FIGURE 8
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2021

GWENT CO-OCCURRING CONDITIONS NEEDS ASSESSMENT

PART 1 - THE REPORT

Prepared for Gwent Area Planning Board and Aneurin Bevan University Health Board

EVIDENCE INTO PRACTICE

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The research team offers its sincere thanks to all the individuals who have participated in the interviews, focus groups, working groups and stakeholder events. Particular thanks go to the members of the working groups and those interviewed, who have been an immense help to the research team in developing their findings. The research team recognise that those who participated in the study all had other significant demands on their time and also that services across Gwent are under significant pressure – most notably from the current COVID-19 crisis.

REPORT FORMAT

This report has been written primarily with the practice community in mind. Supplementary appendices are also available containing further data, and detail about the research methodology **(see Part 2 – Supporting Evidence Report)**. Each strand of data collection and synthesis – dataset reviews, interviews, stakeholder events, working groups, focus groups, and surveys – contains a box with key findings. **To preview this report, the researchers would recommend reading the key findings from each section followed by the final recommendations (Chapter 6 of this report).**

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CHAPTER 1: INTRODUCTION

1.1 Introduction and background

Figure 8 Consultancy Services Ltd. were commissioned by Gwent Area Planning Board [APB] and the Aneurin Bevan University Health Board [ABUHB] in October 2019 to complete a needs assessment of adults with co-occurring mental health and substance use problems.

Alcohol and drug use is common in people with mental health problems and 70% of those in drug services and 86% of those in alcohol services report having experienced mental health problems.[1,2] The level of harmful and problematic drug and alcohol use amongst patients of community mental health services is estimated at around 44%[3]. The relationship between mental illness and substance use is complex, and individuals with co-occurring mental health and substance use problems experience poor health outcomes[4], increased use of health and other statutory services, and an increased chance of being homeless or known to the criminal justice system.[5] Suicide rates are also significantly higher in this population, with a history of alcohol and/or drug use being recorded in 54% of all suicides.[6] Co-occurring conditions are more prevalent among psychiatric inpatients and people in secure services[7], and are also common among the prison population (up to 75% of prisoners)[8].

There are several challenges to supporting recovery in this population group; and, despite the high prevalence of co-occurring conditions, detection of the problems remains low; and historically, individuals with such complex needs have experienced difficulties in accessing services which meet all their needs. This often leads to a lack of engagement for some, disengagement for others, and poorer patient outcomes.

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[1] Weaver et al (2003) Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. The British Journal of Psychiatry Sep 2003, 183 (4) 304-313.

[2] Delgadillo J, Godfrey C, Gilbody S and Payne S (2012) Depression, anxiety and comorbid substance use: association patterns in outpatient addictions treatment. Mental Health and Substance Use Vol. 6, Iss 1, 2013.

[3] Public Health England (2016). Health matters: harmful drinking and alcohol dependence. Available at: https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence

[4] Hayes R, Chang, C, Fernandes A, Broadbent M, Lee W, Hotopf M, Stewart R. Associations between substance use disorder sub-groups, life expectancy and all-cause mortality in a large British specialist mental healthcare service. Drug and Alcohol Dependence, 2011vol. 116 Issue 1.

[5] Strathdee G et al. (2002). Dual diagnosis in a primary care group – a step by step epidemiological needs assessment and design of a training and service response model. Department of Health/National Treatment Agency.

[6] The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2016: England, Northern Ireland, Scotland and Wales October 2016. University of Manchester. Available at: https://documents.manchester.ac.uk/display.aspx?DocID=37580

[7] Strathdee G et al. (2002). Dual diagnosis in a primary care group – a step by step epidemiological needs assessment and design of a training and service response model. Department of Health/National Treatment Agency.

[8] Prison Reform Trust. Prison Fact File December 2011. Available at: http://www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefing%20December%202011.pdf

Mental health and substance misuse services are usually commissioned separately which can present organisational and clinical barriers to effective treatment, for example this may lead to disjointed care protocols resulting in services that are unwilling to manage the risk presented by people with co-existing mental health problems and substance misuse.

Research also shows that, despite the shared responsibility that NHS and local authority commissioners have to provide treatment, care and support to people with co-occurring conditions, they are often excluded from services[9,10].

1.2 Language – terminology considerations for describing those who experience problems with mental health and/or substance use

In 2018, Figure 8 Consultancy led the latest review of the Welsh Government's Substance Misuse Strategy where they recommended a shift in focus (nationally) from a substance misuse specific strategy to a broader whole population and wellbeing focus. This is required in order to achieve alignment and integration of substance use (not 'misuse') policy with the now-dominant Social Services and Wellbeing [Wales] Act 2014 and the Future Generations [Wales] Act 2015. We have the sense that the current conversation and priorities in the drug and alcohol treatment field is now about whole populations and wellbeing (i.e. a continuum of users and non-users).

> "Consideration needs to be given to developing a broad understanding of what 'success' looks like – not just in relation to substance *misuse* and associated harms, but also in terms of whole population approaches to alcohol and drug *use* and future wellbeing."[11]

It is for this reason that we choose to refer to 'Drugs', 'Alcohol' and 'Substance Use' throughout this report, rather than the narrower terminology of 'Substance Misuse'.

We also believe the importance of terminology goes further in changing culture and challenging stigma. Words such as 'misuse' and 'abuse' have been identified as being potentially stigmatising and we would suggest that they shouldn't be used, in line with guidance from the Global Commission on Drug Policy[12].

In considering the role that language has in reflecting and framing critical conversations, we also have consideration for other terms within the wider discourse that warrant some reflections due to their prior use. Perhaps the most obvious and commonly used of these is 'service user', a narrow term applied to those who use or have used treatment services, rather than being a person-centred term to describe a whole population of people (whether in treatment or not) who have chosen (for whatever reason) to use substances (whether legal or illegal). We have favoured the use of the term

[9] Care Quality Commission (2015) Right here, right now - http://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcrisiscare_summary_3.pdf

[10] The Recovery Partnership. State of the Sector 2015. The Recovery Partnership. Available at: http://www.recovery-partnership.org/uploads/5/1/8/2/51822429/recovery_partnership_-_state_of_the_sector_2015.pdf

[11] **Livingston, W., Perkins, A., McCarthy, T.,** Madoc-Jones, I., Wighton, S., Wilson, F. & Nicholas, D. (2018). Review of Working Together to Reduce Harm: Final Report. Cardiff: Welsh Government GSR report number 21/2018 http://gov.wales/statistics-and-research/review-working-together-reduce-harm/?lang=en (pp.82)

[12] Available at: http://www.globalcommissionondrugs.org/wp-content/uploads/2018/01/GCDP-Report-2017_Perceptions-ENGLISH.pdf

'individual' or 'a person who experiences problems with drugs and/or alcohol'. This is a direct approach to help:

- counter the stigma of possible labelling;
- reflect the ambiguities of boundaries and identities; and
- adopt a more inclusive and person-centred position.

Ultimately, the language used has helped shape the scope of this Needs Assessment project. For example, using the terms 'substance use' and 'individuals who experience problems with mental health and/or drugs and alcohol' (as opposed to 'service users') has allowed the Needs Assessment to consider harder to reach populations who haven't been engaged with the treatment system, as well as the wider population (which allows for consideration of greater focus on preventative measures and offers).

Historically, the term 'dual diagnosis' has most frequently been associated with individuals who experience problems with diagnosed mental health and substance use conditions. However, 'dual diagnosis' is also used in other contexts such as referring to individuals that have a learning disability and a mental health condition. Additionally, it may be used to describe other conditions including physical health problems.[13]

Although the term 'dual diagnosis' is commonly used across current services, it is pertinent to note that the Welsh Government's preferred terminology is 'Co-occurring Conditions' and that the most up-to-date guidance from the National Institute for Clinical and Health Excellence [NICE] uses the term 'Co-Existing Severe Mental Illness and Substance Misuse'. 'Co-morbidity' is another frequently used term.

The authors of this report have chosen to use the term 'co-occurring conditions' to encourage all stakeholders to update themselves on the latest national guidance. However, where stakeholders have used other terms (mainly 'dual diagnosis') and are quoted, then the authors have retained the language used by them.

It is also worth noting the recognition that those with co-occurring mental health and substance use problems almost invariably have what can only be described as 'complex needs' or 'severe and multiple disadvantage'. In 2015, the Lankelly Chase Foundation conducted a mapping of 'severe and multiple disadvantage' across England.[14]

> 'This study sought to provide a statistical profile of a key manifestation of 'severe and multiple disadvantage' (SMD). In this report, SMD is a shorthand term used to signify the problems faced by adults involved in the *homelessness*, *substance misuse* and *criminal justice systems*, with *poverty* an almost universal, and *mental ill-health* a common, complicating factor.'

[13] National Institute for Health and Care Excellence (NICE), (2016), *Co-existing severe mental illness and substance misuse: Community Health and Social Care Services,* (2016), Available at: https://www.nice.org.uk/guidance/cg120

[14] https://lankellychase.org.uk/wp-content/uploads/2015/07/Hard-Edges-Mapping-SMD-2015.pdf

1.3 National context

In 2015, Welsh Government published a framework designed to inform and influence integrated and collaborative practice in the delivery of mental health and substance use services[15]. Welsh Government indicated that oversight and assurance should be provided by Substance Misuse Area Planning Boards (APBs) and Health Boards via their lead role in Local Mental Health Partnership Boards (LMHPBs). The recently published 'Review of Working Together to Reduce Harm: Final Report'[16] concluded that stakeholders felt a greater emphasis should be placed on the interface between mental health and substance use services for those experiencing co-occurring problems. This issue is also subject to review by Health Inspectorate Wales.

1.4 Local context

Historically in Gwent mental health and substance use services have developed separately. Individuals with co-occurring conditions have largely been treated by either substance use services or mental health services alone and although more recent developments have provided some 'dual diagnosis' workers and improved joint-working, it has been recognised that there are still some significant gaps and inconsistent approaches across the area.

1.5 Purpose of the study

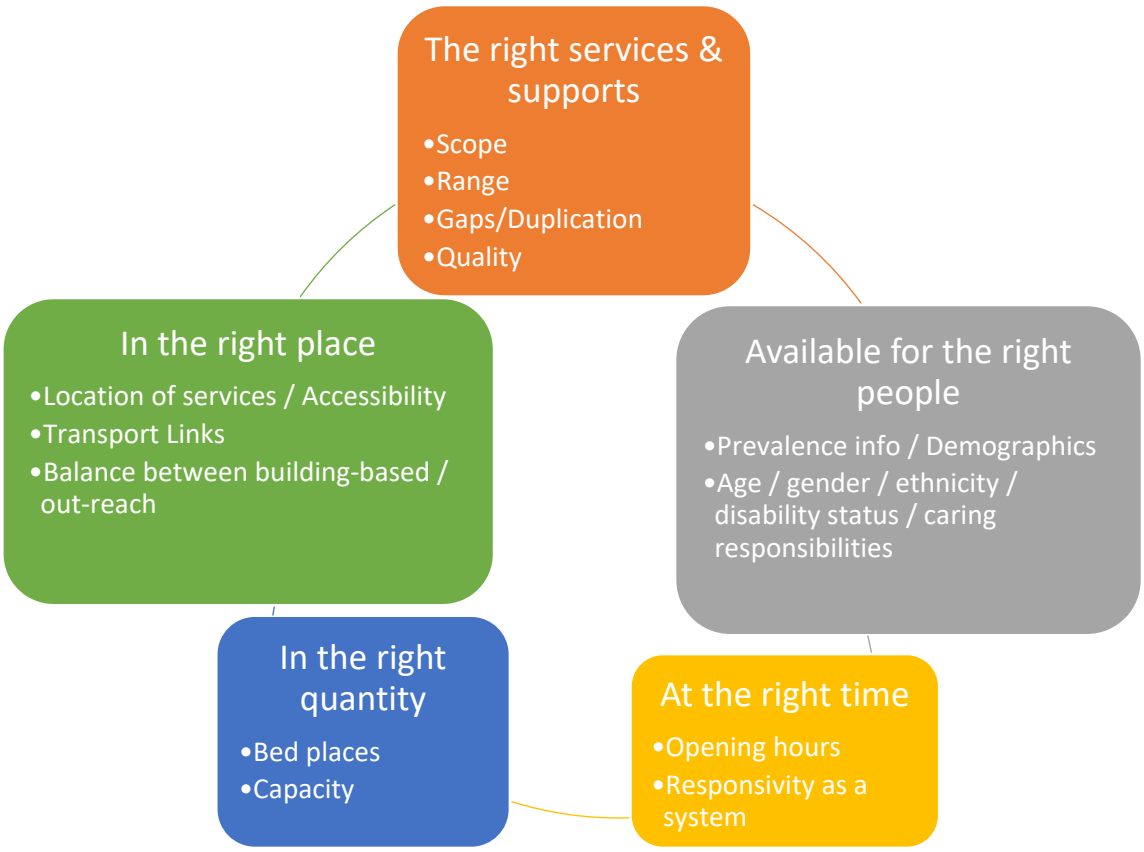
The purpose of the study is to help Gwent APB, ABUHB and their mental health and substance use partners to develop strategies to manage co-occurring conditions effectively and efficiently by looking at how well mental health services, combined with alcohol and drug services, serve people; as well as assessing local needs, gaps, innovations and aspirations.

Fundamentally, this study set out to answer whether in Gwent services are transforming and integrating sufficiently well in order to meet the needs of adults with co-occurring mental health and substance use problems. In order to assess this, the following questions have been pivotal to our approach: Are the right services and supports ➔ in the right place ➔ available for the right people ➔ in the right quantity ➔ at the right time?

[15] Welsh Government (2015). Service Framework for the Treatment of People with a Co-Occurring Mental Health and Substance Misuse Problem. Available at: https://gov.wales/sites/default/files/publications/2019-02/service-framework-for-the-treatment-of-people-with-a-co-occurring-mental-health-and-substance-misuse-problem.pdf

[16] Livingston, W. et al. (2018). Review of Working Together to Reduce Harm: Final Report. Available at: https://gov.wales/sites/default/files/publications/2019-02/service-framework-for-the-treatment-of-people-with-a-co-occurring-mental-health-and-substance-misuse-problem.pdf

Figure 1.1:The purpose of conducting needs assessments



1.6 Objectives

The specific objectives of this study were:

- To provide a better understanding of the needs of adults with co-occurring mental health and substance use problems.
- To assess the extent to which current services and plans are meeting the needs of this population.
- To identify where there are gaps in the capacity and capability of the workforce and the potential for new or extended roles (e.g. peer mentors, link workers).
- Identify ways to more effectively meet the needs of adults with co-occurring mental health and substance use problems through service redesign, integration and/or the commissioning of services.
- To translate the recommendations from the needs assessment into a programme for change with the development of measures to demonstrate improvement in access, experience and outcomes.

1.7 Stakeholders

It is essential to engage as broad a range of interests as possible in the needs assessment process. To this end, the research team sought the views of a range of different mental health and alcohol and drug services, people who use services, families and carers; and other stakeholders. The

qualitative element of the study in particular aimed to consult with staff from specialist mental health and alcohol and drug services, together with a sample of the following groups which support people affected by co-occurring conditions:

- Individuals with co-existing mental health problems and substance use who are currently/recently engaged with local specialist services;
- Families and carers of individuals with co-existing mental health problems and substance use who are currently engaged with local specialist services;
- Frontline workers in assertive outreach, harm reduction and crisis management services including staff in acute admissions;
- GPs and Pharmacists;
- Voluntary Sector providers;
- Police;
- Generic services who work with individuals who may have a mental health and/or substance misuse problem, e.g. children and young persons' services;
- Mainstream services such as:
    - Primary healthcare;
    - Homelessness services and hostels;
    - Learning Disabilities Teams;
    - Domestic/Sexual Abuse/Women's Aid organisations;
    - LGBT organisations; and
    - Military Veteran organisations.
- Recovery services including peer led recovery groups, and advocates.

1.8 The Needs Assessment Process

This needs assessment project uses a tried and tested model for health needs assessment (which is detailed below) and is applied to both the health and social care needs of people with mental health problems across Gwent.

In broad terms, health and social care needs assessment is the systematic approach to ensuring that the Health and Wellbeing Boards use their resources to improve the health and wellbeing of the population in the most efficient way. It involves methods to describe the health and wellbeing problems of a population, identify inequalities in health and social care (and access to services and support provisions), and determine the priorities for the most effective use of resources.

