmacies being ready and willing across Western Bay, there has been a tendency for secondary services to continue to do the dispensing. We have heard how this leads to increasing travel time and cost for individuals, often incurring multiple bus journeys, and decreasing satisfaction with the treatment provided. It also represents a missed opportunity, if as with GP care, there is an opportunity to get support with other things going on in that building. We have also heard indications of how these practices can lead to higher dropout rates.

It appears that despite the number of ‘signed up’ pharmacies, there is a concentration of a smaller number of active pharmacies supporting people who experience problems with drugs (issuing medication, needle exchange and other harm reduction practices). The providing pharmacy is often a long way from individuals place of residency and especially difficult, costly, and at times inaccessible for those who are on daily ‘pick up’.

Primary care in its various forms, delivered in local venues, would also help ameliorate the accounts we have heard of people having to travel into town and city centres from outlying localities such as the Gower or the Valleys.

Going forward, we would expect to see, and local stakeholders have stressed the importance of, consistent use of GP prescribing and or shared care as an integral part of any future transformational landscape. We will come back to this issue in our conclusions and recommendations.

We would highlight that there is a reasonably sized cohort of clinicians who have completed the Royal College General Practitioners Part 2 Certificate in the Management of Drug Use training in Western Bay who are not currently using their skills and training. Several local GPs have expressed to us that they are keen to provide more shared care. Both GPs and patients have expressed that the GP setting is appropriate in this regard.

Except for one Swansea-based GP and those GPs currently working with CDAT, it has been difficult to establish any sense of leadership on this issue, especially within Swansea Bay University Health Board (SBUHB).

## Layered experiences

As our evidence gathering progressed, it became abundantly clear that there is a more complex and nuanced story to tell that transcends well beyond the early messages highlighted above. We have chosen to tell this narrative in the form of a set of ‘layered’ experiences – i.e. experiences which should be layered onto, and across, the messages identified through our early evidence gathering.

We have grouped these ‘experiences’ under the following headings. They are not presented in any form of priority order. When taken as a whole, they will help to shine a light of where the main challenges lie if the system of local services and supports is going to move beyond the current aspirations for transformation through to real transformative change and support. We would define real transformative change as a system of drug treatment and support that delivers, based upon real-time evidence, a healthy balance of appropriate services and support, for the right people, in the right place, and at the right time.

### Lived/living experiences

Although not presented in any particular order, and as mentioned above, the first layered experience that we are compelled to comment upon, is a severe lack of lived and living experiences embedded within services and the wider system. For the Commission, the most consistent place to harness a group of people with living experience to capture their views and input was with individuals queuing up outside a service (Dyfodol), early morning, to obtain their script.

Towards the end of our evidence gathering period, there have been some encouraging early signs of improvement throughout the course of our work in this regard, mainly focused on the appointment and work of the current Participation and Engagement[[5]](#footnote-6) Officer in the WBAPB. Beyond this, there is a meagre lack of activity and progress, which speaks to a historic culture and level of expectation.

We have experienced this first-hand through the challenges we have had as a Commission in identifying and supporting individuals with lived experience to support our work as Commission members. There is a dearth of any active peer-led community, which is a reflection on the historic inability of the local treatment system to inspire and consistently support individuals through to long-term recovery. We have vast experience within the Commission of recovery communities across other areas of the UK, so offer this criticism from a place of knowing what is possible. We would suggest that significant attention needs to be paid to this area and particularly learning from other areas.

Our engagement with the lived and living experience community has not been as strong as we would have liked or even expected. Our observation is that that when reaching out to speak to individuals with lived experience via services, that we were introduced to those who were ‘doing well’. Often, despite multiple requests, we were re-introduced to the same individuals which has left us with the impression that the cohort of those ‘doing well’ in their recovery is not big. We found it extremely challenging to find any connections with those who are currently not in service. Again, given our vast experience from elsewhere, we consider this to be a reflection on local services’ current deficits to identify and engage with this population.

Most people that we spoke to reported that they have never been asked for their views of services and how they should be developed. The most powerful message that we heard from people with lived and living experience is captured by the phrase, *‘****include us when it’s for us’***.

There are two other strong experiences that we are compelled to report. The first is where we have heard on multiple occasions the perception that for some individuals, **the justice pathway offers one of the quickest routes to receiving treatment**. The second is the honest reflection by many individuals that ***‘the nature of drugs are changing, but the services are not’***. We believe that this understanding from lived experience groups speaks volumes. They should be considered as a direct challenge to those responsible for the Transformation Programme, to listen to these experiences, and to then provide opportunities to further understand and act upon, as part of the Transformation Programme development over the coming years.

The plea from the numerous individuals who have generously shared their experiences with us over the last 18 months, is that they are seeking services that address the ‘why’ of drug use, rather than just the complications of use. We have heard a lot of ‘transactional’ service provision, rather than ‘transformational’ interactions (i.e. about the way individuals feel, and about what they do regarding purpose, meaningful activity, and even reasons to get out of bed in the morning). This goes way beyond the provision of a medication ‘script’.

### Families and communities (affected by)

The simple yet critical message that we need to report in this regard is that current services are not experienced by families and communities as utilising whole family approaches in their service design and delivery.

We have found little, and in some instances no, evidence of family members being included in services, either alongside their loved ones or by way of consultation over service design.

We did hear from several families their experiences of often being excluded from the 'treatment and support' service discussions about their loved ones. This appears to be consistent with a legacy understanding of providing an adult confidential service. Whilst such confidentiality, and need to access a service without others knowing, remains an important consideration for a number of individuals, in many instances families are the affective support and network ingredient that ensures individuals are engaging in treatment. By supporting such engagement there is a higher likelihood of success regarding a long-term sustainable passage of recovery. It feels important to emphasise that going forward, adult drug service providers need to consider how their models of practice should be far more attuned to a whole family inclusive approach, rather than just the traditional individual user appointment-based provision. This should also take the regard for providing family and carer support groups, including for those whose family member is not yet seeking engagement in treatment.

Given there is so little evidence to report in this area, we strongly urge all services and commissioners to prioritise this area going forward. A good starting point would be to review the set of strong messages contained within the following blog, and to strengthen the emerging plans within the Transformation Programme towards a foundation of whole family approaches for all future drug service provision across Western Bay.

In short, The Global Family Recovery Alliance is a voluntary global network of individuals and organisations that promotes a strengths-based approach to family recovery by applying the concept of recovery capital. The Alliance aims to build an evidence base for family recovery through measurement, testing, and the accumulation of strengths. It seeks to address gaps in recognition, funding, and research for family support groups globally. The focus is on fostering growth and hope for families affected by addiction. The full blog and further information can be found at the following link:

[Global Family Recovery Alliance: Launch of a strengths-based approach to family recovery](https://recoveryreview.blog/2024/07/11/global-family-recovery-alliance-launch-of-a-strengths-based-approach-to-family-recovery/)

### CYP (as individuals who experience problems with drugs themselves and as children of parents who experience problems with drugs) and Families

Whilst the focus of the Commission was on the experiences of adults (18+), we encountered a range of perspectives about two significant and overlapping considerations:

* The provision of drug services for young people who use, and experience problems with, drugs. This is a complex overlap as some young people's responsibilities and services can be defined as under 25, where other services refer to children as being specifically those under 18.
* The experiences of families, whether as those living with and supporting another individual who experiences problems with drug use, or the context of parental drug use and its impact on children, or the complexity of familial co-dependency.

This report notes the key messages we have heard about these matters rather than providing any detailed reporting on data collected.

Critically, and early into the Commission’s evidence collecting period, we encountered a matter of significant concern about the provision of services to those under 18 who were using drugs. The matter in question related to a young person accessing medical staff for clinical treatment and prescribing provision. It became evident that it was standard practice to require children/young people to attend adult services to access such support. This is inappropriate and a matter of significant child safeguarding concern. The Commission immediately raised this matter with both Directors of Social Services responsible for Western Bay. Following prompt intervention, we have been provided as a Commission with the reassurance that, going forward, local clinicians will see young people in appropriate (young people-based services, and their own homes, etc.) rather than locations than run the risk of exposing them to older adults who experience problems with drugs.

We did visit some local young people's services. Our main observation was that some of these services have an 'open door' approach. This is in stark contrast to our previous observations of there being no ‘open door’ within any adult drug service across Western Bay. We observed how the open-door nature of these young people’s services meant that they are more accessible, with less barriers to engagement.

Culturally, it is clear that in NPT the approach of Children Services, its significant success in reducing numbers of children on the child protection register, and those in Looked After Care, has been able to embed genuine systemic change and transformation. The elements of this have been described by the Head of Service as:

* Shift the culture.
* Develop a clear framework - genuinely co-produced with individuals and workforce.
* Have a clear philosophy/approach.
* Provide training, support and time.
* Strong leadership.
* Embed and use reflection.

This success also includes a significant investment in 'practice leaders' and 'consultant social workers', and time for staff to reflect on their practice. It would be worthwhile for the lessons learnt from this experience to be explored, understood, and translated into the fabric of adult drug services across Western Bay.

We did engage with a small number of 18–25-year-old young people who use drugs. They reported what is widely known and understood, i.e. that much of the generational cohort's use was that which is described as the excessive and normalised behaviour of adolescents and young adulthood. However, within this they identified a smaller minority who are using drugs in a more complex, regular, and dependent fashion. This was often linked to difficult experiences of family, trauma, and/or peer pressure of excluded lifestyles, including homelessness.

### Staff experiences

Across the course of our work, we have encountered lots of committed staff members. It is important to note, and a positive finding, that we have heard very little in terms of disgruntlement from those individuals engaged in drug treatment towards staff. Disgruntlement is something that we have been familiar with hearing in many other areas beyond Western Bay.

Interestingly, the experiences we have heard from the many staff that we have spoken to, resonate with the experiences we have heard from those with lived and living experience, mentioned earlier. The overwhelming experience shared has been one of not feeling included. Despite a sense of inclusion and purpose for those staff who have been involved in the Transformation Programme agenda to date, for those who have not been included there is a strong sense of feeling excluded – i.e. that the Transformation agenda is being done unto them, rather than with them.

In many of our conversations with staff, we have picked up a strong sense of ‘burn out’ amongst the workforce. There were also significant concerns raised about disparities in pay scales across Third Sector providers, where there were reports that *all the experience is leaving the room* within one particular provider due to the contracted service budget.