Health and social care needs assessment has become important as the costs of health and social care are rising and resources are, at the same time, limited. In addition, there is a large variation in

availability and use of health and social care services and support provisions across the UK by geographical area and point of provision.

Another force of change is consumerism. The expectations of members of the public have led to greater concerns about the quality of the services they receive, from access and equity to appropriateness and effectiveness.

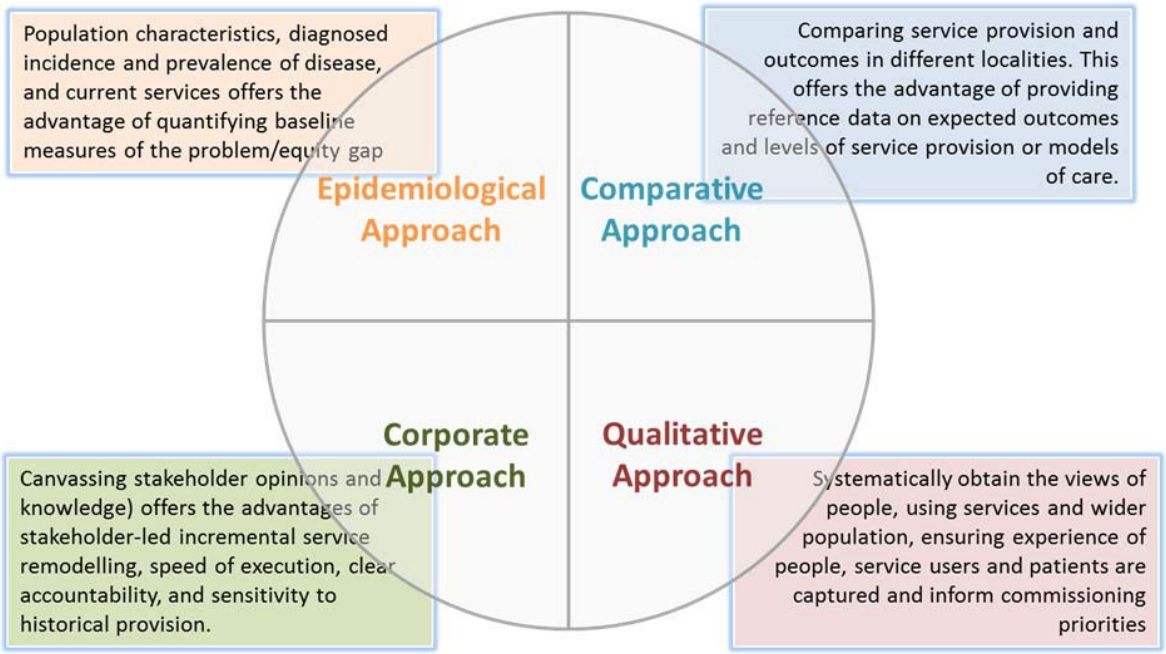
The needs assessment process has been defined, in guidance from the National Institute of Clinical Excellence (NICE), as:

> *"A systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities."*[17]

The assessment process involves identifying need from four different perspectives (see Figure 1.2 below):

- **Epidemiological needs** – the use of health and social care information based on the population, including demographic trends, health status and risk, as well as evidence of clinical effectiveness of services and interventions.
- **Felt and expressed needs (Qualitative)** – the views of the public, from surveys, focus groups and the like, often using participatory appraisal methods.
- **Normative or expert needs (Corporate)** – as identified by professionals or experts.
- **Comparative needs** – the scope and nature of services available to the population and how these compare with services elsewhere.

Figure 1.2 Diagram of the needs assessment process



[17] Cavanagh S and Chadwick K (2005), "Health needs assessment: A practical guide". London: NICE. Available at: http://www.nice.org.uk/

The study methods used in this needs assessment (outlined in section 1.9 below) were designed to capture each of these four different approaches/perspectives and are identified in Table 1.3 below.

1.9 Summary of Study Methods

The study was conducted in four stages. Each stage was tailored to the needs of the study, requiring a mix of data collection methods and sample populations. These are set out in Table 1.3 below. All questionnaires and interview schedules were approved by commissioners prior to use.

Table 1.3: Summary of Data Collection Methods

Stage 1	**Method**		**Link to approaches / perspectives**
Rapid Literature Review	Rapid literature review (a 'review of reviews') to provide a backdrop for the study and to identify the expected prevalence and trends of co-occurring mental health problems and substance use across the study population.		• Epidemiological • Comparative
Review of Existing Datasets	Desk-based review of national and local datasets and any local specialist service data available.		• Epidemiological • Comparative
Review of 'better practice'	Desk-based review of models of service delivery and good practice for identifying and supporting individuals with co-occurring mental health problems and substance use from elsewhere in the UK.		• Epidemiological • Comparative
Stage 2	**Method**	**Sample**	
Quantitative Survey	Online Surveys	• Staff in specialist mental health and substance use services as well as generic health and social care services.	• Normative/Expert (Corporate) • Comparative
Stage 3	**Method**	**Sample**	
Quantitative Surveys	Online and paper-based surveys	• Service users • Carers, family members, advocates	• Felt and Expressed (Qualitative) • Comparative
Stage 4*	**Method**	**Sample**	
Stakeholder Events / Working Groups / Qualitative Interviews / Focus Groups	Initial Stakeholder Events	• All key stakeholders invited to a half-day event (one in Ebbw Vale and one in Newport).	• Normative/Expert (Corporate) • Felt and Expressed (Qualitative)
	Working Groups	• Sample of key stakeholders recruited via approaches from the Project Advisory Group, and via the stakeholder events above. The working groups (Ebbw Vale	• Normative/Expert (Corporate) • Felt and Expressed (Qualitative)

		and Newport) both met twice to explore key themes identified out of the initial stakeholder events.	
	Semi-structured interviews	Sample of: • Specialist services • A range of non-specialist services • Other relevant stakeholders	• Normative/Expert (Corporate)
	Focus Groups	• Service users • Carers, family members, advocates	• Felt and Expressed (Qualitative)
	Final Stakeholder Events	• All key stakeholders invited to a half-day event (one in Ebbw Vale and one in Newport) to test out the emerging findings of the study and to identify key (thematic) areas for the study recommendations.	• Normative/Expert (Corporate) • Felt and Expressed (Qualitative) • Comparative

* NOTE: Stage 4 was paused in March 2020 due to the COVD-19 pandemic and was restarted in August 2020.

The numbers of completed surveys received, interviews completed and participants involved in the Stakeholder Events and Working Groups are outlined in the supplementary **Appendices** document.

1.10 Data Sources

This needs assessment incorporates data from a wide variety of sources (full references are contained in footnotes throughout the report) and includes evidence collated from an extensive consultation process with services users, local organisations and professionals.

1.11 Terminology

When quoting individual respondents or citing literature sources we will use the terms they have chosen for accuracy of representation.

1.12 Considerations and limitations

There are a number of factors which should be taken into account when reading this report. These are:

- The views of those interviewed and surveyed were taken and reported in good faith and are their own, not necessarily those of Figure 8 Consultancy Services Ltd. or the organisations they represent. It cannot be assumed that the views of the participants in interviews, focus groups, stakeholder events or working groups are representative of all similar stakeholders.

- As with all studies of this nature, and particularly those that have a significant qualitative element, there has been an element of self-selection from those who participated in the evidence gathering activities. This needs to be borne in mind when considering that there are potentially other views that have not been heard.
- The study was originally due to have been completed by Easter 2020. However, due to the Covid-19 pandemic the completion of study fieldwork had to be put on hold. This has brought delays to the report findings being produced, although it has also provided an opportunity to consider how services in Gwent have had to adapt to highly challenging circumstances. There are undoubtedly some lessons learned that demonstrate how significant system change can be achieved. These lessons will need to be applied to the challenges of providing improved services for those with co-occurring conditions, which will be outlined in this report.
- Due to the Covid-19 pandemic it was not possible to interview key personnel from Public Health Wales as part of the data and epidemiological review section of the needs assessment (**Chapter 3**). This means that reliance has had to be given to data provided by local services and other data that is accessible in the public domain. The findings of the needs assessment are subsequently focused more heavily on the qualitative findings that would otherwise have been the case.

CHAPTER 2: LITERATURE REVIEW – CO-OCCURRING CONDITIONS 'REVIEW OF REVIEWS'

2.1 Introduction and Aims

Hundreds of studies relating to co-occurring conditions have been published, far too many for most people involved in providing treatment and care to identify and consider when making decisions. The research team concluded that a systematic review (or overview) of reviews would be a logical and appropriate approach for this study, allowing the findings of separate reviews to be compared and contrasted. A review of systematic reviews utilises the same techniques as the traditional systematic review method, including the use of 'rigorous and transparent methods, clear eligibility criteria, description of the search strategy, and documentation of the selection procedure and the attrition of studies'.

2.2 Methods

The criteria used for the review of systematic reviews were essentially the same as that of conducting a conventional systematic review: a search strategy to identify relevant sources of literature, an inclusion and exclusion criteria, a transparent and rigorous method for recording the attrition of literature, and an overview of the final selection of identified studies[18]. However, the necessary difference is that the search strategy was geared toward locating only systematic reviews.

2.3 Search strategy

Literature sources were identified via searches of titles in the journal databases: PubMed, Science Direct, Web of Science and ASSIA. A Boolean search was used to identify literature. To reduce selection bias, a range of English synonyms were used to produce the following search algorithm:

ti (co-occur* OR dual diag* OR co-exist* OR co-morbid*) AND ti (hous* OR accommodation OR home*) AND ti(prevent* OR early OR interven*)

The term 'systematic review' was not included in the Boolean search. This was due to the term's potential to reduce the return of relevant studies. For example, there was a possibility that the term 'systematic review' would not be included in the title of relevant articles. As such, the search strategy located a broad range of studies that were screened by a member of the research team. Results with publication dates from 2014 were screened, with duplicates being removed and remaining articles examined based on their pertinence to the research questions. To ensure all relevant literature was identified, scans of grey literature were also conducted. This involved searches in Google and Google Scholar using the same algorithm as used for searches for peer-reviewed literature.

[18] Holloway, K. R. & Bennett, T. H. 2016. Drug Interventions. In: Weisburd, D., Farrington, D. P. & Gill, C. (eds.) What Works in Crime Prevention and Rehabilitation: Lessons from Systematic Reviews. New York, NY: Springer New York.

2.4 Results

Following the relevant searches, the following **six** 'review of reviews' were identified and included in our analysis:

Table 2.1: Overview of Systematic Reviews with Authors' Conclusions

Author / Year	Number of studies	Purpose	Main findings
Morisano et al., 2014	**Narrative review**	To critically evaluate the literature on the co-occurrence of substance-use disorders (SUDs) with other psychiatric conditions.	Clients with co-occurring disorders tend to have a more severe course of illness, more severe health and social consequences, more difficulties in treatment, and worse treatment outcomes than clients with a single disorder; the authors address the implications of these findings for the design of treatment services.
Lai et al., 2015	**22**	To determine the strength of association between substance use disorders (SUDs), mood and anxiety disorders in population-based epidemiological surveys.	There is a strong association between SUDs, mood and anxiety disorders. The issue has now been recognised worldwide as a factor that affects the profile, course, patterns, severity and outcomes of these disorders.
Megnin-Viggars et al., 2015	**52**	1. To review the health and social care needs of people in the UK with a severe mental illness who also use substances. 2. To review the current configuration of health and social care community services in the UK and describe the care pathway through which people with co-occurring severe mental illness and substance use are recognised, treated, managed and followed-up.	Two large case-control studies found a prevalence of co-occurring conditions in the general adult UK population of 0.05-0.16%. Consistently higher rates of drug use were observed for children and adults with severe mental illness.

Hunt et al., 2016	**9**	To estimate the prevalence rates of substance use disorders (SUD) in persons with Bipolar Disorder (BD) based on national or international surveys of household populations.	People with an alcohol use disorder (AUD) were 4.1 times more likely to be at risk of having a BD compared to those without an AUD. The risks were even higher for illicit drug users where they were 5 times of greater risk of having BD compared to non-users.
Kingston et al., 2017	**18**	To conduct a systematic review of the prevalence of co-occurring mental health conditions in people accessing treatment for substance use in Australia.	'Prevalence estimates of current mental disorders in substance use treatment clients varied (47 to 100%). Mood and anxiety disorders were particularly prevalent, with the prevalence of current depression ranging from 27 to 85% and current generalised anxiety disorder ranging from 1 to 75%.' (p. 1)
Garcia-Guix et al., 2018	**Overview/review of advancements in the field**	Guest editorial on psychiatric co-morbidity among women with substance use issues.	Women with SUD present more psychiatric co-morbidity than men with SUD and women without SUD; the most frequent psychiatric disorders being depression, anxiety and PTSD. They also have a greater risk of suffering IPV and report more sexual and injecting risk behaviours associated with HIV and HCV infection. These particularities have an impact on both disorders in terms of response to treatment and quality of life; therefore, psychiatric comorbidity among women seeking treatment for their SUD, should be specifically addressed. Policy makers must guarantee the access and appropriate treatment to women with SUD and comorbid psychiatric disorders.

The full thematic findings identified from the above systematic reviews are detailed in the **Part 2 – Supporting Evidence Report** at **Appendix II**.

CHAPTER 3: REVIEW OF THE POLICY AND EPIDEMIOLOGICAL EVIDENCE BASE FOR THOSE WITH CO-OCCURRING CONDITIONS

3.1 Introduction and Aims

Within this current report; the focus is on those who experience co-occurring substance use and mental illness. Research specific to co-occurring conditions (and all variations of terminology) is limited, so it can be difficult to present recent literature and data surrounding this area. Previous research indicates that this client group are at a higher risk of vulnerability and complex needs relating to health, social, economic, and emotional stressors or circumstances, which can often be exacerbated by their substance use.[19] Furthermore, people with co-occurring conditions are more likely to have experienced difficulties with education, employment, housing, personal relationships and their physical health. They are also more likely to have suffered trauma or abuse.[20] Recent research indicates that the difficulties that are faced by individuals with co-occurring conditions have remained consistent over time.[21]

Research has shown that service users with co-occurring conditions typically use NHS services more. For instance, a recent report by Turning Point[22] indicates that Accident and Emergency (A&E) departments are frequently accessed by those who are undiagnosed or have unmet needs. Furthermore, due to a lack of appropriate services in the community, individuals are most likely to attend A&E when they have reached a crisis point.[23] The cost to the NHS is also greater due to the higher frequency of use by service users with co-occurring conditions. A study of services in South London found a greater proportion of the service users with co-occurring conditions used the support of community psychiatric nurses, inpatient care and emergency clinics. Their analysis found that such individuals had significantly higher 'core' psychiatric service costs (a difference of £1,362) and non-accommodation service costs (£1,360) than those without diagnosed co-occurring conditions.[24] Moreover, service users with co-occurring conditions are more likely to be non-compliant and fail to respond to treatment than either people with substance misuse issues or a mental illness, and in their National Audit of Violence, the Healthcare Commission and the Royal College of Psychiatrists identified drug and alcohol use as a major trigger for violence in mental health services.[25]

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[19] Afuwape S. A., 'Where are we with dual diagnosis (substance misuse and mental illness)?: A review of the literature', November 2003.

[20] Banerjee, S., Clancy, C., Crome, I., *Co-existing problems of mental health and substance misuse (dual diagnosis): An Information Manual*, Royal College of Psychiatrists, 2002. Available at http://www.rcpsych.ac.uk/pdf/ddipPracManual.pdf.

[21] Turning Point. *Dual Dilemma: The Impact of living with Mental Health Issues Combined with Drug and Alcohol Misuse*, 2016. Available at: http://www.turning-point.co.uk/media/1138757/dual_dilemma.pdf

[22] Ibid.

[23] Ibid.

[24] National Mental Health Development Unit, Briefing 189, *Meeting the challenge of dual diagnosis*, September 2009. Available at http://nmhdu.org.uk/silo/files/seeing-double-meeting-the-challenge-of-dual-diagnosis.pdf.

[25] Ibid.

The aim of this element of the project was to review existing datasets to identify the prevalence and trends of co-occurring conditions across Gwent, and to identify the health and social care needs of this demographic.

3.2 Method of Data Collection

There are few routinely available national or local datasets on the prevalence of co-occurring conditions, and because the definition of the term varies widely, so do prevalence estimates. Information was identified and drawn together from a range of local and national sources which indicate prevalence of mental health issues and substance misuse problems. Other sources (e.g. suicide and self-harm data), speak of the vulnerabilities that those with co-occurring conditions are subject to.

Due to the Covid-19 pandemic it was not possible to interview key personnel from Public Health Wales as part of this element of the needs assessment. This means that reliance has had to be given to data provided by local services and other data that is accessible in the public domain. The findings of the needs assessment are subsequently focused more heavily on the qualitative findings (presented in later Chapters) than would otherwise have been the case.

3.3 National Context

The number of individuals assessed by specialist substance use services in Wales in 2018-19 has risen by 0.7% compared to the previous year. However, this was following a decrease of 11.8% since 2014/15[26]. In 2018/19 there were 9,676 new individuals assessed for substance use in Wales, representing 59.9% of all individuals assessed in that year. This comprised 5,375 assessments for primary problematic alcohol use and 4,259 assessments for primary problematic drug use[27].

The number of individuals in Wales admitted to hospital for alcohol-specific conditions are 1.9 times higher than the admissions for illicit drug use[28]. Of all of the specialist service assessments undertaken in Wales in 2018/19, 51.7% were primarily problematic alcohol clients and 48% were primarily problematic drug users. The remaining cases were those who reported a problematic use of both drugs and alcohol. In comparison to 2017, deaths from drug use increased by 12.4 per cent to 208 deaths in total and alcohol specific deaths fell by 3.1 per cent to 406 deaths in 2018[29].

[26] Turner, D and Smith, J. (2019), p10. Data mining Wales: The annual profile for substance misuse 2018-19. Public Health Wales Online: Available: http://www.wales.nhs.uk/sitesplus/documents/888/Final%20Annual%20Profile%202018-19%20ENGLISH.pdf

[27] Ibid., p33.

[28] Ibid., p10.

[29] Ibid., p10.

3.4 Local Context

Aneurin Bevan University Health Board (ABUHB) as of 2017 had a population of 587,743 making it the second most populated health board in Wales beneath Betsi Cadawaldr University Health Board with a population of 696,284. This is out of a total Welsh population of 3,125,165[30].

GDAS[31] estimate that in Gwent there are approximately 23,352 problematic drug users and 58,536 problematic alcohol users. This means that out of a total population in Gwent around 14% use substances problematically.

Overall annual hospital admissions for ABUHB are 179,371 which represents 30.6% of the population. Within this health board the areas of Blaenau Gwent U001 and Blaenau Gwent U002 are amongst some of the highest admissions rates at 31.7% and 31.3% respectively. This is against an average Welsh rate of 26.8% with 848,035 admissions[32].

Overall deaths for the ABUHB were 6,231 in 2017 at a rate of 1083/100kpop. This was the third highest across Wales with Cwm Taf University Health Board holding the highest mortality rates followed by Abertawe Bro Morgannwg University Health Board. The overall mortality rate for the Welsh NHS that year was 1% at 33,247 deaths. Of these 6,750 were deemed preventable deaths in Wales overall and in ABUHB there were 1,296 deaths that were noted as being preventable[33].

3.5 Demographics

3.5.1 Introduction

The demographic data presented below is for the whole of Wales and not just for ABUHB.

3.5.2 Deprivation

The proportion of all Welsh patients admitted for alcohol-specific conditions living in the 10% most deprived areas was 3.3 times higher than those from the least deprived areas. In relation to illicit drug use, this figure rose to 6.0 times higher[34]. Turner and Smith[35] argue that these high rates in areas of deprivation could reflect the contribution of additional factors such as "criminalisation on deprivation and the associated impact on health and risk behaviours."

[30] Health Maps Wales (2019). Health Maps Wales. Online. Available: https://www.healthmapswales.wales.nhs.uk/IAS/home/

[31] GDAS (2020), p3. Mental Health Report for APB about Quarters 1 to 19. Gwent Drug and Alcohol service: Gwent.

[32] Op. cit., Health Maps Wales (2019).

[33] Ibid.

[34] Op. cit., Turner and Smith (2019), p10.

[35] Ibid., p30.

3.5.3 Age

In 2018/19 there were a total of 449 school exclusions as a result of alcohol or drugs amongst school aged children. This figure reflects a decrease of 1.8% from the previous year[36]. In the same year (2018/19) there were 999 hospital admissions of young people aged under 25 with an alcohol-specific condition which represents an increase of 4.8% compared with 2017-18. There was a decrease however in young people's admissions for illicit drugs of 1.2% amongst those aged under 25[37]. For hospital admissions involving drug use the most common group was 25–49-year-olds who represented 59.4% of admissions[38]. Deaths from illicit drugs are prominent in the age ranges 15-19 to 65-69 with very low rates reported for older people[39].

Hospital Admissions for different age groups has stayed relatively stable over time. There is a common decline in drug-related admissions after the age of 34 whereas alcohol related admissions increase after this age, peaking at the ages of 55-59[40]. In 2018/19 over 50s accounted for 55.5% of all individuals admitted for alcohol related admissions. The death rates for alcohol related deaths range widely across the lifespan with rates commonly reported between 20-24 through to those over 90 years old[41].

3.5.4 Gender

The number of assessments in Wales for under 20y/o women has stayed relatively consistent however there has been an increase for woman 30-59 with an increase of 15.4% from 2014/15[42]. There has been a 28% increase in assessments for illicit substances for men under 20 and a 14.8% increase for men ages 20-29[43].

The median age for all mind-altering substance use across Wales is 31 years old with a range of 14 to 74. This is gendered however with the median age for women being 25 years and the median age for men being 31 years[44,45].

[36] Ibid., p10.

[37] Ibid., p10.

[38] Ibid., p12.

[39] Ibid., p13.

[40] Ibid.

[41] Ibid., p13.

[42] Ibid., p33.

[43] Ibid., p33.

[44] PHILTRE (2018). Annual Report. Online. Available: http://www.wales.nhs.uk/sitesplus/documents/888/Philtre%20Annual%20Report%202018%20FINAL.pdf

[45] The overall median reflects the much higher number of male users.

3.6 Alcohol Consumption

3.6.1 Background

The Linked Environment for Alcohol Deaths Research report (2017)[46] was developed by Public Health Wales to identify factors in Wales that might reduce mortality related to alcohol. It linked data from across different data sets in Wales to give a picture of 10 years of Welsh alcohol related deaths. It found that across a 10-year period of 2005-2014 there were 7,901 alcohol related deaths. Of these 93.8% had been previously admitted to hospital in a total of 74,775 admissions of which 34,820 were alcohol related. It also found that out of 9,755 individuals admitted to hospital in 2005 with an alcohol related condition, 15.4% of them (1,505 individuals) had died of an alcohol related condition within ten years[47].

3.6.2 Welsh Overview

There have been 10,388 individuals admitted to hospitals with an alcohol-specific condition in 2018-19, accounting for 15,681 admissions in total[48]. This reflects a similar number to those admitted over the last five years meaning that admission rates have stayed constant over that time. Over 2018-19 there were 38,033 individuals admitted to hospital for alcohol-attributal conditions. These are conditions that are partly but not entirely caused by alcohol as opposed to the complete alcohol causation of alcohol-specific conditions[49]. There has been an increase in alcohol-attributable conditions of 5.8% over the previous years rates although it is worth noting that Turner and Smith (2019)[50] argue that there has been an increase in recognition of alcohol-attributable conditions in literature in recent years. It is worth noting too that for both alcohol-specific and alcohol-attributable admissions that there are generally double the admissions for men as there are for women. This has stayed consistent since 2014[51].

3.6.3 Aneurin Bevan University Health Board

ABUHB has the second highest rate of alcohol-related hospital admissions in Wales with 10,645 (1.8%) admissions in the years 2017/18[52]. This is second to Cwm Taf University Health Board which has a higher proportional admission rate at 2% with 5,904 admissions. This is against the Welsh

[46] Emmerson, C. and Smith, J. (2017). The Linked Environment for Alcohol Death Research (LEADR). Public Health Wales: Substance Misuse Programme. Online. Available: http://www.wales.nhs.uk/sitesplus/documents/888/LEADR%20report%20FINAL%20for%20publication%20Jan%202017.pdf

[47] Ibid., p6.

[48] Op. cit., Turner and Smith (2019), p15.

[49] Ibid., p15.

[50] Ibid.

[51] Welsh Government (2019b). Treatment Data- Substance Misuse in wales 2018-19. Online. Available: https://gov.wales/sites/default/files/publications/2019-10/treatment-data-substance-misuse-in-wales-2018-19.pdf

[52] Op. cit., Health Maps Wales (2019).

average of 1.7% with 54,950 total admissions[53]. Blaenau Gwent (in ABUHB) has both the highest rate of alcohol-specific hospital admissions and the highest rate of alcohol-attributable admissions[54].

There was a gendered divide in hospital admissions for alcohol attributable admissions with females making up 3,909 admissions and males making up 6,736 in 2017/18[55]. This gendered divide was reflected in alcohol-specific admissions with females comprising 1,025 admissions and males comprising 1,959 in the same year.

Chronic Liver Disease death rates for ABUHB are the third highest in Wales at a rate of 14.5 per 100,000 population with 84 deaths. This is the third highest in Wales and slightly lower than the Welsh average rate of 14.6 per 100,000 population[56].

ABUHB also has the third highest rate of alcohol-attributable deaths at a rate of 51.9 per 100,000 population with 298 average annual deaths (this is a three-year average across 2015-2017). This is against the Welsh rate of 52.9 per 100,000 population at a total of 1,650 deaths. ABUHB has the second lowest rate of alcohol-related deaths with a rate of 12.7 per 100,000 population at 167 deaths. This is against the Welsh average rate of 13.9 per 100,000 population with a total of 953 deaths. It should be noted here however that this data is a little outdated as the most recent data available from Health Maps Wales on this topic is from 2010-2011.

3.7 Drug Use

3.7.1 Welsh Overview

There has been a 17.2% increase in illicit drug hospital admissions in Wales[57] between the period 2014-15 and 2018-19. In 2018/19 there were 5,292 individuals admitted to hospitals across Wales for illicit drug related issues, 59% of whom were male. For both males and females however there has been an increase in admissions over the last five years with male rates having risen by 22.1% and female rates having risen by 13.3%[58].

There has also been an increase of 35.5% for admissions for multiple drug use over the last 5 years[59]. The high levels of admissions and high levels of drug related deaths in Wales reflect a general UK trend[60].

[53] Ibid.

[54] Ibid.

[55] Ibid.

[56] Ibid.

[57] Op. cit., Turner and Smith (2019), p22.

[58] Ibid., p22.

[59] Ibid., p25.

[60] Welsh Government (2019a), p15. Working Together To Reduce Harm: Substance Misuse Annual report and Forward Look 2019. Online. Available: https://gov.wales/sites/default/files/publications/2019-10/substance-misuse-annual-report-and-forward-look-2019.pdf

3.7.2 Aneurin Bevan University Health Board

ABUHB holds the second highest illicit Drug Use hospital admission rates in Wales. In 2017/18, Health Maps Wales (2019) reported that this rate was 263.7 per 100,000 population with 1,472 admissions. As with alcohol-related admission rates this is second to Cwm Taf University Health board which has a rate of 0.29% but with a lower number of admissions at 843. This is against the Welsh average of 0.22% and 6,506 total admissions for 2017/18. However, Turner and Smith[61] report that more up to date figures put the admission rates for ABUHB at 0.29% showing that the trend of increased figures continues.

There was again a gendered divide in these rates. For females in ABUHB this was a rate of 0.2% with 578 admissions out of a welsh total of 2,571 admissions and a rate of 0.17%. For males this rate was higher at 0.33% with 894 admissions out of a Welsh total of 3,935 admissions at 0.27%.

3.7.3 Prevalence of Drug Type

PHILTRE[62] note that WEDINOS (Welsh Emerging Drugs & Identification of Novel Substances Project, the organisation in Wales that collects and tests substances in Wales) recorded three prominent substances in 2016. They were cocaine, MDMA and Diazepam. These reflected wider European patters in which cocaine and MDMA were the most used drugs across Europe.

GSSMS and CMHT data from Gwent[63] shows a range of substance reported by those in mental health support services. This data came from 150 different cases across 14 different teams. These teams are; Bellevue Ward, Caerphilly, EIS, Gold Tops (Newport), Inpatient, Lower Mon, Newport AOT, Newport CMHT, Newport East, Newport West, Newport West CMHT, South Caerphilly, Talygarn Ward and West. Newport West had the most reports with 8 cases presented in total. Lower Mon followed with 4 cases and Newport East after with 3.

Of all the individuals who were included in this data set, 146 out of the total of 151 has co-occurring substance use. 3 out of the 151 did not and two were currently not reporting co-occurring substance use but were implied to have had co-occurring substance abuse issues in the past.

The Substances Listed in this data set were; Alcohol, Cocaine, Cannabis, Amphetamines, Opiates, Benzo's, Legal Highs, Crack, Crack Cocaine, Cocaine ++, Heroin, Methadone, MDMA, Ketamine, LSD, Sedatives, Spice, Street Diazepam, Subutex, Xanax, Tramadol, Gabapentin and butane gas.

In the general Welsh data, opioids are the substance group with the highest number of admissions associated with it with 3,171 related admissions in 2018/19. This is an increase of 4.4% on the previous year[64]. In Gwent however the most commonly reported substance was Cannabis with 67

[61] Op. cit., Turner and Smith (2019), p26.

[62] Op. cit., PHILTRE (2018), p6.

[63] The data used by the research team was provided by GSSMS and GDAS in Excel form.

[64] Op. cit., Turner and Smith (2019), p23.

counts reported. Cannabinoids are the second highest substance group reported in wider Welsh statistics with 1344 admissions in 2018/19 and an increase of 8.7% compared to the previous year[65,66].

Alcohol was the second most common substance in Gwent with 36 counts and the next most common was cocaine at 21 followed by amphetamines at 13. This broadly reflected the wider Welsh healthcare data which shows that the largest increase in admissions involved cocaine with an increase of 105.9% over 5 years. Turner and Smith[67] argue that this increase is due to the increased availability and purity of cocaine.

In Wales, admissions for benzodiazepines has stayed stable over the last 5 years and there has been a decrease in the number of admissions of "other stimulants"[68].

The most common combination of co-occurring substance use in the Gwent data was cannabis and amphetamines with 14 people declaring these as their two main substances. This was followed by cannabis and alcohol which 11 people stated were their substances of choice.

3.7.4 Drug Related Deaths

There has been recorded increases in drug deaths in Wales over the last few years. The 2017/18 PHILTRE annual report noted an increase of 13.9% over 2016[69].

GDAS[70] note that there is often a delay in deaths being recorded as drug related and that therefore statistics often see a delay.

In 2016-18 in ABUHB, Torfaen had the highest rate of drug related deaths at 8.7, this was followed by Blaenau Gwent at a rate of 8.5[71].

GDAS[72] note that there has been a definite rise in drug related deaths over the last couple of years although they note that part of this is because of their focus on those who are most at risk including those leaving custody and those who are recovering from suicide attempts. There has been an increase in uptake of life saving programmes such as the needle exchange programme with 25,571 individuals accessing this in 2018/19[73] and 1,308 new individuals accessing the take home Naloxone programme in the same year[74].

[65] Ibid., p23.

[66] In this hospital data there is no distinction between cannabinoids.

[67] Ibid., p25.

[68] Ibid., p15.

[69] Op. cit., PHILTRE, p6.

[70] Op. cit., GDAS (2020), p11.

[71] Ibid., p11.

[72] Ibid., p11.

[73] Op. cit., Welsh Government (2019a), p7.

[74] Ibid., p6.

3.8 Mental Health Statistics

Available literature suggests that around eight out of every ten individuals who have substance abuse issues also have mental health challenges[75]. Over the last five years, psychiatric admissions for alcohol-specific conditions have increased by 21 per cent and for illicit drugs by 38.1 per cent[76]. Admissions for illicit drug use are significantly more likely to involve psychiatric treatment than alcohol-specific admissions although the proportion of admissions receiving psychiatric treatment for both has increased across Wales[77]. In 2018/19 6.6% of alcohol-specific admissions and 11.2% of illicit drug admissions also had contact with psychiatric services[78].

3.8.1 Aneurin Bevan University Health Board

In 2018/19 there were 1,919 formal admissions to mental health facilities in Wales. Combined with the 6,399 informal admissions made there were a total of 8,315 admissions to mental health facilities in that year. Of this total, 1313 of them were in Aneurin Bevan University Health Board comprised of 164 formal admissions and 1149 informal admissions[79,80]. The rates of those with mental illnesses who are in mental health hospitals in Aneurin Bevan University Health Board have broadly decreased over the last decade going from 192 in 2009 to 154 in 2019[81].