We have observed and heard about some good inter-agency working relationships but also some reports of strained relationships (both inter-agency and intra-agency), including at management levels. We have heard reports of a lack of training for staff across the sector but have been unable to corroborate with any certainty such reports. We would suggest that this needs further exploration. We have heard few reports of positive experiences or investment in professional development opportunities.

We have been left with a sense of a workforce that does not feel sufficiently invested in, appreciated, or equipped to respond fully to the changing complexity of presentations within services.

We have heard some emerging positive reports from staff regarding the Transformation Programme, but that only comes from the minority of staff who have been engaged in workshops run as part of the Transformation Programme. There is a need to take all staff on this journey.

### Core treatment service experiences

We have found that the map of services provided across Western Bay has a long historical footprint, a lot of which appears difficult to shake off. The breakdown of, and lack of, shared care approaches, services being known and referred to by past names (e.g. Adferiad being known and referred to as WCADA), the unique and historic commissioning arrangement with the PSALT service, an inconsistent footprint for Barod across NPT and Swansea, are a few obvious examples for us.

Services appear to be mainly centric to Swansea City Centre, Neath and Port Talbot despite the WBAPB being responsible for a much greater geography than this. We heard multiple reports of individuals having to travel long distances to access support and treatment (for example, from the Valleys or the Gower), often spending significant proportions of small budgets to do so. It is our suspicion that there are other individuals who choose, or are unable to, access services from living in non-centric areas of Western Bay. For example, we heard from one gentleman who was stable on his medication. He then had to switch to another service who wouldn’t prescribe what he had been on. This resorted in the individual using illicitly to get back into the first service and back onto his preferred prescription that had been working for him.

We have heard substantive reports from both service staff and those individuals who use drug services across Western Bay of the changing nature of drug use over time. As mentioned earlier, there is a sense that *‘the drugs are changing but the services are not’*. The core drug treatment service (CDAT) that receives the largest proportion of funding, by some distance, is still very much an opiate treatment service. There appears to have been little evolution in provision (over time) to effectively respond to the broad range of drugs currently being used across the region, with particular concern for individuals using combinations of substances including heroin, cocaine, and/or illicit benzodiazepines (MSJs), with the latter two featuring increasingly in drug-related deaths. There is a real sense for us of static service provision over time, rather than adaptive and responsive provision.

Waiting times across different services vary, especially when regard is given for difference between being first seen and assessed, as opposed to accessing preferred treatment. Regarding core CDAT substitute prescribing we heard direct reports from staff that waiting times are generally considered to be about 12 months for getting on treatment. When visiting one part of CDAT we were informed that the current waiting list of individuals requiring assessment for treatment was 108 individuals. There was a worrying normalisation of long waiting times, amongst both individuals using drugs and those providing services.

The obvious, straightforward, and honest reaction to these waiting times is one of concern. Evidence dictates that reducing the waiting time for individuals is likely to have protective qualities against the potential for drug-related death. When we heard from the Dundee Drugs Commission and the expert witness from Scotland regarding the national journey towards same day prescribing, through the implementation of national Medication Assisted Treatment Standards, we were encouraged that significantly quicker access to drug treatment is not only possible but also lifesaving. We were disheartened to hear from staff on the frontline in Western Bay a sense of acceptance and resignation to the current waiting times being the ‘norm’, with no hope that same day prescribing would even be a possibility. We would expect that commissioners and service planners do not accept this status quo.

The current situation speaks to the two matters that we consider are most critical in responding to the high levels of drug-related deaths. Firstly, the need for significantly **quicker access** into treatment. This is not just a capacity issue in any one service but needs to be looked through a whole-system lens. Opportunities for planned discharges, investment and adoption of shared care approaches, and a review of risk-averse approaches towards putting individuals on treatment quickly should all be considered as priority matters. Secondly, significant attention needs to be paid to the **culture** within and between existing services considering our findings regarding acceptance and resignation of the current state of play being the best that is currently possible. Leadership needs to focus on inspiring and motivating services to come together to demand better solutions. There feels like there has been little hope amongst most services and staff across treatment services that things can be better. The Transformation Programme is starting to address this, but our sense is that there is still a long way to go. Despite the work of the Transformation Programme, we have experienced drug treatment services to be mainly working in their own silos.

There has been, for many years, an over-reliance on appointment-based approaches across the region, which are generally put in place to meet service needs, rather than the needs of individuals who use services. There are also a few reports of, and even reluctance to engage in, outreach work. There is minimal provision of services outside of Monday-Friday office hours (9-5), whether from existing commissioned services or through supporting the development of peer-led recovery communities across the region.

### Diversity

The individuals we engaged with as a Commission, typically reflected those within current drug and alcohol provision across Wales. They were predominantly white, Welsh/British, with males significantly outnumbering females. We met with a smaller number of women who expressed some specific gender-sensitive issues. The Commission has considered these important issues, and they are reflected within **Recommendation 3** at the end of our report. As a consequence, we did not hear particularly about Black and Minority Ethnic Communities, or LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer, plus) communities. As such we have not provided a narrative on meeting their specific needs.

### Environment

We have already noted our observation that there is currently no open door for adults who experience problems with drugs to walk through and access support from drug treatment providers (without the need to face a locked door, buzzer entry system, and/or a glass partition to speak through). The development of a First Point of Contact approach across all services/area seems to reinforce the experience that it is not possible to walk in anywhere and ask for help. It continues to emphasise delivery in urban centres (Neath, Port Talbot or Swansea) as opposed to outlying areas (such as the Valleys or the Gower). Changing this should be an immediate priority.

Through our visits to all WBAPB-commissioned services across the region, we have been struck by the low quality and limited investment in appropriate and respectful premises. It doesn’t feel like investment in good quality premises that individuals would happily attend is any kind of priority. It should be noted that other areas/APBs and services within Wales, do operate much more open and welcoming door/environments and have continuously been successful in accessing SMAF capital funds to facilitate such. The difference that can be made through investment, innovation, and consideration of how to develop psychologically informed environments would go a long way to improving the experiences of both staff and individuals who engage with services.

Typically, across Wales total alcohol and drug monies spent, predominates in funding towards statutory and medical services, rather than third sector and or social orientated approaches. Consequently, service orientation reflects this. Western Bay is not any different in this regard. APB expenditure plans for 23-24/24-25 were shared with the Commission. These indicate an overall cost of service provision at approximately £8.5 million. Of this total at least £5.5 million is directly seen to be spent on Health Board, CDAT and prescribing related service provision.

# 8. our ANALYSIS AND INTERPRETATION OF THE KEY MESSAGES

## Introduction

Our work has been an in-depth review of how drug use affects the region and the support available to those who use drugs. The Commission has included local members, supported by experts from across Wales and the UK. Throughout our work, we have identified inadequacies and delays in local services and systems. However, we also heard from people and families who felt they had received the help they needed. Our recommendations are based on the experiences shared with us by people across Western Bay (an area covering both Neath Port Talbot and Swansea local authorities).

Over the past 18 months, we have gathered evidence from more than **250** individuals. This includes individuals with personal experience of problematic drug use, family members affected by drug use, members of the public, clinicians, GPs, staff working in drug treatment and support services, staff in broader health and social care services, senior officials from Neath Port Talbot Council, the South Wales Police and Crime Commissioner's Office, South Wales Police, Swansea Bay University Health Board, Swansea Council, local Third Sector organisations, academics, and politicians. It is not possible to be precise about the number of individuals who have given evidence as some of the evidence gathering methods used were anonymous. We are aware that many individuals have provided evidence on more than one occasion, with a smaller number providing evidence on multiple occasions. The number quoted (250) is a conservative estimate of the minimum number of individuals consulted.

Some individuals and families have told us in detail about the positive support they received and the strategies they used to recover from drug use. Others shared their loss and grief over the harm caused by drugs. We have also heard about the many challenges and barriers that people face when trying to get help, made worse by the stigma attached to drug problems. Staff working in these services have shared both their successes and their frustrations when things do not go as they should.

We have carefully reviewed a large amount of evidence, aiming to present a balanced view. We know that when an independent commission is set up, it often hears more about what isn’t working. However, we also made sure to listen to those with positive stories, whether about making changes to their drug use on their own, with help from others, or receiving the right support from local services. We believe this approach has given us a fair understanding of the real issues people face.

Deep into the compiling of our final report we met with the facilitators of the Swansea Poverty Truth Commission to compare themes and messages from our respective processes. This discussion highlighted many resonances across key considerations. Both Commission’s processes highlighted the importance of lived experience being heard meaningfully, and with authority and power. This requires the creation of accessible, inclusive spaces to amplify and include the voices of people with lived experience at every level. Further shared considerations were: the need for kindness and compassion; acknowledging the experiences of a highly pressurised and fatigued workforce; the need to emphasise relationship-based practice approaches; and systemic cultural change [[Online](https://www.scvs.org.uk/swansea-ptc)].

## Limitations of the Commission

It is important to recognise that, within the time and resource constraints facing the Commission[[6]](#footnote-7), we do not claim to have conducted a comprehensive review of all the research and evidence on responses to drug problems, nor have we been able to spend as much time as we would have liked talking to those who experience problems with drugs and their families, service providers, or residents of Western Bay.

Notwithstanding these limitations, the Commission has facilitated and witnessed many significant and far-reaching discussions concerning the nature and extent of the challenges faced and, most importantly, on what can be done to rapidly improve the situation. We have reached consensus on a set of recommendations that we believe could make a material difference to dealing more effectively with drug use related problems across Western Bay and, ultimately, result in reductions in the high number of drug-related deaths across the region. Some of our recommendations are aimed at local partners and leadership and some are aimed at national leadership.

## Our conclusions

We have been inspired by the experience of the Dundee Drugs Commission (2018-2022) who we have met with, and who have reported that drug death numbers have fallen on consecutive years in Dundee – from the peak of 72 deaths in 2019, to 57 in 2020, to 52 in 2021 and down to 38 in 2022 [[Online](https://dundeecity.gov.uk/performance-indicator/number-of-drugs-deaths)], albeit that the recently released numbers for 2023 have seen an increase (in line with a national increase across Scotland) to 46 [[Online](https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/drug-related-deaths-in-scotland/2023)]. The recent downward trend in Dundee (2019-2022) was more marked that any other local authority area in Scotland, where more than one in five of all areas were still experiencing increases across this period [[Online](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.nrscotland.gov.uk%2Ffiles%2F%2Fstatistics%2Fdrug-related-deaths%2F22%2Fdrug-related-deaths-22-data.xlsx&wdOrigin=BROWSELINK)].