Detentions under section 135 and 136 of the Mental Health Act in the quarter ending September 2020 totalled 64 in ABUHB. This was comprised of 3 in the 16-17 age category and 61 in the over 18 category[82]. This was the fourth highest rate out of the Welsh health boards with Betsi Cadwaladr University Health Board having the highest number with a total of 511. Within this same quarter, for the month of September 2020, Aneurin Bevan University Health Board saw 1,491 referrals to local primary mental health support services[83]. This was the highest number out of any health board in Wales and comprised a significant part of the Welsh total referral number of 5,720.

The numbers of those presenting to emergency departments for mental health issues has stayed relatively stable over the last few years. In 2017 there were a total of 4490 attendances, in 2018 this fell to 4232 and in 2019 there was a very small increase to 4234. This data comes from four hospitals in the Aneurin Bevan University Health Board; Royal Gwent, Nevill Hall, Ysbyty Ystrad Fawr and Ysbyty Aneurin Bevan. Of these, Royal Gwent had the highest rates with a total of 7788 attendances over the three years and Ysbyty Aneurin Bevan had the lowest with 95 over the three years. Across the

[75] Op. cit., GDAS (2020).

[76] Op. cit., Turner and Smith (2019), p10.

[77] Ibid., p28.

[78] Op. cit., Welsh Government (2019b).

[79] Stats Wales (n.d). Substance Misuse. Health and Social Care. Online. Available: https://statswales.gov.wales/Catalogue/Health-and-Social-Care/Substance-Misuse

[80] There were also 217 admissions made to independent hospitals of Wales, some of which would be individuals from Gwent, although it is not clear how many.

[81] Ibid.

[82] Ibid.

[83] Ibid.

three years and the four hospitals there were a total of 12,956 attendances in emergency departments for mental health issues.[84]

Deaths linked to mental and behavioural disorders in ABUHB in 2017 were at a rate of 0.12% with a total of 691 deaths out of the Welsh total of 3,907 and a national Welsh rate of 0.12%. For this rate ABUHB was only fourth highest out of seven health boards with Abertawe Bro Morgannwg Health Board having the highest rate of deaths followed by Cwm Taf University Health Board and Cardiff and Vale University Health Board. For 2017, there were 224 deaths related to mental and behavioural disorders amongst males in ABUHB and 467 females[85]. This indicates a significant gender divide that is in opposition to the gendered divide for substance use.

Suicide rates in Aneurin Bevan University Health Board are the lowest across all Welsh health boards at 10 per 100,000 population. This is an average of 57 suicides annually. The average rate for the whole of Wales is 11.3 per 100,000 population and 345 annual deaths[86].

Diagnosis statistics show that the most prominent mental health condition reported for those with substance abuse issues in Gwent is depression at around 17%. This is followed by the second most common, Anxiety and the third, Anxiety and depression at 5.4% and 5.1% respectively[87]. Self-reported mental health conditions show a similar prominence of depression and anxiety. When diagnosed and self-reported mental health statistics are combined however, PTSD also emerges as a prominent mental health condition with over 1% of cases reporting PTSD[88].

GDAS[89] note the link between substance use and homelessness, noting that many of those they engage with are insecurely housed and that this also has a negative impact on mental health. PHILTRE[90] also note this, stressing the importance of setting in drug use and acknowledging the prevalence of drug taking following a prison stay or a period of homelessness.

3.9 Referrals

GDAS[91] note a challenge with referring those with substance abuse problems to Gwent Specialist Substance Misuse Service who then refer clients back to GDAS. GDAS[92] also note that there is a real challenge with getting individuals into mental health services as those with co-occurring needs don't

[84] The data used by the research team was provided by GSSMS and GDAS in Excel form.

[85] Op. cit., Health Maps Wales (2019).

[86] Ibid.

[87] Op. cit., GDAS (2020), p4.

[88] Ibid., p6.

[89] Ibid., p10.

[90] Op. cit., PHILTRE (2018), p7.

[91] Op. cit., GDAS (2020), p7.

[92] Ibid., p7.

meet requirements and are often told to deal with substance issues before they are given access to mental health support.[93]

3.9.1 Maternal Health

There were 12 hospital admissions in Wales in 2018/19 for Foetal Alcohol Syndrome, an increase of 1 from the previous year[94]. In previous years however there had been an overall decline in hospital admissions for foetuses and neonates affected by maternal substance use or withdrawal and in 2018/19 the admissions rates were at their lowest since 2009/10[95]. The rate of foetuses and new-borns who were recorded as being affected by alcohol or drugs was 25% lower in 2018/19 than any other point in the last decade[96].

3.10 Summary

- Aneurin Bevan University Health Board is the second highest populated health board in Wales.
- Around 14% of the population of Gwent are estimated to use substances problematically.
- ABUHB has the second highest rate of alcohol related hospital admissions in Wales and Blaenau Gwent within ABUHB has the highest rates of both alcohol-specific admissions and alcohol-related admissions.
- Twice as many men as women are admitted to hospital in ABUHB for alcohol attributable reasons.
- ABUHB has the third highest rates of Chronic Liver Disease in Wales and the third highest rate of alcohol-attributable deaths in out of all Welsh health boards.
- ABUHB has the second highest rate in Wales of illicit drug use hospital admissions. There were significantly more men than women admitted for illicit drug use.
- The most common substances used in Gwent are Cannabis, Alcohol and Cocaine. Co-occurring substance use is very common with cannabis and amphetamine use being the most common combination of substances.
- There has been a rise in drug-related deaths over the last few years and in ABUHB Torfaen/Torfaen and Blaenau Gwent had the highest rates of drug-related deaths.
- In 2018/19 there were 1313 admissions to mental health facilities in ABUHB. The numbers of people in mental health facilities in ABUHB has generally decreased over the last decade.
- ABUHB has the highest number of referrals to local primary mental health support services.

[93] Since the time of data collection for this report GDAS has now begun working with a Dual Diagnosis Nurse who has helped address some of these challenges.

[94] Op. cit., Turner and Smith (2019), p35.

[95] Ibid., p35.

[96] Op. cit., Welsh Government (2019a), p6.

- The most common mental health condition reported for those with substance abuse issues in Gwent is depression followed by Anxiety.

CHAPTER 4: KEY FINDINGS – PROFESSIONAL VIEWS

4.1 Introduction

This chapter presents a thematic analysis of the key findings of each of the mixed methods of the study that focused on the views of professionals:

- Semi-structured interviews [n=**32**];
- Stakeholder Events [n=**33**] and Working Groups [n=**42**]; and
- Staff Surveys (Substance Use Service Staff [n=**34**]; Mental Health Service Staff [n=**103**] and Staff from generic services [n=**115**]).

The full detail of the transcribed groups and interviews, and surveys are presented in the accompanying **Part 2 Appendix Report (Appendices III, IV and V)**. These key findings have then been analysed by the research team against the original objectives of the study in order to inform the study recommendations (see **Chapter 6** below).

For maximum insight, it should be read in conjunction with **Appendices IV**, which set out the range of viewpoints articulated in the wide range of interviews undertaken.

4.2 Context for conducting evidence gathering activities with professionals

To provide context for our evidence gathering from professionals, a rapid review was undertaken of similar Co-Occurring Needs Assessments and equivalent studies from around the UK.

Literature sources were identified through searches of internet websites Google and Google Scholar during October-November 2019. A series of Boolean searches were conducted, with the team deciding on the following search terms: 'needs assessment' AND 'co-occurring' / 'dual diagnosis', 'mental health' / 'substance (mis)use', and 'co-existing'.

Eight relevant co-occurring documents from different areas of the UK were identified and analysed to draw out any key themes and any potential lessons that could be learned for the Gwent study. Where possible, full relevant needs assessment were included, however, evidence from Kirklees and Warwickshire are chapters from wider mental health needs assessments which limits the depth of analysis possible. In total six needs assessment documents and two guidance documents (detailed in the table below) have been included. This is not an exhaustive list; however, it presents an overview of several relevant issues in terms of supporting people with co-occurring conditions which helps to situate the current report into the wider context.

Table 4.1: Relevant Co-Occurring studies

Study Title	Authors	Date
Kirklees Mental Health and Wellbeing Needs Assessment	Elliott, R., Wearmouth, L., and Richardson, O.	2018
Derbyshire Co-occurring Conditions Needs Assessment	Figure 8 Consultancy	2018
Better Care for People With Co-occurring Mental Health and Alcohol/Drug Use Conditions: A Guide for Commissioners And Service Providers	Public Health England	2017
Norfolk Dual Diagnosis: Health Needs Assessment For co-existing mental ill-health and substance misuse (A dual diagnosis recovery approach)	Edwards, D., Habib, S., and Pereira, A.	2015
Dual Diagnosis Needs Assessment (West Sussex)	Figure 8 Consultancy	2014
Dual Diagnosis Needs Assessment (Brighton & Hove)	NHS Brighton & Hove, Brighton & Hove Council	2015
Warwickshire Dual Diagnosis Needs Assessment		2012
Dual Diagnosis in A Primary Care Group (PCG), (100,000 Population Locality): A Step-By-Step Epidemiological Needs Assessment and Design of a Training and Service Response Model: Executive Summary	Strathdee, G., Manning, V., Best, D. W., Keaney, F., Bhui, K., and Witton, J. et al.	2005

Full details of this evidence review are provided in tabular form in **Appendix II**). Below are the key messages and themes to emerge from the review.

Table 4.2: Key messages and themes from review of similar Needs Assessment studies

ACCESS TO SERVICES /DEFINED PATHWAY	There should be an 'open door policy' for people with co-occurring conditions.
	Development of care pathways/protocols to aid efficient use of resources and work as a communication tool between agencies.
	Accessing mental health support is difficult for individuals who are using other substances.
HOUSING	Accessing suitable housing is difficult for those with co-occurring conditions, especially those who are homeless.
INFORMATION SHARING	Lack of an information sharing protocol.
JOINED-UP WORKING	Joined up working between mental health services and substance use services is patchy.

	Services with staff trained in co-occurring conditions could provide an alternative to working in independent silos.
PREVALENCE	Limited data exists to assess the trend in prevalence rates of co-occurring conditions.
	Co-occurring mental ill-health and substance misuse is more common than evidence from drug and alcohol services suggests.
	The number of people have a co-occurring condition in unknown.
SAFEGUARDING	Issues of adequate safeguards being in place for people with co-occurring conditions in terms of their health, social, and economic needs.
	Emotional stressors or circumstances can be worsened by an individual's substance use.
WORKFORCE DEVELOPMENT	Adequate training of staff who support people with co-occurring conditions is lacking.
	Hesitancy to engage with people who are accessing mental health support who are actively using substances.

4.3 Professional views – key findings

The key findings from each of the evidence gathering methods (used with professionals) are presented first below; and then, to give structure, our analysis of views and what they tell us will be presented under the headings of Strengths, Weaknesses, Opportunities and Threats (SWOT).

4.4 Key Stakeholder Interviews – Key Messages

A total of 32 people representing public and 3rd sector services who are directly or indirectly engaged in the provision of substance use and mental health services participated in extended semi-structured interviews. This included twelve (12) face-to-face or telephone interviews that were conducted prior to the Covid-19 national lockdown (March 2020). The remaining twenty (20) interviews were conducted as online face-to-face interviews (via Microsoft Teams) after lockdown (between April – October 2020).

Interviews were semi-structured in nature, primarily focusing on the following topics:

- Equity and accessibility to services
- Multi-disciplinary and partnership working
- Workforce development
- Data availability/usage and information sharing/communication
- Prevention and early intervention
- Housing issues

Interviews were professionally transcribed and were then anonymised prior to independent coding and analysis of responses by two members of the research team. The analysis has identified the following high-level consistent themes and messages following an initial identification of a wider set of sub-themes (detailed in **Appendix IV** of the **Part 2 – Supporting Evidence** report).

4.4.1 Equity and accessibility to services

All interviewees were asked to comment on the current provision of co-occurring services across ABUHB. Most interviewees indicated that although a range of separate mental health and substance use services existed, access was often hindered by a strict exclusion criteria. One common example, expressed by multiple interviewees, related to the capacity of individuals with co-occurring conditions to access mental health services if they were still using substances. Mental health services would only grant access to those that had evidence of abstinence. This resulted in many service users being 'bounced' between services.

> *'From a clinical experience…because a person has a mental health problem, mental health services will kind of say you need to address that first and go to GDAS or whichever agency that is the gateway into services…I guess the issue with that is these clients are not the best at engaging or self-referring to these services though. So, when they do get referred into secondary mental health services it often like, well, you need to go and address your substance use first rather than it being addressed concurrently.'*

> *'A lot of GPs will say go straight to GDAS…because I know the system I'll refer straight to GSSMS. I don't think there is a great understanding among primary care colleagues about the best place for these people to go to. If they were very concerned they may refer them to the psychiatrists, who will then bounce them back to the GP. I don't think there is any clear or general understanding where the patient should go to.'*

> *'The biggest issue is around access. Considering the issues this group will bring, the level of access is totally limited…the actual door to get into these services (mental health) is very difficult to get in. Access is worse now than what it has previously been even though we've tried to put thing in place to change this.'*

The introduction of the Mental Health (2010) Wales Measure was cited by numerous interviewees as a major contributing factor as to why access to services had become more difficult in recent years. One interviewee neatly summarised how the measure had led to a 'fundamental' change in policy of GSSMS, which meant that - regardless of an enduring mental health issue - if clients were not receiving support from a primary mental health service they could not be referred to mental health from a drug service. As such, some drug services faced difficulties in referring clients who had severe co-occurring conditions.

> *'[The mental health measure] What this meant is that GDAS were left with people who were diagnosed with mental health issues who could or could not be mentally well at the time. And the only time we could get them into a specialised co-occurring service (GSSMS) we had to first get them into the mental health system…which for us was completely impossible because that*

system has a system where you miss two appointments and you are discharged, they have a bounce back of this is a drug issue and not a mental health issue, you have to do work around the drug and alcohol issue first, so we ended being left with some pretty ill people who couldn't get into services…the general response to that has been to put in the COG[97] panel…'

Further difficulties in accessing services related to the equity of provision across the region. Gwent is composed of rural, semi-rural and urban environments. Some interviewees stated how primary and secondary care provision was more concentrated and accessible in larger urban areas such as Newport and Caerphilly, in comparison to Monmouthshire or Blaenau Gwent. As such, many service users faced difficulties in travelling to and accessing services on a regular basis:

'Issues in Monmouthshire are that people are fairly isolated…often people have retired to Monmouthshire or their younger family have moved away…so people are often more isolated in Monmouthshire……areas such as Blaenau Gwent have proved difficult in terms of recruiting GPs, Primary Care provision maybe isn't as robust in Blaenau Gwent as it is in Newport.'

Concerns were expressed that people may not be accessing appropriate help because the qualifying threshold for access to mental health services is high. Interviewees emphasised that caseloads and access thresholds have risen in community mental health services. The *Dual Diagnosis* (2002) guidance and the *Coexisting severe mental illness and substance misuse* (2016) do have formal definitions that entail severe and enduring mental illness as the criterion for case management to be coordinated in mental health services:

'The mental health system has always been incredibly difficult for people with substance use issues to access…there has always been a view and idea that the issue is their substance use and not their mental health, even though if you look back through their history the will be a history of ADHD prescribing in child, of diazepam in child, psychological services when they were young, so these things have always existed before. So, there is always that myth that you need to sort out your drug use before mental health. The level of self-medication is huge, people do things to dampen these.'

On the whole, many interviewees stated that specific services for those with co-occurring conditions were 'limited' and was in need of improvement across the region:

'Limited is what I'd say…within GDAS [there is] a co-occurring nurse that advises, and the COG panel, which has arisen really due to the lack of services and lack of access. It is supposed to be a gateway, or bridge to services for this group. Then you've got GSSMS, and a smattering of small projects such as Growing Space which don't exist solely for that purpose but offer support. You have a few services set up in GDAS, and actually services, which is GSSMS, and there are services that will take referrals for people with mental health and substance use issues…and some of them take a bit of persuading and pushing about…one time they wouldn't take referrals from us and then they do…but, its quite patchy.'