We have remained convinced, ever since meeting with the Dundee Commission, that there are significant lessons to be learned from the significant advances that have been made across Scotland in recent years, particularly with the introduction of the national Medication Assisted Treatment [MAT] Standards [[Online](https://www.gov.scot/publications/medication-assisted-treatment-mat-standards-scotland-access-choice-support/)] and the accountability being demanded by Scottish Government of all Health Board and Local Authority areas towards full compliance with the MAT Standards. For example, there have been significant moves towards same day prescribing which have involved extensive efforts, innovations, and critically, risk acceptance (rather than risk aversion) towards removing barriers and speeding up access to treatment. The message from Scotland is that it can be done, albeit that it takes time, strong and expert leadership, and a set of ambitious national standards to raise the bar for accountability of services. The drive towards same day prescribing across Scotland is in stark contrast to the lengthy waiting time targets that are set in Wales, and which appear to be accepted as the norm on the frontline of the drug treatment services we have engaged with.

Wales has a set of ‘*National Core Standards for Substance Misuse Services in Wales’* but these were issued in 2010 [[Online](https://www.gov.wales/sites/default/files/publications/2019-02/national-core-standards-for-substance-misuse-services-in-wales.pdf)]. Similarly, many of the elements of the ‘*Substance Misuse Treatment Framework’* are over a decade old and in need of updating, including the 2011 ‘Guidance for Evidence Based Community Prescribing in the Treatment of Substance Misuse’. Subsequent reviews have all highlighted the need for this updating and improvement in service provision [[Online](https://www.hiw.org.uk/sites/default/files/2019-06/180725smen.pdf)] [[Online](https://www.gov.wales/sites/default/files/statistics-and-research/2019-06/180419-review-working-together-reduce-harm-en.pdf)].

The recently reported increases across Scotland are a reminder that this is not a simple problem to be easily fixed, and that despite extensive efforts and additional resources through an additional investment of £250m over five years through the Scottish Government’s National Mission on Drugs (2021-2026) [[Online](https://www.gov.scot/policies/alcohol-and-drugs/national-mission/)], that the challenge of reducing drug-related deaths demands a long-term plan.

The local political interest and support for the Commission has been significant from the beginning. Without it, the Commission would never have been instigated in Western Bay. The time is now right to hand back the evidence and findings of our work to elected leaders and ask them to set the standard for the leadership and accountability that is going to be required across Western Bay to turn the tide and help steer a new course towards hope and recovery.

We want to acknowledge the political weight of drug-related death data. At the outset of the Commission’s journey, the working assumption was that Western Bay is an outlier in Wales regarding high rates of drug-related deaths. As discussed in this report, it has not been possible to confirm whether Western Bay is in fact an outlier, or whether there are issues of underreporting in other areas. This initial assumption had to be challenged and reframed to a more accurate position of acknowledging that Western Bay has a significant problem, without making comparisons with other areas regarding data. However, we want to emphasise that if it becomes proven or known that Western Bay is being inaccurately identified as an outlier, then it could lead to further defensive political postures rather than constructive dialogue about the underlying issues. This would only serve to distract the necessary dialogue and add to delays to implementing the changes demanded in this report.

As a Commission we broadly welcome the aspirations inherent in the plans of the WBAPB in pursuing its Transformation Programme. There is a plan with substantial efforts and resources being invested. We also want to pay special mention to those working in the sector across Western Bay. As mentioned earlier we have observed and heard genuine passion and commitment to the cause. Despite the restrictive and rigid historical system in Western Bay, we have heard how staff have navigated the systemic barriers faced in order to focus on the needs and potential of those individuals they work with. Where we have discussed and offered critique in this report of historic service provision, it is not intended as personal criticism of any individuals, and our hope is that it will not be interpreted as such. In the main, we have experienced a workforce who are as keen as anybody to see improvements and ultimately to experience a turning of the tide in relation to the traumatic loss and grief of the harms and deaths associated with problematic drug use. We hope that leaders will prioritise and invest in the needs of the workforce and have made specific recommendations in the next chapter in this regard.

Despite these positives, it would be remiss of us to not speak honestly and transparently about the inadequacies of the past, to focus attention on better long-term solutions.

Our main observation is that people in Western Bay who experience problems with drugs have been swimming in a disjointed system that struggles to meet their needs. This is because of cultural paralysis, and a lack of service provision reflecting changes in the nature of drug use and increasing complexity of individual presentations. We have used the analogy of swimming because we have heard many accounts of the efforts that individuals have had to put in to just tread water. They have described how their circumstances have led them to use drugs as a means of self-medication to cope with trauma and numb their pain. These stories give a clear impression of people being overwhelmed by waves of despair, with the pull of drug use and traumatic life circumstances being too strong to resist being pulled under the waves.

Many people have told us that the treatment they need has not been readily available at the time that it is most needed, including lengthy waiting lists and lack of support outside of office hours. Past approaches to delivering these services have felt transactional rather than transformational. Local leaders recognise that making real, positive, and impactive change is currently an aspiration rather than a reality. For this reason, we have purposely chosen the title of our report, *Turning the Tide*, to highlight the scale of the challenge ahead.

Despite the limitations of available lived experience and/or peer support networks, the story that we did hear is all wrapped up around the phrase that we have heard from those people we have spoken to, that ***‘the drugs are changing but the services are not’***. Although, through the course of our work, we have started to see the green shoots of change in service provision because of the developing Transformation Programme, these changes are yet to be felt and experienced by those who need the change most. The changes are not yet able to demonstrate the protective qualities of service provision that will be required to evidence long-term reductions in drug-related deaths and harms.

The expressed urgency (instigated by the 2019 ‘critical incident’) and the scale of the challenge have largely been met over the last five years with reconfiguration and restructuring of existing resources and responses, rather than the transformation that is aspired to and desperately needed. We acknowledge that it will take time for the benefits of the Transformation Programme to be realised. So, despite our critique of the slow pace of change over the last five years, we want to throw our support behind the direction of travel outlined in the Transformation Programme. However, we also want to keep reminding everyone not to rest on their laurels with the evolving Transformation Programme. The lesson that experience across Western Bay demands is that reconfiguration is not transformation. We offer a note of caution that there is a danger of the Transformation Programme being yet another siloed response. What we mean by this is being careful not to fall into the trap of trying to bring transformation only within the confines of the drug and alcohol sector, rather than the whole system. We believe that WBAPB cannot bring the change that’s needed in its own right due to the dominant issues of housing insecurity/homelessness and mental health that we have documented and reflected upon within this report. Partners of the WBAPB must be vigilant to avoid the blame game but rather need to put organisational agendas to one side in order to wholeheartedly commit to the transformation agenda that needs to go well beyond the drug and alcohol treatment sector.

The WBAPB need to be careful not to be too led by the power of the notion of an Alliance commissioning approach (one of the five key points of the Transformation Programme). At its core the Alliance model is about a new way of commissioning, rather than leading on the cultural change that is needed if real transformation is to occur. There needs to be a substantive shift from a dominance on commissioning processes to cultural (language, philosophy, ethos, values, beliefs, norms, communication practices and processes) change. This will require some transformational leadership, which will require facilitated conversations around cultural change at a senior level. We offer the observation that the WBAPB need to take all communities, families, individuals and staff on the transformation journey with them, and that to date, only a small proportion of staff appear to be on that journey.

# 9. our recommendations for next steps

## Introduction

We do not hide from the fact that the recommendations detailed below are going to be challenging to implement, and will also require dedicated, consistent, and distributed leadership over many years. This will require an honest and transparent acknowledgment of the shortcomings that have taken place in the delivery of drug treatment services (in a ‘no-blame’ environment), and the willingness and determination to learn and exploit the lessons that are evident from these failings. We have already experienced the beginning of this journey through the leadership and oversight of the Transformation Programme Board.

We have scrutinised and discussed the evidence that has been received by the Commission over the last 18 months, and have also looked for examples of best practice from elsewhere to:

1. Identify immediate steps that can be taken to start improving the situation; and
2. Begin a longer-term journey to realising a vision for a high-quality system of treatment and care for some of our most vulnerable citizens who deserve better.

We also recognise that some of the required changes are not solely within the gift of the Western Bay Area Planning Board and its partner organisations. This is why a series of ‘national considerations’ are also offered below. We sincerely hope that these will be responded to by the Welsh Government, Public Health Wales, and the UK Government because many of the levers for change in the local systems are held outside of local control. The changes we are recommending will require a renewed determination to work more effectively across local, regional, and national structures to deliver them. Our insight of best practice from other countries would, similarly, require changes in national policy and legislation and systems/practices to allow Western Bay (an area covering both Neath Port Talbot and Swansea local authorities) to implement fully the changes that are required.

The changes proposed in these recommendations are based on five key sources of information:

1. People across Western Bay including people who experience problems with drugs, their families, friends and our wider community.
2. Professionals who work in Western Bay.
3. Experts from across Wales.
4. Members of the Dundee Drugs Commission and other non-Welsh experts; and
5. International research evidence and best practice guidance.

In total, **twelve** different evidence sources were used across the above groups (which are detailed in **Chapter** **5** of this report as well as in **Appendices II-IX** in the **Part 2** report).

## Our recommendations for local partners

The following are our primary set of **twenty-four ‘headline’ recommendations** that we believe are within the abilities of the Western Bay APB and all constituent partner leaders/agencies to progress. Underneath each headline recommendation we provide further details of what will be required to see each recommendation fulfilled. This level of detail should be considered as a secondary set of sub-recommendations and should be factored into a resultant action plan for Western Bay APB following receipt of the report.

The recommendations are grouped under the following three headings:

1. People’s lives (outcomes and impact)
2. Principles (values and culture); and
3. Practices and processes (configuration).

The order of these groupings is purposeful.

We start with **people’s lives** as it is all those who are affected by their own (or someone else’s) drug use that has been at the forefront of all our deliberations. Our findings have led us to consider how the efforts to reduce the harms associated with drug use can deliver improved outcomes and long-term positive impact for all those affected. Keeping people’s lives at the forefront of all future decisions should be everyone’s ambition.

Secondly, we outline a set of **principles** that need to be considered by senior leaders to enable the prioritisation of healthy values across the drug and alcohol service sector. By so doing, we firmly believe that the cultural change needed to deliver the aspirations for improvements in people’s lives, can be achieved.

Finally, we outline a set of recommendations focused around improving **practices and processes**. Usually, this is the area that receives primary attention and resourcing. We have purposely placed these last as we would encourage all stakeholders to prioritise people’s lives and the cultural considerations in the first instance. Only by doing so will the genuine aspirations of the Transformation Programme lead to real long-term changes, well beyond the lifespan of the Transformation Programme, and ultimately reductions in drug-related deaths and harms.

With this in mind, at the end of this chapter, we also offer **two final recommendations** that should be considered in order to provide the necessary commitment and impetus for meaningful long-term improvements.

In between the headline set of recommendations and the final two recommendations are a set of **considerations for the Welsh Government**. We have already indicated that our recommendations are focused on the areas that we believe are within the gift of local leaders and agencies to act upon. As also stated above, there are some critical areas that we believe are outside the gift of local leaders and agencies, and which will require support and consideration by the Welsh Government (and subsequently other national bodies such as Public Health Wales).

Many of the recommendations appear at a high level and it could be argued that they can equally be applied to substance use services anywhere in the UK, and at any point in the past two decades. This is deliberate and suggests for us two things:

* 1. Where Western Bay is not unique, it is seeing some of the acutest problems and thus has a greater urgency in needing to respond to such recommendations.
  2. It is not for the Commission to prescribe a ‘how to’ for local partners, rather than a ‘what needs doing’. To be successful, the final plan and solutions must be internal and locally co-produced and not externally dictated.

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| **A. PEOPLE’S LIVES (OUTCOMES AND IMPACT)** |

This first suite of recommendations **(1-8)** is concerned with a wider understanding of the causes and effects of drug use to inform a truly holistic response to one of the most vulnerable, stigmatised and marginalised groups across Western Bay.

**Recommendation 1: Design and development of a treatment (whole) system that supports harm reduction through to recovery.**

Whilst recognising that the evolving Transformation Programme is already starting to build the foundations for a healthy and nurturing system of treatment and support across Western Bay for individuals affected by drug use, it is an important starting point in our recommendations to highlight the elements that we believe need to be present in any new (whole) system.

* First and foremost, WBAPB must ensure a continual focus is given to developing person-led provision, and not service-led, in regard to the goals of the individual. This should include burying the historical tension between harm reduction, maintenance, and abstinence philosophies by acknowledging that all philosophies sit on a full and healthy spectrum of provision.
* The WBAPB’s Transformation Programme needs to readdress the balance from an historic narrow, medical-led, NHS adult-based treatment system to a whole system. There needs to be a shift away from the narrow OST, resource intensive/dominant, system to account for the fast-changing nature of drug use. Specific regard should be given for significant development of psychological interventions.
* Primary focus should be given to a move away from the traditional office-based appointments and focus more on assertive outreach and drop-ins. These services should be available in hub-based, multi-disciplinary settings and extend beyond the usual urban-centric, 9-5, Monday-Friday schedule. WBAPB needs to ensure access across the entire Western Bay area, including satellite locations.
* Given our finding that there is currently no drug service in Western Bay where an adult experiencing problems with drug use can just walk through an open door and be seen, there needs to be literal open access to services.
* Post-treatment support (i.e. recovery) needs greater attention. This should focus on supporting individuals towards their outcome goals rather than merely treatment completion or medical interventions.
* There needs to be better regard (age-nuanced) for the needs of the 18–25-year-old group in line with the recently published (2024) ‘Substance misuse treatment framework for children and young people’ [[Online](https://www.gov.wales/sites/default/files/pdf-versions/2024/7/1/1720449607/substance-misuse-treatment-framework-children-and-young-people-integrated-impact-assessment.pdf)] by The Welsh Government.
* The role of Primary Care (GPs, Pharmacists, and others) needs to be reviewed and enhanced/improved.

**Recommendation 2: Address mental wellbeing and housing in the same space and at the same time as drug treatment.**

The Commission has heard numerous accounts during its evidence gathering that mental wellbeing and housing issues/insecurity are the dominant problems that individuals are struggling with, and from their perspective are a large part of the reason why they end up using drugs problematically. With this in mind, the WBAPB should ensure that drug services across the area are working directly with the needs of individuals by being closely aligned to local mental health and housing providers.

Our evidence highlights the importance of recognising the role of frontline housing providers in supporting people who may or may not be using drug treatment services. Housing providers need to be more involved in the decision-making and planning of drug services.

Narrow terms like ‘severe and enduring dual diagnosis’ should be avoided. Instead, there need to be a focus on addressing the broad mental health needs of most people using drug services including the experience and contribution of trauma, whilst recognising the challenges that are faced by mental health services in meeting demand.

**Recommendation 3: Ensure that the needs of women who experience problems with drugs are assessed and addressed via adoption of gender-mainstreaming and gender-sensitive approaches to service planning.**

The Commission recommends that the WBAPB considers the specific unmet needs of women across Western Bay who experience problems with drugs. Regard should be given for the likely more substantive issues (e.g. trauma, victim, family/carer demands) and consideration should also be given to the different experience for a lot of women regarding existing waiting room areas and groupwork practices for women. Critically, prioritisation should be given to an expansion of more timeous counselling provision for women.

Research undertaken in Scotland by Tweed et al. (2018) [[Online](https://www.gov.scot/binaries/content/documents/govscot/publications/research-and-analysis/2018/06/drug-related-deaths-women-increasing-scotland-9781787810129/documents/00537548-pdf/00537548-pdf/govscot%3Adocument/00537548.pdf)] on women and drugs related deaths suggests that women might need different approaches or types of services to address their specific needs and associated potential risks and harms. The report states that, on the evidence gathered by their scoping review, women who use drugs are likely to be particularly affected by the adverse impacts of welfare reform and public sector austerity measures and that such changes “may interact with other risk factors such as abusive or coercive relationships, commercial sex work, experiences of trauma, mental health issues, and changes in drug treatment services” (page 4). Other review informants highlighted the potential role of poor drug treatment practices and insufficient throughcare support for women in the criminal justice system. These are areas that resonate with the limited evidence that the Commission has gathered. Drawing on the scoping report’s practice and policy recommendations, the Commission recommends that the WBAPB recognises: the commonalities between men and women who use drugs as well as the differences; the diversity of experiences within genders; and the intersections between gender and other axes of inequality, such as deprivation.

Our view is therefore that the Partnership should take cognisance of this far-reaching report that explores both women’s potential particular risks and the gender-sensitive recommendations for policy and practice therein.

**Recommendation 4: Commitment to equal and reciprocal partnerships with all those affected by their own or someone else’s drug use.**

Peer-led, advocacy, and mutual aid groups, as well as Recovery Communities, must be resourced effectively to build capacity for people who use services and peers to become partners in care. They must also be valued in an equal and reciprocal partnership. This is one of the most effective ways to address power imbalances that create service-led rather than people- or beneficiary-led care. Resources should be redirected into rebalancing the sector to support more community-based provision. This will increase choice and enable all those who require services and support to exercise their rights. Specifically, focus should be given to:

* Greater development of lived and living experience involvement in harm reduction provision (needle exchange, naloxone, outreach).
* Support to develop, resource, and nurture (independent) peer-led recovery communities.
* Development and design of a Whole Family Approach that is preventative in nature and not crisis led. This should include:
  + co-ordinated, holistic services aimed at children, young people, their parents/carers and their wider family, all of whom are likely to have been affected by drug use as well as a range of other difficulties; and
  + working with families – as individuals and as a collective, planning alongside families in the same way – all underpinned by a clear belief in the possibility of change in order for difficulties to be overcome and recovery attained.
* Greater regard for developing specialist advocacy provision for individuals and families affected by their own or someone else’s drug use.
* Greater levels of information sharing between services, ensuring protocols are enablers to this rather than barriers.

**Recommendation 5: The WBAPB should ensure that there are genuine outcome-based evaluation approaches embedded within and through the Transformation Programme.**

If individuals are only being supported to achieve treatment outputs, rather than recovery outcomes, then the historic revolving-door of service provision that we have heard about will continue. The WBAPB and all partners should recognise and understand that impact can only be demonstrated through long-term, longitudinal research and evaluation that extends well ‘beyond treatment’. The focus within the Transformation Programme must be on genuine outcomes and not simply output-based, and an independent learning partner should be considered to design and deliver an appropriate evaluation framework.

**Recommendation 6: The WBAPB and all partners should attend to the intergenerational nature of drug use problems and place the safety and wellbeing of children at the heart of all planning, alongside proactive support for parents.**

The WBAPB should explore the possibility of creating family support worker roles within the Transformation Programme. Such roles would focus on providing support ahead of families reaching crisis point and requiring social work intervention. In practice this would mean providing support to prevent individuals/families requiring intervention by an Intensive Family Support Service.

The WPAPB should ensure that all drug service provision for under 18’s takes place away from adult services and in age-appropriate settings.

**Recommendation 7: Respond to the root causes of drug use.**

The root causes of drug use are widely understood and evidenced as including: poverty, trauma, violence, neglect in childhood and adulthood, incarceration and criminalisation, stigma towards people who experience problems with drugs, drug and health policies that exclude rather than include, and lack of access to effective and high-quality treatment and support [[Online](http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/scottish-affairs-committee/problem-drug-use-in-scotland/written/100340.html)]. Greater acknowledgement of these root causes is required.

Studies are increasingly identifying the importance of early life experiences to people's health throughout the life course. Individuals who have adverse childhood experiences (ACEs), during childhood or adolescence, tend to have more physical and mental health problems as adults than do those who do not have ACEs, and ultimately greater premature mortality.[[7]](#footnote-8) ACEs include harms that affect children directly (e.g. abuse and neglect) and indirectly through their living environments (e.g. parental conflict, substance use, or mental illness).

The Commission has heard detailed accounts of second and even third generation families across Western Bay who are affected by a loved one’s problematic drug use – all of whom have devastating stories which highlight the root causes of drug problems being about the issues above rather than the drugs themselves. Drugs should not be looked at in isolation of the reasons why people can use them to the point of becoming dependent upon them. Most drug use does not lead to problems or dependence.