[97] The Co-Occuring Gateway [COG] Panel is a new initiative (covering Newport) which aims to provide those with co-occurring substance misuse and mental health problems with the most appropriate care.

4.4.2 Multi-disciplinary and partnership working

Most interviewees indicated that effective multi-disciplinary and partnership working *across* mental health and substance use services was limited. Apart from occasional examples of valued collaborations, seemingly predicated on the initiative of individuals rather than being systemic organisational initiatives, most respondents were supportive but unclear how to achieve joint working.

With systems under pressure the need for partnership working increases and the perceived cost of taking time to invest resources in it diminishes. Apart from a newly established group where mental health workers go to joint review meetings at the drug service where service recipients regularly attend (The Co-Occurring Group 'COG' Panel) there were few examples of joint working.

Frequent comments on good practice through this process highlight the importance of especially talented and (socially) skilled individuals who initiate collaborative working. It seems that for joint working to develop and become embedded in routine practice there will need to be leadership and that may need to be directed. It may not be enough to rely on commissioned services to deliver KPIs – they may have to be given specific instructions as to how and precisely what to do to optimise the functioning of the overall local systems.

4.4.3 Workforce Development

Many interviewees detailed how they felt they lacked the necessary skills and attributes to deal with issues outside of their area of specialism. For example, mental health service staff stated how they lacked sufficient knowledge in drug-related advice (for example, harm reduction) whilst drug service staff repeated a similar experience in relation to mental health advice:

> *'Lack of communication…misconceptions on what each other can do. I think it's because there's a lot of mental health practitioners have come through mental health training, psychiatry and so on, and therefore substance use services think they should manage these patients. Substance use services might not be as up to date with developments or issues around psychosis and so on.'*

As such, many clinicians and staff members stated how they required training and relevant preparation in these areas. Training courses, the sharing of information, and secondments were all suggested as ways of improving knowledge and understanding among service deliverers.

4.4.4 Data availability/usage and information sharing/communication

Perhaps unsurprisingly many of the comments on this issue related to the operational practicalities of recording and data sharing. Many interviewees alluded to how clear lines of communication were often fragmented between mental health services. Others alluded to how outdated systems

prevented sufficient recording and sharing of data. The current database used across Gwent APB was also regarded, by almost all interviewees, as outdated and a barrier to information sharing:

> *'I guess when I started I was shocked that we still used paper notes…we're not digitalised at the moment. We write all our detailed notes by hand. There are definitely plans to go ahead with digitialising stuff but there are barriers in place. WCCIS is looking to come in, [but] we're still using EPEX at the moment..you can go on there and see if another service has seen that person, but there are no outcomes or any details of that appointment…[the quality of communication] is really poor.'*

Of course, that does not prevent professionals sharing information with appropriate consent in a variety of ways. Anxiety about information sharing is often a result of lack of understanding about the legal and organisation positions and untested assumptions that presume service recipients are unwilling to have data shared. This is frequently, perhaps usually untrue and securing informed consent should be routine. Requiring compatible electronic systems to be deployed might be a challenge but providers should shoulder some responsibility for ensuring appropriate levels of liaison and information sharing.

4.4.5 Housing issues

Interviewees often remarked upon housing, with the lack and suitability of housing options and gaps in appropriate housing options for those with co-occurring conditions raised. Many felt that the housing situation was currently worse than it had previously ever been:

> *'We see people who are homeless who haven't been homeless before, that's because things have got harder for people. We see people who we never thought we would see before.'*

The lack of a stable home was cited as one barrier to individuals with co-occurring conditions accessing services:

> *'I think it gives you stability, feeling comfortable in your own surrounding. But the most important thing is the wellbeing aspect…when you go inside someone's house it's often dire…having a nice house should be everybody's right. It should be warm, clean, a safe haven.'*

Furthermore, it appears that if people are using drugs this could further hinder the issue of accessing suitable housing. Criteria for accessing housing support appears to be too high (including potentially too high for the legal position of housing as a human right), whereas it was noted that chaotic individuals using substances are not always easily housed.

A lack of integration between health, social care and housing was also discussed, and the apparent lack of suitable housing options in the community also appears to have resulted in people being kept in hospital, a barrier to a smooth transition back into the community. Within the housing structure, it was stated that if mental health and substance use services had multi-disciplinary meetings there could potentially be better plans for housing individuals.

4.4.6 Provision for specific populations

As highlighted in the working groups with service providers, a lack of service provision for specific populations were alluded to by many interviewees. Older people in particular were recognised as one population who faced significant barriers to accessing services. For some interviewees, this was due not only to the remoteness and limited transport infrastructure in some regions, but also the inability of older residents with co-occurring conditions to present to services. Some clinicians within primary care also felt they were 'not being good enough' at asking and diagnosing such conditions in this population. Often this was due to awkwardness in consultations around asking older adults about their substance use (*"one saying we have is that you never ask a patient anything you wouldn't ask your granny*"), but also an under-recognition of the issue among mental health staff:

> *'I think under-recognition [is the main issue]…because its under-recognised therefore our staff don't know a lot about it when we do see patients…we feel unskilled, I think…because we don't recognise it, we don't see it.'*

Similar concerns were raised about services for young people. Although one service does exist specifically for young people with substance use problems, the current provision across the region was seen as lacking:

> *'Don't even start on CAMHS…I don't think there is any service for young people with substance misuse problems in GWENT, not that I'm aware of…they have got to be seriously unwell before CAMHS would look at them…'*

4.4.7 Moving Forward

Many of the aspirations for the future looked both at the need to build capacity within and to look beyond the key specialisms of traditional alcohol and other drugs and mental health service approaches in identifying how best to address coexisting conditions sustainably.

Several interviewees highlighted the need for a fully integrated mental health and substance use service similar to models existing elsewhere. Two models in particular – the Trieste[98] and COMPASS project in Birmingham[99] – where multiple integrated services operate in a 'hub' environment for those with co-occurring conditions were highlighted as a form of 'better' practice that had proved successful:

> *'I went and saw the model in Trieste which is fantastic because it's a completely non-clinical approach…they've got a similar system in London where you have the 3rd sector, clinicians, LAs, but they are all on the same unit. And when someone comes in they talk to everyone. If you look at Trieste…it's like going into someone's living room.'*

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[98] file:///C:/Users/Andy%20Perkins/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/DVDEL3MH/TMHCommunityMentalHealthCareInTrieste.pdf

[99] https://www.bsmhft.nhs.uk/our-services/addictions-services/dual-diagnosis-compass-programme/

'I think it's more about collaborative teams, kind of like integrated teams, that are joint funded by APBs and health directorates, it doesn't have to just be mental health directorates…and having kind of like a multi-agency teams…the COMPASS team in West Midlands and Birmingham Trust…they are health orientated, occupational therapy, social worker, psychologist led…they did a lot of work…what they do is more therapy CBT based…what they try and do is prevent that revolving door. What you do is see client with the care-coordinator to try and get the therapy to work with that person, but also training the staff up to try and prevent relapses as well. So that was a project we were looking at setting up.'

4.4.8 Care Co-ordination

Finally, several interviewees highlighted a need to align future co-occurring services with NICE guidelines and 'care-orientated' approach to working. One interviewee had become aware of this approach through 'best practice' methods when dealing with individuals with co-occurring conditions.

'One thing I've heard from going to a conference and reading the NICE guidelines is having substance use services care co-ordinated…we don't…a care coordinator will be solely responsible for that person but also co-ordinate the care with other services and kind of be the first king of contact for that service itself. It's in the NICE guidelines.'

4.5 Stakeholder Events – identification of key themes for the Needs Assessment

The key messages and themes which emerged from the rapid literature review (see **Table 4.2** above) were used at the initial stakeholder Events in December 2019 to see whether the identified key messages and themes resonated with the current situation in Gwent.

Following the Stakeholder Event discussions, the following list of **six** priority themes/issues/messages were agreed as being 'essential' for this Needs Assessment study to consider:

1. Equity and accessibility to services and pathways for defined populations
2. Multi-disciplinary and partnership working to better provide a holistic approach to care
3. Workforce development
4. Data availability/usage and Information sharing/communication
5. Prevention and early intervention
6. Housing issues

These priority issues are consistent with the key messages identified from similar studies around the UK reviewed by the research team (see **Table 4.1** above).

In addition to the above issues, the Stakeholder events also agreed two further areas for consideration by the Needs Assessment:

1. 'Transition' issues for young people into adult services; and
2. The Needs of Older Adults who experience co-occurring mental health and substance use conditions.

4.6 Working Groups – Key Messages

The original plan had been to set up two working groups of professionals that would each meet three times during the course of the study. However, given the initial timescales for completion of the study, it was agreed that meeting three times for each group would be too much of a commitment. Following discussions with the Clinical Director for Older Adult Mental Health it was agreed to run a working group with staff from Older Adult Mental Health services, rather than try and cover this topic within the adult-focused working groups. This made it possible to run three working groups (each meeting twice) rather than the original plan of two working groups (each meeting three times). All the working group sessions were digitally recorded to aid accurate transcribing of notes and key messages.

Each of the working groups focused on covering the six priority areas mentioned above. The adult-focused working groups also considered the transition needs of younger adults into adult services, whereas the older-adults working group considered the six main issues through the lens of older adult service provision.

All three working groups agreed that all conversations should be grounded through consideration of the following two key principles which were outlined by Public Health England in their 2017 report 'Better care for people with co-occurring mental health and alcohol/drug use conditions'[100, 101]:

1. *It's everyone's job*. Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.
2. *No wrong door*. Providers in alcohol/drug, mental health and other services have an open-door policy for individuals with cooccurring conditions and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point.

A full summary of the working group discussions is provided in the **Part 2 – Supporting Evidence** report at **Appendix III**.

[100] Public Health England (2017). Better Care for people with co-occurring mental health and alcohol/drug use conditions. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/625809/Co-occurring_mental_health_and_alcohol_drug_use_conditions.pdf

[101] The PHE guide is intended to cover all ages, all settings and every combination of substance use and mental health. Although most issues are covered briefly, the document provides some practical points that commissioners and providers should consider. These include therapeutic alliance, optimism and workforce training needs.

4.6.1 Adult-focused working groups (Ebbw Vale and Newport) – key findings

- Those with co-occurring conditions often struggle to get support as they are expected to address their substance use before accessing mental health services.
- Those with complex or additional needs experience barriers when trying to access support. This is especially true for those who cannot self-refer.
- It is not always clear what the responsibilities are for each service and therefore it can be unclear which service is best suited to an individual's needs.
- There is an overall lack of engagement and communication between services, although this seems to be a particular problem between services and the NHS and police.
- There is an overall lack of workforce development and some staff are left feeling that they do not have the tools to support those who offer the correct advice.
- It was felt that staff were generally overworked and that their caseloads were too big.
- Information sharing is a key challenge in collaborative working, one which has only become even more challenging since GDPR.
- Early intervention was recognised as key with a particular emphasis on education and counselling options.
- Housing is a complex and intricate challenge as many have complex housing needs. There have been moves to make housing services more trauma informed however.

4.6.2 Older adult-focused working group (Ebbw Vale) – key findings

- Older people have more complex access needs and it is often unclear which service is best suited to them.
- There needs to be a clearer and more one-to-one approach to supporting older people.
- There is a lack of workforce development when it comes to engaging with older communities.
- The NHS and Police are complex partners in offering support and communication issues exist between these organisations and services.
- The housing needs of older adults are complex but good work is being done in this area.

4.7 Staff Surveys – Key Messages

A series of three surveys were developed for distribution amongst:

1. Staff working in Substance Use services - from whom 53 staff members started the survey, with a total of **34** responses used for analysis.
2. Staff working in Mental Health services – from whom 136 staff members started the survey, with a total of **103** responses used for analysis.

3. Staff working in wider services (such as Learning Disabilities, Housing, etc.) - from whom 158 staff members started the survey, with a total of **115** responses used for analysis.

Each of the surveys have been analysed with key themes identified under the following headings:

1. Language and terminology
2. Sources of learning, training and development about co-occurring conditions
3. Learning, training and development opportunities
4. Future learning, training and development needs
5. Criteria for assessing co-occurring mental health and substance use conditions in Gwent / in your service
6. Joint working between mental health and substance use services
7. Primary responsibility for treating those with co-occurring conditions
8. Challenges facing those with co-occurring conditions
9. Gaps in Current Service Provision
10. Areas of Duplication and Overprovision
11. Other assets, resources, groups, individuals, and/or opportunities
12. Groups who have co-occurring conditions who are NOT well-catered for
13. Co-occurring principles ('It's everyone's job' and 'No wrong door')
14. Areas of support that are particularly good in mental health OR substance use services for those with co-occurring conditions
15. Service improvements
16. Other comments

Full details of the survey results is provided within the **Part 2 – Supporting Evidence** report in **Appendix V**.

4.7.1 Substance Use Staff Survey – Key Messages

- There were **34** responses to the Substance Use Staff Survey, with the majority of respondents were female (85%, n=**29**).
- Staff came from a variety of job roles within alcohol and drug services, with 41% (n=**14**) in a Keyworker / Case Holder position.
- The majority of staff who responded work for Gwent Drug and Alcohol Service (79%; n=**27**).
- A key theme to emerge in terms of issues /challenges around the language/terminology centres on the term 'Dual Diagnosis' and in the main, respondents considered this a useful definition. For some, the term was useful with regard to understanding the term from a client's perspective.

Although some respondents favoured the term 'Dual Diagnosis', this view was not held by all, with some preferring the term co-occurring conditions.

- Respondents' main sources of learning were through 'In-service education', which was followed by 'Multi-agency training day.' Respondents' primary source of learning was through 'In-service education', which was followed by 'Own reading of research.'
- The majority of respondents indicated that the learning, training and development opportunities they had received, had been sufficient to enable them to work effectively with individuals with co-occurring conditions.
- The majority of respondents were not aware of any defined criteria for assessing co-occurring conditions in Gwent. That said, over 70% of respondents noted an awareness for a defined criterion in their own service, with this occurring during the assessment process.
- How well mental health and substance use services work together for people with co-occurring conditions needs improving, as few examples of effective joint working were noted.
- In terms of which service should take primary responsibility for differing (combined) severity of mental health and substance use presentations, respondents were of the view that when presentations include equal levels of both substance use and mental health problems, both services should take primary responsibility. Mixed views are observed when it comes to primary responsibility for high-level substance use and low mental health problems, with just over half of respondents thinking substance use services should take primary responsibility and just under half thinking this should be the role of both services.
- Challenges facing those with co-occurring conditions include 'Access to mental health services', 'Housing / homelessness' and 'Accessibility.'
- In terms of gaps in current service provision, mental health support was recognised as a priority area and there was recognition that those with co-occurring conditions are not receiving adequate support.
- People affected by homelessness are a group that are considered to be not well catered for in Gwent.
- Respondents believe that the principles of 'It's everyone's Job' and 'No wrong door' are not well embedded and embraced across Gwent.
- Dual diagnosis support and dual diagnosis specific staff and the links into dual diagnosis services are areas of support that are considered particularly good in mental health services for those with co-occurring conditions.
- Services can be improved for those with co-occurring conditions by making better links with mental health services and providing more staff training.

4.7.2 Mental Health Staff Survey – Key Messages

- There were **103** responses to the Mental Health Staff Survey, with the majority of respondents female.
- Staff came from a variety of job roles within mental health services, such as older adult mental health services, community mental health teams and the Gwent Primary Care Mental Health Support Service.
- Two-thirds of respondents work within adult services.
- Mixed views were expressed in terms of the challenges around using the terminology. There was recognition that terms used can be vague and present difficulties in terms of clinicians diagnosing a condition. Moreover, the terms used to describe individuals can have a stigmatising effect.
- Respondents' main sources of learning were through 'Own reading of research', which was followed by 'In=service education.' Respondents' primary source of learning was through 'In-service education', which was followed by 'Own reading of research.'
- Over half of respondents were of the view that the learning, training and development opportunities they had received, had been sufficient to enable them to work effectively with individuals with co-occurring conditions. Conversely, just under half of respondents reported that it has not been sufficient.
- Overwhelmingly, respondents were not aware of any defined criteria for assessing co-occurring conditions in Gwent.
- Just under half of the 60 respondents who answered the question were of the view that joint working between mental health service and substance use services is currently limited or poor. That said, a number of respondents were of the view that joint working between the services is working well. Several respondents did provide examples of joint working between the Gwent Specialist Substance Misuse Service and other partners, however there were mixed views in terms of the effectiveness of the process.
- In terms of which service should take primary responsibility for differing (combined) severity of mental health and substance use presentations, respondents were of the view that when presentations include equal levels of both substance use and mental health problems, both services should take primary responsibility. Over two-thirds of respondents agreed that mental health services should take the primary responsibility when there are high levels of mental health problems co-occurring with low levels of substance use, with a similar number of respondents of the view that substance use services should take primary responsibility in the opposite situation.
- Challenges facing those with co-occurring conditions include access to services. Concerns were raised that individuals may not be accessing the appropriate services, which suggests that gaps exist in the current service provision. There was also acknowledgement that access to mental health provision for people actively using substances is challenging, and at times non-existent. Housing needs were also identified as a challenge for those with co-occurring conditions.