The Commission would like to stress the importance of enhancing the provision of employability, education, training, and volunteering opportunities, to address the boredom, social isolation, and lack of opportunities that many encounter when attempting to reduce or cease drug use [[Online](https://www.gov.scot/publications/drug-related-deaths-women-increasing-scotland-9781787810129/pages/8/)].

Given the high prevalence of drug deaths occurring for those who live in areas of higher deprivation, it is imperative that the work of the Swansea Poverty Truth Commission and the anti-poverty team in Neath Port Talbot is joined up and considered when putting action plans together to tackle the recommendations in this report. Consideration should be given to the availability of food and clothing supplies, reimbursing transport costs to attend treatment, as well as the needs of those who require childcare to be able to attend treatment (i.e. all of which are barriers to accessing treatment support). Many of these issues are the everyday reality for those currently accessing treatment services across Western Bay and they should not be ignored or just merely dealt with through signposting.

Approaches should be considered that address the role of social inequalities in health outcomes, rather than just a narrow provision of medical-based drug treatment approaches. This should include, but not limited to, more active work with people on debt management, managing budgets/benefits, education/employment opportunities, etc.). This should not be seen as just the remit of the WBAPB to deliver on, as this sits within the wider health and social care partnership remit.

**Recommendation 8: Meeting people where they are at. Seeing people for the problems they experience rather than those they might cause.**

Drug use is not the fundamental problem. Drugs are, for many people, a logical coping mechanism with the ability to numb the pain and trauma of life and social circumstances. The Transformation Programme brings an opportunity to frame and develop the local drug treatment system in a completely different way, taking account of the social and economic determinants of health (see **Recommendation 13** below). The challenge is to design a new system that is wholly person-centred rather than a system that is shaped and dominated by the needs of services, over and above the needs of those who require the help and support on offer from services.

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| **B. PRINCIPLES (VALUES AND CULTURE)** |

This second suite of recommendations **(9-17)** is focused on the need for cultural change across drug treatment services, related disciplines and communities of Western Bay, and changes in local systems that will help facilitate such cultural change.

**Recommendation 9: The Western Bay APB Partners must consider their leadership role and work together to develop a set of leadership standards which they will use to support the full implementation of this suite of recommendations.**

Leadership, accountability and governance should be prioritised as an immediate priority, as this will take the greatest effort and change to improve. Drug deaths are not inevitable and are absolutely preventable. This is a message that needs to be driven home from the top of all public organisations across Western Bay.

Leadership needs to mean taking clear responsibility for the problem and putting in place a dynamic, responsive, cohesive plan to address the harms created by drug use, as well as a transparent framework of accountability for the action that is required to reduce drug-related deaths across Western Bay. A ‘whole system’ approach needs to be taken, inclusive of people who use (and have used) drugs, family members and local community responses. The Transformation Programme being led by the WBAPB is demonstrating early signs that the foundations for a health whole system approach is being prioritised, and this work should continue.

The litmus test of whether the recommendations within this report are being met will be that agreed changes are owned and supported by all statutory and third sector services, recovery communities, service users and families. Equally, a positive sign will be that the WBAPB are not being solely relied upon to deliver on the whole agenda.

Leaders across the WBAPB and partner organisations need to ensure there is coordination of activities by avoiding unilateral commissioning, decision-making and service provision that contradicts partnership ambitions.

**Recommendation 10: Ensuring accountability and provision of dedicated and distributed senior leadership across all partners (organisational and not individual representation across partners).**

Senior leadership needs to be strong and distributed, along with themes of accountability, which should be mutual at times of trouble. This will help to ensure that leadership is shared appropriately and not role or individual dependent. The Chief Officers are accountable, but they must work in an environment that places clear roles and responsibilities on them. Political leadership is important and so is listening leadership – and there was plenty that the Commission heard that shows that leaders have not been sufficiently connected with people who experience problems with drugs and affected families.

We believe that ‘civic’ leadership is required here, including: political leadership (which is connected with local and national (Welsh, UK) elected leaders, who are in a position to take action); and Chief Officer leadership (which is mutually accountable, strongly bonded and clear about the key priorities and the action that is required).

The WBAPB should recognise and embrace the forthcoming opportunity for cultural change with new executive leaders incoming.

**Recommendation 11: Learning from the things that have gone wrong with attention to continuous improvement to benefit others who are vulnerable and also including learning from elsewhere.**

Progress and success are only possible when mistakes are confronted rather than reframing the evidence to avoid having to change deeply held beliefs. Too many people have lost their lives to drug use across Western Bay and the local leaders must continue to act swiftly to learn the necessary lessons and take significant action to turn the tide of this situation.

Willingness to own and share mistakes is a critical part of the cultural change that is required to be able to learn, adapt and evolve. For example, the development of the StEPS programme of prescribing service redesign without shared care being included was a significant error. This has been brought back into consideration as part of the Transformation Programme, but this kind of mistake needs to be learned from and avoided in future.

The vision for a high-quality and person-centred treatment and support system across Western Bay needs to be built upon a set of agreed principles. These principles, as a minimum, should include (but not be limited to):

* agreement to a no-blame and solution-focused culture;
* agreement to confront past mistakes with a progressive attitude;
* agreement to take a bottom-up approach to discussions, consultations and decision-making; and
* agreement to include all relevant parties.

Consideration should be given to learning from across Wales (and beyond) regarding responses to reducing drug deaths as well as efforts to improve the quality of services and inclusion of whole family approaches, in both drug service systems and other sectors. In particular, we would like to highlight the significant benefits of work undertaken across NPT in relation to children and young people (see section on Children and Young People, page 33), as well as the advances made in Cardiff and the Vale in relation to shared care arrangements for treatment of problematic drug use with primary care services. Additionally, we would signpost to the wealth of learning that has been gleaned and evidenced across Scotland over recent years in relation to the national Drug Deaths Taskforce [[Online](https://drugstaskforce.knowthescore.info/)] and the Scottish Government’s National Mission on Drugs [[Online](https://www.gov.scot/policies/alcohol-and-drugs/national-mission/)].

**Recommendation 12: Developing a culture of ‘openness and inclusivity’.**

One of the biggest opportunities for the WBAPB is to wholeheartedly focus on creating the culture, system and relationships that it will need to be able to learn from errors rather than be threatened by them. For example, acknowledging the unacceptable numbers of drug deaths rather than being apprehensive of potential press headlines. Instigating proactive communications on what is being done to address the issues and any successes going forward should be prioritised.

If this opportunity is grasped it will be characterised by a culture of ‘openness and inclusivity’ and will be evidenced by an equal and reciprocal ownership of all stakeholders’ expertise and perspectives (i.e. all statutory and third sector services, recovery communities, service users and families). Narrow and dominant discourses will need to be avoided.

Greater transparency regarding all partner budgets will also be evidence of the level of openness that we consider necessary (see also **Recommendation 18** below).

**Recommendation 13: Adopt an economic and social determinants approach.**

Future planning of the WBAPB and partner organisations need to recognise the role of health inequalities in drug deaths and harms, whether by gender, age, minority, postcode, economics, neurodivergence, etc. Greater understanding of drug use as a logical solution to the situations people find themselves in will be required to fully adopt a wider determinants approach. Consideration needs to be given to the role of local strategic planning upon health outcomes, including drug use, (i.e. transport, location of pharmacy/health centres, density of fast-food outlets, licensing arrangements, housing provision, etc.).

**Recommendation 14: Understanding the importance of primary rather than purely secondary care in meeting individuals’ needs.**

Individuals who are using drugs have a vast array of everyday primary care needs that need to be met, but who have currently been excluded from provision due to their drug use. This situation needs urgent change, with individuals being treated as ‘whole patients’ rather than ‘people who use drugs’.

**Recommendation 15: Challenge and eliminate stigma and discrimination towards people who experience problems with drugs, and their families, across Western Bay to ensure that everyone is treated in a professional and respectful manner.**

Stigma comes in all shapes and guises. The Commission has heard countless stories and experiences where those affected by drug use and their families have been stigmatised in the forms of labelling, stereotyping, social rejection, and exclusion, as well as the internalisation of negative attitudes in the form of shame by the person/family being discredited. Stigma can also be keenly felt when using services with poor quality physical environments, such as buildings that are not fit for purpose, or buildings that are unwelcoming due to barriers such buzzer entry doors. A review of accommodation used for drug treatment services should be conducted as a matter of priority. The review should have the key aim of finding creative solutions to developing more appropriate accommodation and spaces across Western Bay, where negativity towards people who use drugs and stigma is challenged and addressed, so that individuals attending feel safe and respected. The review should be conducted in full partnership with those who use services to fully understand their experiences and ideas of how the right type of space and environment can aid treatment. We would hope that this could contribute towards improved and increased engagement of people in need, and ideally also retention in services.

The WBAPB should take responsibility for developing proactive campaigns and messaging for challenging stigma across the communities of Western Bay. All too often, this has been picked up by the Third sector and not the Statutory sector, and all partner organisations need to evidence some leadership and planning. The principles of the ‘Inclusive Cities’ concept and project [[Online](https://www.inclusivecities.info/)] are of particular interest in this regard.

As part of this, the Commission would like to see the values of kindness and compassion take centre stage in improving the experiences of people who experience problems with drugs and their families across Western Bay. A positive step forward would be for all services to be tasked by WBAPB with developing a plan (within six months) for tackling stigma and discrimination based on these core values. Each plan should be developed from the bottom-up and be conducted in equal partnership with those who use each service. Evidence of ‘how’ the plan is produced in such a partnership should be included in the submissions to the WBAPB. Each plan should have an in-built mechanism for review, which should focus on ‘lessons learned’ and ‘progress made’. Service providers should share their plans with each other to encourage joint learning and encourage working together.

Further to Recommendation 14 above, people should not be barred, or refused access to services, because of their drug use status. Additionally, the practice of excluding those with mental health symptoms or diagnosis by way of referring to Community Mental Health Teams, rather than responding to the presenting alcohol or drug need, must be addressed and stopped.

**Recommendation 16: Language matters. WBAPB should develop an accessible ‘language’ guide to promote inclusivity alongside compassionate and non-stigmatising attitudes and conversations.**

People who experience problems with drugs, and their friends and families, are part of our communities and it is critical that they are made to feel like they are. Language used to talk about drugs, drugs deaths and harms, and people whose lives are directly impacted by drugs, both in and out of formal public services, needs to change to be compassionate and non-stigmatising. We have heard a significant amount of evidence of this group feeling ‘othered’ (i.e. ‘you’re not the same as the rest of us’).

The Global Commission on Drugs Policy’s 2017 report is clear that the language used to talk about drug use creates a myriad of additional harms. We recommend that the words ‘addict’, ‘abuse’, ‘junkie’, ‘misuse’, ‘dirty’ and ‘clean’ are not used, and that the WBAPB creates an accessible guide to appropriate language use for the area based on the Global Drugs Commission report and other resources, such as the excellent ‘Moving beyond *people-first* language’ guide developed by the Scottish Drugs Forum [[Online](https://sdf.org.uk/wp-content/uploads/2024/05/Moving-Beyond-People-First-Language-A-glossary-of-contested-terms-in-substance-use.pdf)] and the ‘Language Matters’ leaflet developed by the Network of Alcohol and other Drugs Agencies (NADA) in Australia [[Online](https://www.nada.org.au/wp-content/uploads/2021/01/language_matters_-_online_-_final.pdf)].

Specifically, there are a couple of terms which we believe should be explored within the development of a language guide – ‘drug death’ and ‘DNA’ (Did Not Attend).

Firstly, the use of the term ‘drug death’ implies that it is only the drug itself which causes death, rather than sufficient emphasis being place upon the myriads of other factors, such as isolation, ignorance, poverty, lack of ability to test drugs, no-one to turn to, no out-of-hours help, etc. Inappropriate and unhelpful language can clearly compound stigma. On the other hand, by addressing it and developing understanding and literacy of the meaning of key words and phrases, stigma can be reduced.

Secondly, careful consideration should be given to the use of the term DNA (Did Not Attend) as this fails to account properly for those individuals who are either:

* unable to attend (for example, due to the time of day not being compatible with an individual’s hours of employment, or due to restrictions of travel arrangements when having to travel some distance into town/city centres from outlying areas); or
* those who choose not to attend (for example, because they are not happy with the level of service being provided).

**Recommendation 17: Nurturing (equal and reciprocal) partnerships of all stakeholders and ensuring active and inclusive engagement from all partners.**

Similar to the ethos of **Recommendation 4**, we have concluded that the nature of partnership working over recent times has not been up-to-standard, and that a new focus on nurturing equal and reciprocal partnerships of all stakeholders is required. We also believe that the evolving Transformation Programme has the ambition and potential to achieve the level of healthy partnerships that we would envisage.

A simple and cost-effective ‘quick win’ would be to instigate a programme of networking where the WBAPB supports providers to release staff to attend networking opportunities. The value of relationships and connections should never be underestimated and some investment in networking for frontline staff would pay dividends regarding staff inclusivity as well as smoother pathways for individuals moving between services.

Future partnerships need to include meaningful, substantive, and sustained involvement of, and co-production with, people who experience problems with drugs, their families and advocates, across all aspects of policy, practice, and research within Western Bay (including consistent participation of lived experience in WBAPB structures).

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| **C. PRACTICES AND PROCESSES (CONFIGURATION)** |

The third suite of recommendations **(18-24)** is concerned with the provision of drug treatment and support services across Western Bay. An analysis of the balance of evidence provided to the Commission tells a compelling story of a system that has not been fit-for-purpose over many years.

**Recommendation 18: Delivering on the ambition of transformation (whole system).**

We have noted, and welcome, the ambition of the WBAPB’s transformation programme. Having heard the aspiration of the responsible leaders for transformation it is now important to ensure that the WBAPB is able to move beyond aspiration to delivery of the programme. There are a number of elements that we would encourage the WBAPB commit to in order to ensure successful delivery of the Transformation Programme:

* The patterns of reconfiguring contracts and re-commissioning based upon historic arrangements needs to cease. We acknowledge that this is the core tenet of the new Alliance-based approach to commissioning that the Transformation Programme is based on so we are optimistic that this will be achieved with successful delivery of the new Alliance contract.
* Reframe all drug use services, ensuring Health and OPCC provision is an integral and committed part of the Transformation Programme (i.e. more than a reconfiguration of SMAF funding).
* CDAT need to have a Lead Clinician who is then enabled to work closely with the WBAPB.
* Commitment to, and delivery of, a fully shared budget.
* Given that alcohol is the primary drug of presentation, equitable recognition, resource and attention needs to be given to alcohol treatment provision within the Alliance contract and the Transformation Programme.
* Consistent with the Recommendations in **Section B** above, all partners need to ensure that the Transformation Programme is not a siloed response (i.e. focused on drugs and alcohol only without recognition of the wider issues, and particularly the dominating issues of housing insecurity/homelessness and mental wellbeing).

**Recommendation 19: Ensure that the Transformation Programme feeds into the long-term planning and provision that will prioritise access, retention, quality of care and the safety of those using services, in line with the evidence base.**

The Commission acknowledges that a vision for a high-quality and person-centred treatment and support system across Western Bay will take time and considerable courage and efforts to come to fruition. In the short-term it is therefore critical that efforts are focused on reframing current drug services so that they can come out of their silos and develop stronger working relationships. This will require strong and distributed leadership, with a clear focus on the evidence base that will help improve services and which will result in fewer drug-related deaths (as a primary and key measure).

The evidence base is clear that engaging and retaining individuals in treatment should be a ‘protective’ factor. Attention therefore needs to be placed squarely upon prioritising and improving access (including geographic disparities), retention, quality of care, and the safety of those using services. Quick access and strong retention should be for all: those returning from prison, those who drop-out of service, those who are discharged from hospital and new attenders. Significant learning can be gleaned from Scotland regarding changing systems to facilitate quick access via the implementation of a national set of Medication Assisted Treatment (MAT) Standards [[Online](https://www.gov.scot/publications/medication-assisted-treatment-mat-standards-scotland-access-choice-support/)].

There should be a broad menu of evidence-based services, supports and interventions to reflect the range of needs of people who experience problems with drugs. Priority focus should be on following contemporary evidence-based practice around optimising OST, and a clear ambition set for offering low threshold (same-day) prescribing treatment when needed by the person seeking help. There should be a spectrum of drug treatment and support interventions, from assertive outreach, prescribing and harm-reduction, through to inpatient detoxification and residential rehabilitation when need is clearly assessed. It is also vital to ensure access to a range of psychological and social interventions within the new system model, including welfare support, housing and mental health support. Attention should also be paid to providing nurse-led hospital liaison services for people who experience problems with drugs.

Continued active use of, and commitment to, Buvidal, alongside sublingual buprenorphine and methadone should be considered, especially in the light of any findings that emerge from the ongoing Welsh Government evaluation of the Buvidal programme. At the same time, attention also needs to be paid to the significant change in the nature of drug use patterns across Western Bay (i.e. not just heroin, but including crack/cocaine, benzos, gabapentinoids, nitazines, ketamine, etc.), and the need to horizon-scan and have a drug treatment and support system that is able to proactively change over time, including redistribution of resources into treatment for other drugs, rather than reacting to existing pressures.

There should be a review and refresh of the community pharmacy model for OST across the Health Board, engaging all stakeholders to develop an integrated and holistic approach to the care and treatment of people who use drugs.

**Recommendation 20: Long-term prioritisation of, and investment in, primary care and shared care models of support for people who experience problems with drugs.**

It is the view of the Commission that local General Practitioners are a severely under-utilised resource in the provision of services to people who experience problems with drugs across Western Bay. The Commission therefore strongly suggest that the WBAPB prioritise immediate and ongoing discussions with Pan Cluster Planning Groups regarding how local GPs can be more actively involved in supporting the delivery of high-quality services to people who experience problems with drugs, especially with regard to taking a prescribing role in OST.

The Commission firmly believes that meaningful and wider involvement of primary care, and specifically GPs, would support and enhance the other recommendations that are made in this report. Crucially, where done well, involvement of primary care and GPs can expand reach and access to people who can be supported almost entirely in primary care because their needs can be met there without substantive involvement of more specialised services. GPs (and primary care based non-medical prescribers) can also take on shared care arrangements with specialist services if there are local arrangements in place. This can help specialist services to discharge people into safe and supportive care and prevent the bottle necks that we have seen develop across Western Bay where specialist services have nowhere to discharge their clients to. Greater GP involvement would significantly improve and enhance existing use of primary care in drug treatment support due to the access that it provides to meet a wider range of unmet needs (e.g. diabetes, dentistry, podiatry, etc.). Additionally, it also has the potential to improve support for the even larger population of alcohol users, who are often identified and treated within the primary care setting without any ongoing engagement with alcohol treatment services.

Whilst we are also keen to see primary care-based non-medical prescribing supported we do believe that the very low numbers of involved GPs is itself a problem that needs to be specifically addressed. This should be done in addition to providing support more generally for wider primary care involvement in the care of people who experience problems with drugs, such as non-medical prescribing professionals.

The Commission does understand that there are substantial challenges within primary care/general practice more generally, nationally and locally, in terms of shortages of staff, succession planning, and concerns about working in an area where practitioners can lack confidence and sometimes willingness to work with this client group. However, there are other areas of Wales (for example, Cardiff and The Vale) where shared care arrangements are working very well notwithstanding having similar generic challenges. To achieve this there will need to be clear and designated responsibility and leadership for shared care.

**Recommendation 21: Choice is important and having the choice of accessing a full menu of services (including community and/or a residential setting) to support recovery should be available to all people across Western Bay, at appropriate locations and times that primarily suit the individual, as a priority over and above the service needs.**

One of the strongest messages that the Commission has heard repeatedly is a frustration with the lack of choice and options for treatment for people who use drugs. The widely held perception amongst those who use services is that it is ‘methadone (opioid substitution treatment) or nothing.’ Although the reality is not as blunt as this, it is important to recognise that this is how the treatment system is perceived by many of the people who are closest to it. Whilst it is acknowledged that pharmacological treatments are a vital part of the system response, the perception, and sometimes reality, of the predominance of OST prescribing seems to take place at the expense of a system that should have a broad spectrum of options for the wide range of people who require help.

The Commission believes that the WBAPB should conduct a review of evidence-based responses for people who do not use opiate drugs, to inform decisions regarding what might be suitable developments to meet needs across Western Bay.

Ultimately, there needs to be greater flexibility and choice for individuals than is currently available.