- In terms of gaps in current service provision, access to mental health support and joined-up working were noted. A number of respondents viewed the current level of mental health provision as inadequate to meet the needs of those with co-occurring conditions, with threshold criteria, waiting lists and limited resources highlighted as areas of concern.
- The majority of respondents do not think there are any areas of duplication or overprovision.
- Older people, people with mental health issues and those experiencing homelessness, are groups which are not well catered for in Gwent.
- The principles of 'It's everyone's Job' and 'No wrong door' are considered to be only partially embedded and embraced across Gwent.
- Supporting clients and signposting are areas of support that are particularly good in mental health services for those with co-occurring conditions.
- Services can be improved for those with co-occurring conditions by improving joint working and providing more staff training.

4.7.3 Staff in Generic Services Survey – Key Messages

- There were **115** responses to the Generic Staff Survey, with the majority of respondents female.
- Staff came from a variety of job roles within wider, generic services, with just under one-third in a Project / Support Worker role. The most frequent response came from respondents within housing services.
- Mixed views were expressed in terms of the challenges around using co-occurring conditions terminology. There were mixed views in terms of the preferred terminology, with some preferring the term 'Complex Needs', whereas some were of the view that 'Dual Diagnosis' is a more appropriate term. Moreover, there was recognition of a number of challenges associated with the terminology. For example, issues of clarity, signposting and referral pathways for clients accessing services were expressed.
- Respondents' main sources of learning were through 'In-service education' which was followed closely by 'Multi-agency training day.'
- Over half of respondents indicated that the learning, training and development opportunities they have received, has been sufficient to enable them to work effectively with individuals with co-occurring conditions. On the other hand, for just under half of respondents it has not been sufficient.
- Just over half of respondents were of the view that joint working between mental health and substance use services is currently not working well. A key concern for several respondents is that individuals with substance use issues appear to have to address their substance use first before they can access mental health support.

- Just under half of respondents were of the view that joint working between mental health service and substance use services is currently limited or poor. That said, a number of respondents were of the view that joint working between the services is working well.
- Challenges facing those with co-occurring conditions include social isolation, housing support/ homelessness and access to services, including mental health services.
- Overwhelmingly, 86% of respondents believe that gaps do exist in current service provision.
- People experiencing / affected by domestic violence, young people and people experiencing homelessness, are groups that are considered to be not well catered for in Gwent.
- The principles of 'It's everyone's Job' and 'No wrong door' are considered to be only partially embedded and embraced across Gwent. However, the 'No wrong door' principle appears to be more embedded and embraced than 'It's everyone's job'.

4.8 SWOT Analysis

A SWOT analysis is an examination of a system's internal strengths and weaknesses, its opportunities for growth and improvement, and the threats the external environment presents to its survival.

Figure 4.3: SWOT Analysis structure

Some areas figure under more than one theme; for example, where there is evidence of both strengths and weaknesses. Similarly, it should be remembered that not all stakeholders were in agreement, and therefore drawing hard and fast conclusions may be inappropriate and disguise the complexity of the position.

Finally, this strand of analysis is based on subjective views and therefore must be combined with other evidence from other sources (such as service users and carers) for a fully rounded perspective.

4.9 Strengths

Traditional SWOT analysis views strengths as current factors that have prompted outstanding performance. Some examples could include: sufficient capacity across services, highly competent personnel or a focus on quality improvement. The aim here is to identify current strengths across the Substance Use and Mental Health sectors in Gwent as well as to identify the building blocks for developing new strengths across the sectors.

What are the perceived strengths of Substance Use and Mental Health services in Gwent in relation to treatment and support for those with co-occurring conditions; either directly stated or inferred from wider comments?

4.9.1 The quality and commitment of staff

The needs assessment was warmly welcomed by staff as a measure to improve the situation for those with co-occurring conditions, and research team noted how much co-operation and generosity people have offered with their time and opinions through the course of this research. Respondents contributed hopeful and constructive observations, with a healthy mix of idealism and pragmatism. Furthermore, the willingness to acknowledge the significant challenges of co-occurring mental ill health with alcohol and other drug problems was encouraging.

Strengths were also identified in terms of workforce development with staff developing their knowledge of mental health and co-occurring conditions issues with their own reading of research.

There was a clear commitment of substance use and mental health commissioners who are keen to improve services across Gwent for people with co-occurring conditions, and there are a significant number of individuals who are highly motivated and enthusiastic to see improvements happen across the region.

There was evidence of a nuanced understanding of both the complexity of the issues and the sometimes simple solutions that are possible almost always requiring a partnership response.

4.9.2 Services for those with co-occurring conditions

Strengths were identified in some aspects of services for those individuals with co-occurring conditions (involving serious mental health problems), and there appears to be clear systems in place across the area to ensure appropriate services are available. However, there seems to be a gap in services for people who fall outside this classic definition of co-occurring.

4.9.3 Accessibility of services (for those with co-occurring conditions)

Although the general consensus amongst those consulted was that there is much room for improvement, it was noted to the research team that people across Gwent are able to access services in a number of ways. Nonetheless, it is somewhat easier to get access to help and support via

substance use services or self-referral, than it is via mental health or primary care, unless an individual presents in crisis.

4.9.4 Partnership working

Some staff felt that there were good practice examples of partnership working in different areas of Gwent, with positive remarks made about the links between mental health services, alcohol and drug services and other specialist or generic services. The consistent examples given were of certain individuals rather than organisations.

4.10 Weaknesses

Weaknesses are either system or organisational factors that will increase costs or reduce quality. Examples could include ageing facilities and a lack of continuity in care and support processes, which could lead to duplication of efforts. Weaknesses can be broken down further to identify underlying causes. For example, disruption in the continuity of care often results from poor communication. Weaknesses also breed other weaknesses. For example, poor communication disrupts the continuity of care, and then this fragmentation leads to inefficiencies across the entire system. Inefficiencies in turn, deplete financial and other resources.

The aim here is to successfully identify, explore, resolve and reduce 'perceived' weaknesses and by doing so, to provide a focus on the areas required for development and improvement.

What are the perceived weaknesses of Substance Use and Mental Health services in Gwent in relation to treatment and support for those with co-occurring conditions; either directly stated or inferred from wider comments?

4.10.1 Pathways for defined populations

Several stakeholders were of the view that there is no structured pathway across Gwent for those with co-occurring conditions. A consistent message noted was in relation to the severity of presenting issues and the pathways for those in crisis, with respondents reporting uncertainty when dealing with an individual who does not present in an emergency. Whilst there is no internal priority given there is a process for referral into mental health services for those in crisis. In the main, substance use services provide an open door to all individuals, so all CMHT patients can be referred as per normal access pathway into substance use treatment.

4.10.2 Access to services for those with co-occurring conditions

There was also acknowledgement that those at the severe end of mental health issues do get good access to mental health services, but this is not guaranteed at the mild-moderate end of the scale.

The methods by which services communicate with service users, and how these can cause problems and barriers to access was also voiced, and some scepticism was expressed that these may be

purposeful methods on the part of some staff and/or services to simply meet targets or to reduce waiting lists/times.

4.10.3 Housing

Interviewees often remarked upon housing, with the lack and suitability of housing options and gaps in appropriate housing options for those with co-occurring conditions raised. Furthermore, it appears that if people are using drugs this could further hinder the issue of accessing suitable housing. In some areas, the criteria for accessing housing support appears to be too high, whereas it was noted that chaotic individuals using substances are not always easily housed.

A lack of integration between health, social care and housing was also discussed, and the apparent lack of suitable housing options in some communities also appears to have resulted in people being kept in hospital, a barrier to a smooth transition back into the community. Within the housing structure, it was stated that if mental health and substance use services had multi-disciplinary meetings there could potentially be better plans for housing individuals.

4.10.4 Sequential or concurrent treatment

Several respondents expressed the view that when people with co-occurring mental health and alcohol or other drug problems present themselves one issue should be dealt with first. This was further evidenced by a number of other respondents, who reported that their understanding is that this view is still current with some mental health professionals in young people's and adult services across Gwent.

It was reported from a range of sources (and across sectors) that there is a widespread view within mental health services that substance use issues should be dealt with separately. This is sometimes articulated as substance misuse should be dealt with before mental health issues (i.e. sequential treatment). With the acknowledgement that often mental health issues and substance use have a recursive and interlinked relationship, it should be noted here that dealing with one before the other without support is not possible for most people seeking help from services.

4.10.5 Staff values and motivation to work with particular issues

Substance use and mental health services are commissioned to deliver evidence-based interventions that are treatment compliant with relevant guidance e.g. NICE. A number of mental health professionals consulted as part of this review, however, stated views that are contrary to the evidence (e.g. as referenced in section 4.9.4 above).

Lack of skills linked with discriminatory attitudes towards people with alcohol and other drug problems in Mental Health services was also highlighted.

It was also recognised that pathways are only helpful if both sets of services have trust and willingness to cross-refer between them, as well as working with service users in a non-judgemental manner. One of the biggest inhibitors of engagement appears to be the perceived stigma that people feel.

4.10.6 Assessments

Difficulties with assessing mental health support for clients who are actively using substances was reported. It appears there is a reluctance to engage with people suspected of having alcohol and other drug problems, as well as the the view that conflicts with the evidence base, that sequential treatment is indicated for people with co-occurring conditions. An individual's perceived use of substances is sometimes considered a barrier to conducting mental health assessment.

4.10.7 Caseloads and thresholds

Community mental health services report an increase in caseloads over recent years. Furthermore, it was noted that CPN's do not have the same amount of time anymore. One consequence is that the threshold to qualify for support is now higher than previously so.

Concerns were raised that people may not be accessing appropriate help due to the high qualifying threshold to access mental health services. Interviewees stressed that caseloads and access thresholds have risen in community mental health services. It was expressed that staff are making assumptions that it is the other person's job to do something resulting in people falling into gaps.

4.10.8 Joint working between mental health and substance use services

Inconsistencies in integrated working within, between and across specialist substance use and mental health services were noted; and other crucial linked services such as housing and employability, as well as recovery communities.

Joint assessments were highlighted as an aspect which could be improved, with other interviewees suggesting that significant improvements could be made to how mental health services and substance use services work together.

Others highlighted the refusal or inability of mental health services to work with substance users unless they are abstinent or have made significant reductions in their substance use.

4.11 Opportunities

Traditional SWOT analysis views opportunities as significant new initiatives available to a system. Examples could include collaboration among health and social care organisations through the development of delivery networks, community partnering to develop new care and support programmes and the introduction of protocols to improve quality and efficiency. Integrated delivery networks have an opportunity to influence health and social care policy at both local and national

levels. They also have an opportunity to improve client satisfaction by increasing public involvement and ensuring client representation on boards and committees. For example, systems that are successful at using data to improve processes have lower costs and higher quality client care. The aim here is to enhance current opportunities as well as to exploit new opportunities.

This section summarises the 'opportunities' identified; either directly stated by interviewees or which can be inferred.

4.11.1 Language

There were mixed views reported in terms of language used, therefore continuing with the term 'dual diagnosis' could be counterproductive. There is an opportunity to formulate an agreed definition and statement for the term, 'co-occurring conditions' which all staff can utilise.

4.11.2 Strategy

A reconsideration of approach and strategy is required for improvements to occur. As noted, there are several individuals who are highly motivated and enthusiastic to see improvements happen. Some saw opportunities for a new strategy to improve joint working, training opportunities and networking, enhance information and put greater emphasis on assertive outreach.

4.11.3 Joint working

There's scope to put more emphasis on joint working and creating networking opportunities. There is an opportunity to develop an integrated working guide involving alcohol/drugs, mental health, housing, employability and other relevant services. Joint training involving services from both sets of services could be an option to facilitate networking.

4.11.4 Future learning, training and development needs

There were those that noted the perceived loss of expertise in front line alcohol and other drug services, however interviewees saw opportunities for more-in-depth training, keeping this training up to date and staying abreast of drug trends. Joint training between mental health and substance use could enhance shared learning.

4.11.5 Housing

Improving housing options for those with co-occurring conditions was proposed. Enhancing the integration between health, social care and housing could facilitate this, with interviewees noting that if mental health and substance use services had multi-disciplinary meetings there could potentially be better plans for meeting people's housing needs.

4.11.6 Integrated pathway

It was observed that there appears to be no structured pathway for those with co-occurring conditions, with additional uncertainty in terms of supporting people who do not present in an emergency. For people presenting with 'classic' co-occurring conditions (involving serious mental health problems), there do appear to be clear systems in place, however, there is need to create formal pathways into the relevant services to smooth referrals and improve joint working practice. A benefit of this would be that all relevant staff know their specific requirements in terms of support offered which could lessen risks in working with those with co-occurring conditions.

4.12 Threats

Threats are factors that could negatively affect system performance. Examples could include: political or economic instability; and increasing pressure to reduce care and support costs.

The aim here is to avoid and thwart direct and indirect threats to the needs of those with co-occurring conditions across Gwent.

This section summarises identified threats; either directly stated by interviewees or which can be inferred.

4.12.1 Language

For some respondents using the term 'dual diagnosis' was not helpful. While there has been some worth in using the term 'dual diagnosis' hitherto, it is possibly unhelpful to continue with this terminology.

4.12.2 Capacity issues

There was concern that capacity constraints / pressure on staff create a barrier in terms of providing adequate support. It was noted that under-capacity results in staff not being able to meet the needs of clients.

4.12.3 Risk management

There is a need to alleviate risks in working with those with co-occurring conditions. Risk assessments were highlighted as unknown, unclear or sporadically applied by some staff.

4.12.4 Potentially increasing health inequalities

Some suggested that the aging population of opiate dependence and the impact of dementia, mobility, health (physical) on dually diagnosed older groups could potentially lead to an increase of health inequalities and create a barrier to the transition from services.

CHAPTER 5: KEY FINDINGS – SERVICE USER AND CARER/FAMILY VIEWS

5.1 Introduction

This chapter presents an overview of the key findings of each of the mixed methods of the study that focused on the views of service users, families and carers:

- Focus Groups [n=**8**] were conducted with service users and volunteers [n=**27**] of Gwent Drug and Alcohol Service (GDAS) and Gwent Specialist Substance Misuse Service (GSSMS).
- Service User Survey [n=**12**].

A family and carers survey was widely distributed but there were only four (4) completed returns.

The full detail of the transcribed focus groups and survey are presented in the accompanying **Part 2 Appendix Report (Appendix VI and VII)**. These key findings have then been analysed by the research team against the original objectives of the study (see **Chapter 6** below).

The key findings from each method are presented first below, and then, to give structure, our analysis of views and what they tell us will be presented under the headings of Strengths, Weaknesses, Opportunities and Threats (SWOT).

5.2 Key messages – Focus Groups

- **Eight** focus groups were conducted with **27** service users and volunteers of Gwent Drug and Alcohol Service (GDAS) and Gwent Specialist Substance Misuse Service (GSSMS).
- There was a sense across a number of groups that staff, from a wide variety of services, do not have enough understanding to effectively respond to those with co-occurring conditions. Moreover, respondents often reported negative factors associated with attending services.
- Mixed views were expressed in terms of communication and information sharing between services in Gwent. For a number of respondents across different groups, communication and information sharing has been adequate, however this depends on which service(s) an individual presents to. Although positive experiences were voiced, the team heard several accounts of poor or non-existent communication and information sharing practices.
- A common problem experienced by respondents was homelessness, and a there was often an expression of frustration at the lack of housing options and support available to help individuals at the required time.
- Barriers exist which prevent individuals from accessing mental health support, with limited availability of mental health provision in their area of choice, a key barrier.
- Clear information on the available substance use support services is lacking in Gwent. Several respondents were of the view that if you are not in contact with GDAS you are extremely limited in knowing what wider support is available. As such, those who are addressing their substance use issue only become aware of the wider support available to them once they are engaged with GDAS.