**Recommendation 22: Improved support for transition within/out with the system (in/out prison, treatment to recovery, people moving into the area, hostel to own accommodation, people leaving rehab, young people to adult, etc.)**

The Transformation Programme needs to prioritise the design and implementation of clear and integrated pathways for individuals, as these have been severely lacking over recent years. This must include closer alignment of substance use and mental health services and support (as this is recommended UK and international best practice).

The Commission would specifically like to emphasise the need to ensure same-day pick-up of OST prescriptions are available for all upon release from prison. Additionally, we would encourage all partners to prioritise cessation of Friday liberations to ensure that individuals are not left for a whole weekend before being able to access relevant help and services upon liberation.

**Recommendation 23: Strategic workforce planning**

Having heard regular reports through our evidence gathering of staff burnout and descriptions of a lack of support for staff, the Commission recommends that the WBAPB should engage partners in a strategic system approach to workforce planning, recruitment and retention, and staff wellbeing – that includes all providers.

The WBAPB needs to ensure that the Transformation Programme continues to be fully co-produced, including plans to take all staff working in drug services on the Transformation journey, and not just those staff who have chosen, or been chosen, to attend workshops and other opportunities presented by the Transformation Programme.

**Recommendation 24: Through the Transformation Programme and beyond, as service reconfiguration takes place, the system needs to move beyond siloed responses.**

A key element of the Transformation Programme should be to design plans for the co-delivery of services and not just focus on co-location. There is a marked difference between multi-agency approaches (where co-location is the main principle, but where each agency, first and foremost, still works to its own agenda) compared to multi-disciplinary approaches (where first and foremost, all agencies work to a co-produced and combined agenda through co-delivery, over and above individual organisational agendas). The Transformation Programme plans do provide reassurances and confidence that this is the aspired outcome, and it is now down to the WBAPB and local leaders to ensure that this is delivered over the long-term.

The Commission would also like to stress the critical importance of ensuring the aspirations of pooling budgets through the Transformation Programme is embedded and realised over the long-term.

## Our considerations for national bodies

In considering how to achieve the lasting improvements that are required across Western Bay, there are a number of areas that are outside of local partners powers to change – resting either with the Welsh Government, the UK Government, or other national bodies such as Public Health Wales and the Coroner’s Office. Western Bay will better succeed in its ambitions to effectively tackle the challenges it faces, where the following considerations are taken up at a national level.

1. The Commission would ask the Welsh Government to consider expediting the development and roll out of a new national delivery plan (to supersede the existing Delivery Plan which covered the period 2019-2022), as well as an updating of ‘*National Core Standards for Substance Misuse Services in Wales’* (2010) [[Online](https://www.gov.wales/sites/default/files/publications/2019-02/national-core-standards-for-substance-misuse-services-in-wales.pdf)]. Similarly, many of the elements of the ‘*Substance Misuse Treatment Framework’* are over a decade old and in need of updating, including the 2011 ‘Guidance for Evidence Based Community Prescribing in the Treatment of Substance Misuse’.
2. The Commission would ask the Welsh Government to consider how it can further strengthen the funding systems in Wales to allow APBs or other bodies to better join-up commissioning approaches (through oversight and utilisation of the whole drug and alcohol spend. This would need to be considered alongside a wholesale review of APBs to ensure that they can function as fully independent strategic partnership bodies. The Commission have questioned whether it is time to consider if APBs are actually the right format for providing oversight and leadership of alcohol and drug harms, given that APBs are not the responsible authority for the predominant issues faced by individuals who experience problems with drugs (i.e. mental health and housing insecurity/ homelessness).
3. The Commission would ask the Welsh Government and Public Health Wales to consider how timely drug-related deaths and harms data can be achieved, without extensive delays in getting these data into the public domain. We believe that there is a need for a national expert group to drive improvements in: (1) consistency and timeliness of data, including an agreed definition of such, (2) expert analysis and interpretation of complex data sets, and (3) how such data can be used to improve practices and processes consistently across the country.
4. The Commission would ask the Welsh Government to consider convening a National Action Learning Set for Drug Death Review Groups (including standardisation of processes and reporting of drug-related deaths across all Health Boards and Coroners).
5. The Commission would ask the Welsh Government to consider how it can move towards an agreed set of national standards regarding access to medical assisted treatment (for all drugs, including alcohol). The standards should be the fundamental base upon which the existing Welsh Government Key Performance Targets are built. However, there is a need for such standards to be developed through a human rights approach and should give due consideration to outcomes, levels of complexity, and appropriate response to crisis presentations. Particular consideration should be given to the Medication Assisted Treatment Standards that have been implemented in Scotland.

## To turn the tide means that it is now a time for action

As an independent Commission we are fully aware that we have provided a significant challenge for the Western Bay APB and its partner organisations in terms of the volume of action and work that will be required to implement our recommendations. Our hope is that all disciplines and services quickly (within three months) prioritise the time necessary to reflect upon the findings and recommendations laid out in this report and provide a detailed response and action plan to the Western Bay APB to describe the part they can all play in helping to tackle this set of significant challenges.

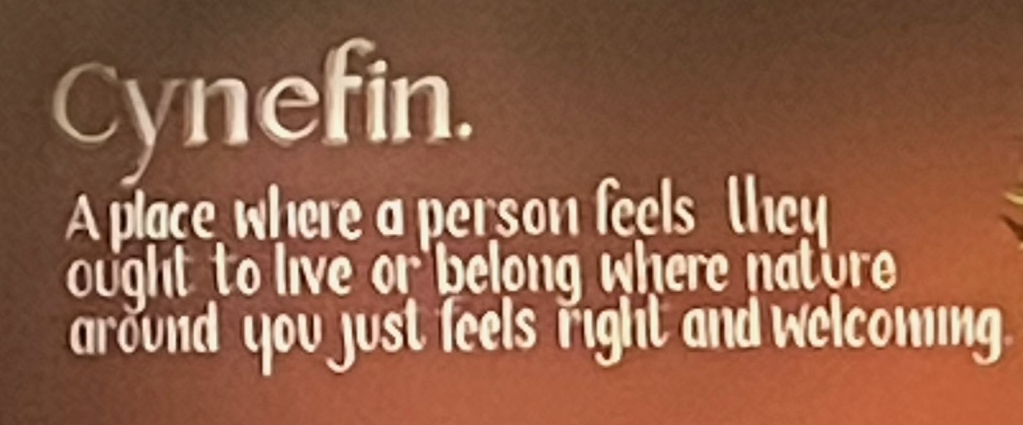
There are some quick wins to be had in learning from past experiences to uncover the solutions for the future and improve service provision. We recognise though that there are no easy solutions to reducing overall drug death numbers.

There is a deep passion amongst the people of Western Bay to assertively respond to the serious challenges faced. As Commission members we are fully prepared to continue in a supporting role to help ensure Western Bay can implement the changes we have sought to describe and understand, and to build upon the strong relationships that we have formed with stakeholders. We would therefore want to support the Western Bay APB as a ‘critical friend’ as they look to take the lead on implementation. Having laid out the scale of the challenge and an ambitious programme of change, it would be negligent of the Commission to deliver its report and walk away.

As an independent Commission we are prepared to support the Western Bay APB as it begins a new journey and to reconvene and collaboratively review progress within an agreed timeframe.

## To turn the tide means that it is also a time to focus on culture change

All of our work and evidence gathering has led us to the conclusion that significant and sustained culture change regarding the way the system and services across Western Bay operate is imperative if the long-term ambitions of the Transformation Programme are to be met. We have been struck by a particular Welsh word that we believe captures the essence of the culture change that people affected by their own (or someone else’s) drug use would like to see and experience. The word is ‘Cynefin’, the essence of which is inclusivity, community, culture, heritage, and identity.



Another helpful definition, developed by the Welsh Government for Welsh Schools is: ‘The place where we feel we belong, where the people and landscape around us are familiar, and the sights and sounds are reassuringly recognisable’ [[Online](https://www.tandfonline.com/doi/full/10.1080/03004279.2023.2229861)].

## Final recommendations

In concluding our report, we want to emphasise two final recommendations that we believe will both retain the correct focus for all stakeholders across Western Bay whilst also reassuring the wider community that the evidence they have generously provided as part of the Commission’s work will lead to lasting improvements. Restoring hope amongst the ever-increasing population of people affected by drug use should be a top priority.

**Recommendation 25: We would challenge the Western Bay APB to instigate a ‘year of inclusivity’ to explore all the ways to nurture an environment consistent with the essence of a ‘Cynefin’ (as detailed above).**

We would suggest that all commissioned services, within three months of receiving this report, should co-produce a plan regarding how they can contribute to a ‘year of inclusivity’. The APB should then bring stakeholders together to share ideas and join individual service plans into a combined plan. Consideration should be given within the plan towards a series of events, campaigns and communications across the ‘year of inclusivity’. Senior (executive) leaders should look to support this and provide opportunities to promote the year of inclusivity across the whole breadth of their organisations in order to challenge the embedded stigmas that surround drug use.

**Recommendation 26: The Western Bay APB should commit to providing long-term active (independent) review and monitoring of the implementation of the recommendations in this report.**

This is critical to ensure that this report does not sit on a shelf collecting dust but remains actively at the forefront of efforts to improve outcomes in people’s lives, including the necessary accountability to drive the programme of transformation.

**10. OUR REFLECTIONS**

**Reflections of members of the Western Bay Drugs Commission**

Full details of Commissioners can be found in **Appendix I** in the **Part 2** report.

**Cllr Alyson Anthony**

“Having missed the early gelling stages due to a major injury I was anxious at being on the periphery looking inwards and not feeling part of the group, this was not the case, everyone was supportive and genuinely cared. This shows the personalities of the commission; it spoke volumes of how people were going to be the right fit for what was needed going forward working with vulnerable people and I am proud I was part of the commission.

I found at times I felt so frustrated to hear stories I heard 25 years ago. The same silo working, hatches down and looking at how they work and not sharing, communicating and sadly not seeing the person in front of them. To be fair staff were disillusioned, and battle worn and struggled with the constant changes.

We must listen to the people with lived experience. We can only improve our services if we truly listen and work co-productively to walk the long road ahead.”

**Dr Mel Bagshaw**

“A lot of time and effort has been spent by large numbers of people touched by addiction or working within services, to gather this information. It will be difficult to effect the changes needed, but that’s not a challenge to be shied away from. This is a unique opportunity to re-configure and hopefully improve services and ultimately save lives.”

**Dr Kerry Bailey**

“I have felt incredibly privileged to be part of this commission and that so many people let us into part of their lives. People with personal experience of substances, relatives, healthcare workers, all shared honestly and with trust their thoughts, their feelings and their experiences. I hope that we can live up to their trust by highlighting the situations that still exist. It was, at times, shocking to hear of the discrimination, lack of services, lack of patient centeredness, indifference although rarely, sadly, unsurprising. Because many of the stories of trauma, stigma, waiting lists, poor care, not meeting criteria for services (sort out your mental health first, sort out your substances first) are not unique to Swansea (although some were), nor are they unique to this time. Many of the incredibly sad stories have been echoing for decades. But there are solutions. We heard so much that was inspiring – of passion, resilience, commitment, solutions. Examples from locally and from further afield. Sometimes small changes of humanity, compassion as well as service delivery and organisation can change lives and save lives. And that leaves me with hope.”

**Dr Sam Clutton**

“When someone is drug dependent, their families live in constant fear of phone call or knock at the door to tell them that their loved one is dead. There was a period before my son’s recovery when I used to regularly wake up in the night and run to the open the front door, convinced the knock had come, thankfully it never did. I was with him in A&E on a number of occasions when he had accidently overdosed, and seconds of time move in slow motion as you hold your breath desperate for the intervention to work. I have been lucky; I still have my son, and I am incredibly proud of him and everything he has achieved despite the experiences related to his drug dependency.

A number of women who I hold very dear have lost their sons, their other children have lost siblings, and their grandchildren have lost their fathers. The impact of a so called ‘drug related death’ on families is sheer devastation. People working in drug services are also left with the trauma of a death of someone they have worked so hard to support.

There is quite rightly a focus of organisations attention when a drug related death occurs. However, there seems to a lack of effective attention on evidence based, joined up, person centred services for those living with drug dependency. Untimely the real answer to preventing drug related deaths is to provide the right support at the right time to people living with drug dependency. This is not a criticism of the staff who work so hard in front line services or of the services themselves, the majority of which are simply overwhelmed with demand. However, we have heard from people how difficult it is to get the right support at the right time and some practice does not sound person centred or trauma informed.

The truth is that the system does not work and has not worked for a long time. Some bold and urgent decisions are needed by senior decision makers and commissioners, working in collaboration. The decision to establish and engage in the work of the Commission is a positive acknowledgement of this. I hope that the evidence that people have taken their time to provide to us, despite the challenges they face, be they people using services or delivering them, has the impact that it is intended to have. Organisations will need to come out of their bunkers and work together on a common purpose to achieve this.”

**Dr Lindsay Cordery-Bruce**

“Every death from drugs is an avoidable tragedy. I cannot overstate the importance of protecting people who use drugs, their families and their wider communities. I have a huge sense of optimism that the work of the commission will lead to tangible culture change, an improvement in services, more linkage between agencies and less human suffering. The system needs to get out of its own way. A movement of people with lived and living experience must rise in Western Bay. The issues addressed in this report are never easy to confront but confront them we have.  I feel a great sense of privilege to have been involved.”

**Katie Dalton**

“Firstly, I want to express my gratitude to everyone with lived/living experience who shared their views during the Commission’s work. Your contributions were invaluable and have had a lasting impact on panel members, as well as heavily influencing the report and its recommendations. I also want to recognise the efforts of frontline workers, who spoke passionately about their desire to make a positive difference, but all too often face systemic barriers, and rarely get the reward, respect, recognition and support they need and deserve. I hope this report helps to pave the way for better experiences and outcomes, where people are listened to and treated with dignity and respect; support is truly person-centred and trauma-informed; services develop open, trusting and collaborative partnerships; and leaders across a range of organisations step up and deliver the change that is needed to prevent drug-related deaths in future.”

**Dr Aled Davies**

“I have gained a tremendous amount personally and professionally from being a member of the commission. It has brought together people with a wealth of different experiences. The evidence presented to the commission by a range of different people demonstrates the complexity of the problem facing Western Bay, and other areas across Wales, but also given me hope that people care and that change to the lives of those affected by drugs in the communities in the Western Bay area can happen.”

**Dr Amira Guirguis**

“I was privileged to be part of the Commission. I was amazed by the wide range of expertise within the Commission, and the evidence they were able to systematically gather over this period. Members’ dedication to make a difference is a true inspiration.”

**Rachel Henderson**

“As a member of the Drugs Commission, I gained a unique perspective on the ever-evolving landscape of Western Bay. I’ve heard about the persistent challenges and barriers faced by individuals, the silent frustrations of the majority, and the profound impact this has had on its community. It was an emotional rollercoaster, and a stark reminder about the importance of reflection: how we communicate, the language we use, if we truly listen, and collaborate to improve service delivery and people’s lives.

Crucially, involving people with lived and living experiences in shaping their own future has been recognised as an essential part of any future planning. The Drugs Commission’s consultation phase gave time for everyone to reflect on values and organizational culture. Seeds of change were sown, and over the following months I was thrilled to see positive shifts taking root already.

Even as we approached the final stages of The Drugs Commission Report, it was evident that it had already been a catalyst for change and the “tide was most surely turning”. People with Lived and Living Experience had a platform to express their needs, hopes, and aspirations for the future. They began to actively contribute to Substance Use Service Planning, engaged in all the Alliance Workshops, and are now sitting on the Service Providers Forum. Their bravery passion and enthusiasm has truly left me inspired.

Co-production is undeniably part of the future solution, the groundwork has been laid, now we must all build upon it. In one of their recent Lived Experience Alliance Forum (LEAF), members unanimously agreed on a crucial action moving forward: **“Include Us When It’s For Us.”** This simple yet powerful phrase will be here to remind us all of the commitment required to embed meaningful inclusion and co production, thankfully the Drugs Commission Report and its recommendations will also be there to guide us.”

**Professor Katy Holloway**

“Being involved in the Western Bay Drugs Commission has been challenging, humbling, and at times it has been troubling. But it has also been inspiring. I have been hugely impressed not only by the expertise and commitment of my fellow Commission members, but also by everyone who has engaged with and contributed to the Commission’s work over the past 18 months. I am hopeful that this report and its ambitious recommendations will help to make a meaningful difference in the lives of those struggling with drug problems in Western Bay.”

**Stuart Johnson**

“I was proud to be part of the Commission and have the opportunity to listen and learn from a wide range of subject matter experts all of whom were passionate and wanted to contribute to a report which could influence change for the better.”

**Cllr Alun Llewelyn**

“I have learned so much by being part of the Drugs Commission.

I have been involved in working with, and supporting, people with complex housing and support needs for over 30 years – both as a Councillor and professionally as a Housing Association Director. But the work of the Commission has focussed on the experiences of people of all ages who are using substances or recovering from the effect of substance use, and their families, who have spoken directly to us. We have also spoken with many dedicated front-line workers and volunteers. Thank you to all of you for sharing with us.

There are huge challenges for all organisations, health boards, councils and criminal justice authorities that work in this field.

For us in Western Bay – which is Swansea and Neath Port Talbot – we have lessons to learn from the years when we have been at the wrong end of the figures of harm and deaths from substance use.

I feel that the work of the Commission and the response to the issues by conscientious officers and members of all the agencies and authorities is beginning to make a difference, but there is so much more we must do.”

**Dr Julia Lewis**

“What struck me, being a part of the commission, was that sense of a common purpose. As commission members we were there because we wanted things to be better for people in Western Bay and we felt that the investigation the commission was undertaking was an important part of that journey. What we quickly learned was that we were joined in that common aim by the people who gave evidence - the local commissioners, the professionals, the service users and their families. Everyone was concerned about the current situation and everyone wanted things to be better. That gives me hope that, when we report our findings, they will be used to help move things forward and make a real difference.”

**Professor Rob Poole**

“What has been striking, listening to evidence and reading the findings of the Commission has been a sad sense of familiarity: the findings would be equally true in any of the five decades and five locations of my career. Far from breeding complacency, this report should spur Western Bay into action. Substance misuse is not someone else’s problem, it is a major cause of illness, death and disability of the working age population. In particular, it should be recognised that people are not segregated by the substance they use. Most opiate users smoke, and many use alcohol. We must start to think in terms of people and their problems, including mental health problems, not individual drugs of addiction. Addressing the problem more appropriately is hard work.”

1. We also considered that the use of the term ‘truth’ in the original title was unhelpful. The original thinking was to align the title with that of the Swansea Poverty Truth Commission. However, whereas the Poverty Truth Commission model has been utilised in various settings and the title is understood in that context, our feeling was that the word ‘truth’ could be easily misunderstood in the context of drug harms. [↑](#footnote-ref-2)
2. The totality of the Commission was a period of five years beginning with a conversation facilitated by The Welsh Government between Figure 8 Consultancy and the Chair/Vice Chair of the WBAPB in February 2020. [↑](#footnote-ref-3)
3. The Commission was focused on gathering drug-related evidence rather than alcohol. There is plenty of publicly available data which highlights the comparatively higher presentation of alcohol. For example, Public Health Wales annual data reports [PHW Data Mining Substance Use 2022-23](https://phw.nhs.wales/publications/publications1/data-mining-wales-the-annual-profile-for-substance-misuse-2022-23/). [↑](#footnote-ref-4)
4. The WBAPB works with real-time data that is fed through the drug poisoning task force and the independent review panel via the case review coordinator. This was one of the outcomes from the Critical Incident Group. [↑](#footnote-ref-5)
5. The funding of a Participation and Engagement post from 2021-2025 via the Home Office’s Project ADDER is welcomed. However, there is an argument that lived experience participation should be core APB business. Whilst these monies appear to be facilitative, the initial period of this activity did not deliver any significant lived experience engagement. Going forward, it is actually the connectivity on the ground with drug using individuals and community that is key*.* [↑](#footnote-ref-6)
6. Commission members all gave their time voluntary. Figure 8 Consultancy did receive a fee for facilitation of the Commission’s work. [↑](#footnote-ref-7)
7. Bellis MA, et al. Measuring mortality and the burden of adult disease associated with adverse childhood experiences in England: a national survey. J Public Health 2015; 37: 445–54. [↑](#footnote-ref-8)