- A barrier for individuals accessing support appears to be the limited availability of substance use service provision that is outwith Monday to Friday 9 to 5.
- Lack of transportation /transport costs appear to be creating barriers for people accessing drug and alcohol support in rural areas.
- Long waiting lists are preventing individuals from accessing necessary substance use support.
- Stigma acts as a barrier to those with co-occurring conditions accessing services and supports. Moreover, there was a sense that stigma prevents an understanding of what those with co-occurring conditions experience in their day to day lives.
- Improving accessibility to mental health support formed a crucial part of respondents' hopes for the future.

5.3 Key messages – Service User Survey

- There were **10** responses to the Service User Survey.
- Depression (n=**7**) is the most common mental health condition reported by respondents, followed by anxiety n=**6**).
- Gwent Drug and Alcohol Service (GDAS) is the most common service used by respondents (50%; n=**5**), and the main service/support provision that they are currently using/accessing.
- Respondents receive a wide variety of support in terms of their health and social care needs from GDAS.
- Overall, respondents have a positive view of the systems, processes and staffing at GDAS.
- The majority of respondents feel safe and comfortable when they attend the service/support provision.
- Engaging in meaningful activities, having their health needs addressed and non-judgemental support are aspects respondents particularly like about the service/support they are receiving.

5.4 SWOT Analysis

To give structure, our analysis of views and what they tell us will be presented under the headings of Strengths, Weaknesses, Opportunities and Threats (SWOT).

A SWOT analysis is an examination of a system's internal strengths and weaknesses, its opportunities for growth and improvement, and the threats the external environment presents to its survival.

Figure 5.1: SWOT Analysis structure

Some areas figure under more than one theme; for example, where there is evidence of both strengths and weaknesses. Similarly, it should be remembered that not all service users were in agreement, and therefore drawing hard and fast conclusions may be inappropriate and disguise the complexity of the position. It should also be highlighted that the number of survey respondents were low in number.

Finally, this strand of analysis is based on subjective views and therefore must be combined with other evidence from other sources within the report for a fully rounded perspective.

5.2 Strengths

Traditional SWOT analysis views strengths as current factors that have prompted outstanding performance. Some examples could include sufficient capacity across services, highly competent personnel or a focus on quality improvement. The aim here is to identify current strengths across the Substance Use and Mental Health sectors across Gwent as well as to identify the building blocks for developing new strengths across the sectors.

What are the perceived strengths of Substance Use and Mental Health services across Gwent in relation to treatment and support for those with co-occurring conditions; either directly stated or inferred from wider comments?

5.2.1 Substance use support provision

There is a wide range of substance use services in Gwent which are relatively plentiful and appear to be well organised and developed around the needs of the service user, which is reflected in their commitment to a person-centred and holistic approach. Many service users of GDAS described being pleased with the support on offer to help them address their substance use issues.

5.2.2 The dedication of front-line staff and volunteers

Staff and volunteers have a strong focus on client outcomes and there is a commitment to the values of lived experience and human rights. Positive sentiments were repeatedly expressed on the support offered by staff members at GDAS and GSSMS. For some clients, GDAS was described as being a 'family' more than a service.

5.2.3 Social integration

There is an 'integrationist' value running through GDAS, with services helping to reduce social isolation and enable clients to re-integrate into society. One to one support, group work and other activities appear to be a conduit to facilitate this process.

5.2.4 Research involvement

There was a clear commitment by staff members at GDAS and GSSMS to help the research team. This commitment was also evident in the participation of clients at each of the focus groups, which reflects well on both services. The team noted the positive relationships between staff members and clients / volunteers. Due to storm 'Ciara' which hit the UK on the week of the focus groups, many participants could not attend the first focus group in Pontypool. However, due to the dedication of a staff member at GDAS another focus group was organised in Ebbw Vale at very short notice.

5.2.5 Lived experience

It was clear to the team that there is dedication to listening to, learning from, and including the lived experience of people who have co-occurring conditions within service provision at GDAS. This appears to result in individuals who receive support accessing the service to feel listened to and understood. The lived experience offered by individuals who have / had co-occurring conditions was suggested to act as an antidote to stigma those with co-occurring conditions may face.

There is dedication to listening to, learning from, and including the lived experience of people who have co-occurring conditions within service provision at GDAS. Constructively utilising people with lived experience's insight and knowledge could help to shape and reform the service for the better.

5.3 Weaknesses

Weaknesses are either system or organisational factors that will increase costs or reduce quality. Examples could include ageing facilities and a lack of continuity in care and support processes, which could lead to duplication of efforts. Weaknesses can be broken down further to identify underlying causes. For example, disruption in the continuity of care often results from poor communication. Weaknesses also breed other weaknesses. For example, poor communication disrupts the continuity of care, and then this fragmentation leads to inefficiencies across the entire system. Inefficiencies in turn, deplete financial and other resources.

The aim here is to successfully identify, explore, resolve and reduce 'perceived' weaknesses and by doing so, to provide a focus on the areas required for development and improvement.

What are the perceived weaknesses of Substance Use and Mental Health services across Gwent in relation to treatment and support for those with co-occurring conditions; either directly stated or inferred from wider comments?

5.3.1 Understanding and responding to those with co-occurring conditions

There was a sense across a number of groups that staff, from a wide variety of services, do not have sufficient understanding to effectively respond to those with co-occurring conditions. Alongside this viewpoint, there was a particular focus on GPs, whom many believe do not necessarily understand, or know how to effectively respond, to those with co-occurring conditions.

5.3.2 Accessing mental health provision

The generally expressed view across all groups was that barriers exist which prevent individuals from accessing mental health support. There was also recognition of this limited support in urban areas such as Newport, but also in rural areas such as Ebbw Vale. Substance use support was widely available; however, the widespread view is that individuals are at a loss when it comes to accessing mental health support.

When mental health support is available, the research team heard accounts of long waiting lists and further barriers such as lack of transportation and finances at the required time.

There were also reports across a number of groups that mental health support is not available until an individual reached a crisis point.

5.3.3 Barriers and difficulties to communication and sharing information between services.

Mixed views were expressed in terms of communication and information sharing between services in Gwent, and positive experiences were voiced. However, the team heard several accounts of poor or non-existent communication and information sharing practices. It seems that this prevents those with co-occurring conditions from being able to access the required support at the right time.

5.3.4 Lack of Information

Clear and concise information on the available substance use and mental health support services is lacking across the area. It appears that, if you are not in contact with GDAS you are extremely limited to knowing what other support is available. As such, those who are addressing their substance use issue(s) only become aware of the wider support available to them once they are engaged with GDAS.

5.3.5 Access to substance use provision

There was acknowledgement that long waiting lists are preventing individuals from accessing necessary substance use support across Gwent. Consistent with the views above relating to the waiting lists for mental health support, examples of long waiting lists for substance use provision were reported. When provision does become available there were reports of people having to travel to other areas.

Several respondents in one focus group were of the view that involvement with the criminal justice system could potentially speed up the process of accessing Opioid Substitution Therapy. For one respondent, who could no longer wait for statutory services, obtaining Opioid Substitution Therapy from a private practice cost her family hundreds of pounds.

Another barrier for individuals accessing support appears to be the limited availability of substance use service provision out with the 'Monday to Friday 9 to 5'. For example, several respondents highlighted the lack of out of hours support available in the evening and at weekends.

5.4 Opportunities

Traditional SWOT analysis views opportunities as significant new initiatives available to a system. Examples could include collaboration among health and social care organisations through the development of delivery networks, community partnering to develop new care and support programmes and the introduction of protocols to improve quality and efficiency. Integrated delivery networks have an opportunity to influence health and social care policy at both local and national levels. They also have an opportunity to improve client satisfaction by increasing public involvement and ensuring client representation on boards and committees. For example, systems that are successful at using data to improve processes have lower costs and higher quality client care. The aim here is to enhance current opportunities as well as to exploit new opportunities.

This section summarises the 'opportunities' identified; either directly stated by interviewees or which can be inferred.

5.4.1 Information

Clear and concise information on the available substance use and mental health support services is lacking across the area, therefore, clear and concise information should be made available in several ways.

5.4.2 Co-occurring conditions knowledge

It is essential to provide staff with a better understanding of the issues related to co-occurring conditions. This could be achieved by developing staff knowledge via co-occurring training opportunities to communicate knowledge across organisations.

5.4.3 Communication and information sharing

There is an opportunity to develop better collaborative networks that facilitate communication and information sharing. Effective communication and information sharing between substance use, mental health, and wider support services is crucial to effectively support individuals with co-occurring conditions to achieve their goals.

5.4.4 Provision availability

Limited substance use service provision exists out-with the 'Monday to Friday 9 to 5'. The team heard suggestions of improvements by increasing provision in the evenings and at weekends. Therefore, flexibility and personalisation in service provision is required, which could help the different needs of individuals.

5.4.5 Funding

Limited funding opportunities and short-term tendering contracts diminishes partnership and integration, and negatively impacts the level of support individuals in Gwent receive. Thus, there is an opportunity to consider funding strategies that make provision available which is both varied and sustainable.

5.4.6 Integrated substance use and mental health services

It was observed that there is a separation between substance use and mental health services. Improving accessibility to mental health support formed a crucial part of participants' hopes for the future.

5.5 Threats

Threats are factors that could negatively affect system performance. Examples could include political or economic instability; and increasing pressure to reduce care and support costs.

The aim here is to avoid and thwart direct and indirect threats to the needs of those with co-occurring conditions across Gwent.

This section summarises identified threats; either directly stated by interviewees or which can be inferred.

5.5.1 Homelessness

A common problem experienced by respondents was homelessness, and a there was often an expression of frustration at the lack of housing options and support available. Across several focus

groups the team heard of examples of people experiencing homelessness residing in hostels and/or shelters, rough sleeping and what is described as 'sofa surfing' with family and friends.

5.5.2 Barriers to mental health provision

There was recognition that housing problems impact negatively on an individual's mental health.

5.5.3 Funding

Limited funding opportunities and short-term tendering contracts diminishes partnership and integration, and negatively impacts the level of support individuals in Gwent receive. Across a number of groups, the team heard of the withdrawal or reduction in funding resulting in reduced levels of support offered across a number of domains such as wellbeing groups, housing support and access to Opioid Substitution Therapy.

5.5.4 Stigma

A key negative consequence of being an individual experiencing co-occurring conditions was the apparent stigma associated with this. There was a sense of a perceived stigma acting as a barrier to accessing services and supports. Moreover, this stigma inhibits a clear understanding of what those with co-occurring conditions experience in their day to day lives.

5.5.6 Transportation

Lack of transportation /transport costs creates barriers for people accessing drug and alcohol support for those in rural areas. Additionally, there was a sense by some that financial barriers for those receiving state benefits further restricted access to the requisite transportation needed to access support.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

The detailed and in-depth views shared with the research team as part of this needs assessment by both professionals and those with lived experience, coupled with our review of local and national policy, literature and data, have provided a significant amount of evidence for analysis and reflection.

The comments and feedback presented for Gwent in this chapter could potentially be made in any area of Wales or indeed the UK. There is some good evidence that they are applicable for Gwent.

This summary and concluding chapter of the needs assessment presents a series of reflections and observations of the research team following the systematic analysis of the evidence collated. It then presents a series of recommendations and considerations for mental health and substance use commissioners and providers to consider in their future responses to improve the health and wellbeing of those who have co-occurring conditions.

6.2 Key reflections and conclusions of the needs assessment

Co-occurring conditions is a complex issue presenting complex challenges to services and commissioners across Gwent. Those who experience co-occurring conditions can be very vulnerable, whilst at the same time proving to be very chaotic and challenging to services. This means that they are frequently accessing services (one at a time) or fall through the gaps. Evidence shows that co-working and joint working in Gwent do increasingly happen, but this is certainly not the norm.

6.2.1 Local context and evolution of services to meet the needs of those with co-occurring conditions

The terminology and language used to describe the nature of co-occurring conditions in Gwent is of real significance when attempting to address and reduce stigma, challenge and change attitudes, and improve responses to a broad population of individuals who experience problems, to varying degrees of severity, with both mental health and substance use (rather than just the narrow cohort of individuals who have received formal diagnoses of mental health and substance use disorders).

6.2.2 Motivation

Traditionally alcohol and other drug use problems have been classified as a mental health issue. However, within mental health services, 'addictions' are designated as a wholly encysted separate specialism.

Some people who apply to work in specialist alcohol and other drug services may not feel equipped or be motivated to work with wider mental ill health issues even though they will inevitably encounter many service users who experience them.

Similarly, some mental health professionals may not ever have considered alcohol and other drug use issues to be part of any remit they signed up to. This is true, despite the significant prevalence of alcohol and other drug use among mental health services' patients and with poor mental health treatment outcomes e.g. the correlation between substance use problems and self-harm including successful suicide.

This mutual lack of motivation may have a range of consequences e.g.:

- Failure routinely to 'look for' alcohol and other drug use during mental health assessments.
- When issues are identified they may only be minimally addressed or considered for referral rather than triggering an immediate 'stepped care' intervention.
- Failure to identify mental ill health issues that could be amenable to specialist treatment – whether through an assumption that all alcohol and other drug problems include psychological issues that are routinely dealt with as part of 'treatment as usual' or, through a lack of training or capacity formally to identify mental health issues (and perhaps simply through lack of identified mental health screening tools embedded in routine assessment protocols e.g. depression inventory).

It should be noted that the issue of motivation to work with an identified group of service recipients has been glossed over in the addictions field across the UK. Until relatively recently alcohol and drug services were separately commissioned, typically from different providers. That made sense historically and the increased emphasis on opioid prescribing interventions for drugs with long term engagement in treatment was different from the evidence base for alcohol (which endorses briefer interventions). Generally, commissioners (across the UK, including Gwent) have not successfully assembled integrated partnerships but have shifted to seeking single bids for all aspects of local alcohol and drug provision, typically resulting in combined drug and alcohol services. The fact that previously some workers identified strongly as either alcohol or drug specialists does not seem to have been addressed. In the externally imposed changed environment with contracting resources, local services reflect a national trend towards amalgamation.

6.2.3 Concurrent, NOT sequential treatment

A significant number of comments have been expressed throughout the needs assessment in respect of the view that when people with co-occurring mental health and alcohol or other drug problems present themselves one issue should be dealt with first. Apparently, this erroneous view is still current among a range of mental health professionals across Gwent. This is a surprising finding. The evidence was already clear, even before it was confirmed in the 2002 Dual Diagnosis guidance (and more recently reiterated in the 2016 NICE guidance), that mental health and substance issues should be addressed concurrently.

Substance use and mental health services are commissioned to deliver evidence-based interventions that are treatment aligned with relevant guidance e.g. NICE. It should not be acceptable that mental

health professionals' express views that are contrary to the evidence[102]. This is a contract management issue. There may be implications for continuing professional development, supervision and training. People living with mental ill health and those with alcohol and other drug problems experience stigma and prejudice. These experiences of being discriminated against can be mitigated by addictions services that are actively engaging with, and sensitive to, mental health issues and by mental health services that are active and competent in addressing addictions.

6.2.4 Openness

It has been striking how much co-operation and generosity people have offered with their time and opinions through the course of this research. The willingness to acknowledge the significant challenges of co-occurring mental ill health with alcohol and other drug problems has been encouraging. It bodes well for the potential acceptance and engagement with future programmes of work to address these issues.

6.2.5 Assessment

Assessment issues in substance use services

Low threshold access substance use services are presumed to deal primarily with early presentations for help and in the longer term with people who have fewer complex problems. The potentially flexible response of services that offer easier access may result in their being the main contact point for people whose conditions make engagement with appointment-based specialist services problematic.

Concerns have been expressed that there is limited capacity in substance use services to recognise mental ill health and a lack of knowledge and training to assess the severity of problems and make appropriate referrals.

Assessment issues in mental health services

There is a perceived reluctance in places to engage with people suspected of having alcohol and other drug problems, as well as the mistaken view that sequential treatment is indicated for people with co-occurring conditions. Perceived use of substances is apparently considered a barrier to conducting mental health assessment. This raises several concerns and issues (which will require further detailed analysis and exploration to ensure improvements in practice, against the evidence, occur) including:

- There is a duty to assess the risk of harm to self and others of people who present to mental health services irrespective of perceived levels of impairment.

[102] It was reported to the research team from a range of sources (and across sectors) that there is still a commonly held view within mental health services that substance use issues should be dealt with separately. This is sometimes articulated as substance use should be dealt with before mental health issues (i.e. sequential treatment). This is contrary to national guidance (2016, 2002) and defies the principle that individuals should be able to choose their 'door' into services.

- It is not clear (nor measured) that mental health professionals could reliably identify impairment due to intoxication rather than other causes.
- It is not clear (nor measured) that there is an identifiable level of intoxication that would disqualify someone from having their mental health needs assessed. Suspected drug impairment may be difficult to identify without confirmatory testing. Alcohol breathalysers do not measure impairment: they record breath alcohol levels, which are used in law as a proxy measure for fitness to drive (or fly).

6.2.6 Referrals and thresholds

Increased demand for mental health services and ongoing challenges in relation to real-term funding for alcohol and other drug services are perceived to have had consequences for the capacity and willingness of some services to actively engage with those who have co-occurring conditions.

Without full integration of mental health and substance use services there will always be a flash-point over service thresholds where mental health services have a high threshold for access (i.e. severe and enduring mental health), whereas drug and alcohol services have a very low threshold for access.

6.2.7 Prevention and investment

If the intention is to have a shift from delivery of treatment to diversion and prevention of people needing to come into treatment, there will be a time lag from the prevention starting and delivering effective results to the savings that can be siphoned off from the other end to fund it within existing resources / make savings. Therefore – prevention requires pump priming investment at the very least.

6.2.8 Gaps in service provision and availability

The evidence gathered from interviews with professionals indicates that for most individuals with 'classic' co-occurring conditions (involving severe and enduring mental health problems), there are systems in place across the area to ensure appropriate services are available, although concerns persist over the application of the Mental Health Measure which requires an individual to be receiving treatment from primary or secondary mental health services in order for GDAS to refer them to GSSMS for specialist support. The perception is that, since the introduction of the Mental Health Measure, access to appropriate mental health support has been reduced. There also seems to be a gap in services for people who fall outside the classic definition of co-occurring conditions, but nevertheless present a challenge to services and require significant levels of support. There are also reported differences across Gwent with regular references to 'postcode lottery'.

6.2.9 Older Adults

Although not specifically mentioned in the scope of the study, our early evidence gathering led us to conduct a series of sessions/interviews with staff from older adult's mental health services. Informants provided evidence of an ever-increasing population of older people who experience co-occurring conditions in Gwent. Recognition was made that mental health services have a clear threshold at which someone is considered to be an older adult (and when access to older adult mental health services begins), as opposed to substance use services in Gwent who do not have a specialised older adult provision (but rather deal with everyone within the same 'adult' service). It was also observed that a lot of service users in substance use services are experiencing physical and mental health conditions associated with old age (e.g. frailty, cognitive impairment) at a significantly younger age than would be picked up by traditional older adult services.

6.2.10 Concluding thought

Ultimately, the responses to the needs of those with co-occurring conditions should be driven less by the demands of systems, and more grounded in the lives of people.

6.3 Recommendations

The following series of recommendations have been structured around a series of key themes.

6.3.1 Future strategic directions and implementation of the recommendations of this needs assessment

- **Recommendation 1: Develop, nurture and implement a new (widely consulted-on) long-term (10 year) vision, strategy and intent for full integration of mental health and substance use services across Gwent.**

  Full integration of substance use and mental health services and support is recommended. UK and international best practice – and a coherent and comprehensive vision needs to be developed to ensure it happens across Gwent within the next decade. Trauma, violence, neglect and social inequalities lie at the root of both mental health problems and substance use problems and the majority of people with substance use problems also have mental health problems.

  Evidence heard during the course of this Needs Assessment indicates a small, but significant, number of professionals who still express the erroneous view that when people with co-occurring mental health and substance use problems present themselves at either mental health or substance use services across Gwent, that one issue should be dealt with first. The evidence has

been clear for many years (and has recently been re-iterated in the 2016 NICE guidance[103]) that mental health and substance use issues should be addressed concurrently.

Substance use and mental health services need to be commissioned to deliver evidence-based interventions that are aligned with relevant guidance (e.g. NICE). It should not be acceptable that any professional express views that are contrary to the evidence[104]. This indicates implications for continuing professional development, supervision and training. People living with mental ill health and those with substance use problems experience stigma, prejudice and discrimination. These experiences can be mitigated by addictions services that are actively engaging with, and sensitive to, mental health issues and by mental health services that are active and competent in addressing addictions.

There are now good UK and international examples of integrated services from other jurisdictions (Public Health England have recently highlighted examples of good practice, and other examples are noted in Australia, Canada and the USA) which should be considered as part of an options appraisal exercise. These could provide the basis of new integrated models of care for Gwent to adopt (including Crisis Care).

There are several challenges and opportunities which drive the need for developing a long-term overarching Co-occurring Conditions Recovery Vision and Strategy for Gwent:

- The growing demands of an ageing population and the implications for health and social care services.
- Overall residents enjoy good health, but there are also variations across the area that must be reduced. Deprivation has a strong direct association with poorer health as well as other aspects of life that influence our health and wellbeing, such as employment.
- The fragile state of the economy nationally makes an ambition for better health and wellbeing even more pressing. The climate of austerity and the need for public services to make efficiency savings and remove duplication could widen health inequalities without a co-ordinated response: taking collective action as public services with local communities to deliver solutions is ever more important.
- Making the right connections with residents, customers and communities.
- Improving the quality of service and the quality of care ensuring we get more for every pound spent.
- Supporting people in their independence and ability to make their own choices about their health and social care for longer.

[103] National Institute for Health and Care Excellence (NICE), (2016), *Co-existing severe mental illness and substance misuse: Community Health and Social Care Services,* (2016), Available at: https://www.nice.org.uk/guidance/cg120

[104] It was reported from a range of sources that there is are some ingrained views within mental health services that substance use issues should be dealt with separately. This is sometimes articulated as substance use should be dealt with before mental health issues (i.e. sequential treatment). This is contrary to national guidance (2016, 2002) and defies the principle that individuals should be able to choose their own 'door' into services (i.e. 'no wrong door' principle).

There is therefore much work to be done in addressing the needs of those with co-occurring conditions, particularly regarding inequalities in health across the area. Having said this, work is not starting from scratch.

In the longer-term, a Joint Working Group should be tasked with developing the blueprint for a detailed, robust, consulted-on and resourced Co-occurring Conditions Strategy for Gwent. The proposed overarching strategy should seek to tackle the health and wellbeing of those with co-occurring conditions in the broadest sense and should recognise that there is a range of current partner's plans and strategies already in place and delivering positive results. Other policies and plans owned by individual organisations will also make a difference to residents' mental health and wellbeing.

The priorities in all strategies and commissioning plans must be informed by the voices of service users, families, carers and residents; and by all outcome frameworks in existence. By using the collective influence gained through the development of a joint strategy, it will also be possible to secure improved outcomes through the other factors that impact on the mental health and wellbeing of communities; including housing, education, employment, and the environment.

The joint strategy should be a tool to raise awareness of co-occurring conditions across Gwent and to address the needs of local residents, and to do so it should set the framework to ensure that commissioning plans relating to health and social care will be effective and robust as well as delivering best value and embedded in the recovery agenda.

- **Recommendation 2: In the shorter-term (next 3 years), the APB should make the necessary moves towards a singular joined-up commissioning plan for substance use treatment provision (including the entire provision of drug and alcohol spend across Gwent) to lay the foundations for long-term integration with mental health resources (Recommendation 1).**

  This will be essential in order to tackle some of the evident inequalities that currently exist in service provision and reach. Any singular commissioning plan should not be based on maintaining existing provision but rather on the preferred new landscape and vision (emanating from acceptance and implementation of Recommendation 1 and all subsequent recommendations in this report). It should also include **all** the current substantive commissioning funds for alcohol and other drug services in Gwent (including APB, ABUHB, OPCC, DIP, and HMPPS), so that future planning can allow for the combined funds to be spent more holistically. Consideration should be given to adopting frameworks for strategy, spend and provision that are consistent with the ideals of 'well-being'.

- **Recommendation 3: Serious consideration should be given to where and how the APB interacts and sits alongside the Regional Planning Board [RPB].**

  Conversations and detailed consideration needs to be given regarding the ability of the APB structure to fully influence, direct and lead the Co-Occurring agenda in Gwent, especially in relation to where the APB sits alongside the RPB – i.e. would the APB be able to be more effective if it sat directly within the RPB? If so, this is something that should be explored. Discussions should

take place with relevant officials at Welsh Government to request a full review of these arrangements across Wales.

- **Recommendation 4: Consideration should be given to the current make-up of the APB to ensure it operates as an impartial and effective commissioning and strategic leadership body.**

  For the avoidance of all doubt, this means that no individual with current local alcohol and/or drug service provision responsibility should be a core member of the APB. There should be senior representation from GPs[105], Community Pharmacy, elected members, those with lived experience and family members. Consideration should also be given to moving towards the appointment of an independent (paid) Chair for the APB.[106]

- **Recommendation 5: Establish a multi-agency co-occurring conditions integrated implementation group.**

  There are a significant number of individuals (professional and service users) who are highly motivated and enthusiastic to see improvements happen. Accordingly, we see a critical need to establish a 'co-occurring conditions' integrated working group to oversee strategic and operational practice developments and to increase the profile and range of responses to this agenda. To avoid any disillusionment setting in (i.e. from the perception of 'lots of talk and no action'), this group could be tasked with developing an action plan to implement the recommendations of this needs assessment report. Careful consideration should be given to the membership of such a group to ensure it is representative of all interested parties, and to ensure it has members who carry sufficient influence to effect and inspire change. In order to lay the groundwork for such an implementation group, a series of workshops should be held with professionals and service users/family members to (1) outline the findings of this needs assessment, and (2) allow consultation regarding the development of an appropriate action plan and prioritisation of the full set of recommendations from this report.

- **Recommendation 6: Develop an agreed joint working guide/protocol (to include information sharing) between Mental Health and Substance Use services for the management of those with co-occurring conditions.**

  It will clearly take time for commissioners to formulate, implement and monitor a robust action plan based on or influenced by this final report to realise improvement areas and other business aspirations. As an interim measure and to facilitate a 'quick win', it is recommended that the integrated implementation group (Recommendation 5) should be tasked with leading the development of a joint working protocol which should take cognisance of the issues and challenges highlighted in this report. The protocol that is developed should be piloted in at least two localities (one predominantly urban and one predominantly rural) with a process of

[105] So long as any GP representative does not have any commissioning or funding conflict of interest.

[106] Evidence from the evolution of Alcohol and Drug Partnerships (ADPs) across the 32 Local Authority areas of Scotland identifies a growing number of independent ADP Chairs who are proving to be more effective and successful in driving forward an ambitious change agenda.

reflection/evaluation and shared learning included in the timescale for the pilots (tests of change), prior to any roll-out across the whole area. This guide/protocol should be based on current best practice for co-occurring conditions from Gwent and elsewhere in the UK.

The current lack of a Gwent-wide information sharing protocol is seen by stakeholders as extremely problematic. However, an information sharing protocol is not the starting point. Given that, on the whole, services are not routinely screening for the other specialism's condition, they are avoiding digging out the information they should be sharing.

Fundamentally, it is about awareness and willingness to share information.

The development of any future protocol should involve the main substance use providers and mental health providers as well as GP's and other relevant stakeholder agencies, including families and those affected by co-occurring conditions.

6.3.2 Leadership

- **Recommendation 7: Resource Co-occurring Conditions Change Agents.**

  Notwithstanding the clear commitment of substance use and mental health commissioners who are keen to improve services across Gwent for people with co-occurring conditions; there are simply no formal co-occurring conditions champions or change agents currently in existence, other than some of the passionate and enthusiastic practitioners that we've met. As a partial solution, commissioners are asked to consider how they could resource two 'co-occurring conditions' change agents / champions – one based in mental health, and one based in substance use services. Whilst recognising that there are suitably qualified co-occurring conditions specialists in the county, the reality is that the number of such professionals is extremely limited. Furthermore, there is a need for change agents/champions to break down cultural barriers on both sides of the substance use and mental health services divide. Accordingly, the needs assessment will firmly recommend that two suitably qualified and influential people are required to lead from the front as 'champions' of change. The key aim of these posts will be to encourage greater focus on co-occurring conditions in services, align strategy and operational practice; ensure quality and promote consistent practice (including joint assessment and development of local co-occurring conditions pathways).

6.3.3 Language/terminology

- **Recommendation 8: Due to significant difference in understanding and appreciation of the depth and breadth of 'co-occurring conditions' amongst services and staff groups across Gwent, there is a need to co-produce a local working definition and statement for the term, including scope; and disseminate this widely to relevant stakeholders.**

  Evidence demonstrates that many who could benefit from treatment can be discouraged from doing so by language, attitudes and behaviours that appear judgmental, even if these are displayed unwittingly. Stigma can negatively impact the morale of those providing support

services, and friends and families of those at risk can often feel the effects of stigma by association, at a time when they too deserve support.

The proposed working definition should be focused around the two key principles outlined in the 2017 Public Health England guidance for Commissioners and Service Providers, which are aimed at supporting timely and effective responses for people with co-occurring conditions:

- *'It's everyone's job'. Commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to meet the needs of individuals with co-occurring conditions by working together to reach shared solutions.*
- *'There should be no wrong door'. Providers in alcohol and drug, mental health and other services have an open-door policy for individuals with co-occurring conditions and make every contact count. Treatment for any of the co-occurring conditions is available through every contact point.*

6.3.4 Current practices – notably, but not limited to

- **Recommendation 9: Surrounding the need for much greater psychological support for the many who have experienced trauma.**

  'What we have is a group of people with severe emotional distress, lacking the resilience to deal with that because of the traumas that they have gone through.'

- **Recommendation 10: Equitable access to specialist inpatient beds for alcohol and/or drug detox.**

  There are currently no specialist alcohol/drugs beds in Gwent, and they have to be requested from Mental Health and, as one participant put it, 'Mental Health always trumps alcohol or drugs' when it comes to bed allocation.

  Recommendation 11: Assessment and risk framework for the management of co-occurring conditions.

  There is a compelling need to develop and implement a consistent assessment and risk framework for the management of co-occurring conditions across Gwent. Currently, risk and need assessments and care pathways are unknown, unclear or sporadically applied by practitioners across the area. This is seen by stakeholders as poor and counterproductive practice, but an issue easily rectified. A new framework will help identify and mitigate risks around working with co-occurring conditions, improve staff confidence and competence in working with complex needs; and help to consistently meet the identified needs of those engaged with services.

- **Recommendation 12: Construct an integrated working guide involving alcohol/drugs, mental health, housing, employability and other relevant services; as well as recovery communities.**

  This study has highlighted inconsistencies in integrated working within, between and across specialist substance use and mental health services; and other crucial linked services such as

housing and employability, as well as recovery communities. In the longer-term there would be great benefit in developing and agreeing an integrated working guide involving alcohol/drugs, mental health, housing, employability and other relevant services; as well as recovery communities.

Given the evidence of variable joint working between agencies and disciplines, we would recommend consideration of strengthened multidisciplinary teams across both in-patient and community settings.

6.3.5 Organisation culture and workforce development

- **Recommendation 13: Further work is required across Gwent mental health services to achieve a consistent response regarding co-occurring conditions and to challenge the stigma and misuse of the label 'dual diagnosis'.**

  Staff working in mental health and substance use services need continuation of training as a matter of urgency on how to manage patients with co-occurring conditions. This will involve recognition that comorbid substance misuse is common and that stigmatising people with co-occurring conditions is not acceptable.

- **Recommendation 14: Prioritise the development of trauma and violence-informed, and psychologically-informed, approaches and services which recognise and respond to previous experiences of adversity and their ongoing influence on people's circumstances and engagement with treatment.**

- **Recommendation 15: Workforce development.**

  Significant focus is required on workforce development. We will be recommending the establishment of a Gwent framework for co-occurring conditions training across agencies, with different tiers of training for different professional and staff groups. This could be developed and delivered in the main by utilising existing resources and personnel within services (and build upon and formalise some of the local training initiatives that have already taken place), with a focus on cross-training opportunities between mental health and substance use services:

  - Tier 1 training to improve awareness, understanding and recognition of co-occurring conditions. This will be designed to reduce stigma, improve recognition of co-occurring conditions and enable early treatment or referral. The target audience for this tier is staff working in voluntary sector, social services, criminal justice; plus, healthcare staff in primary care, community and secondary care settings who do not have a formal mental health or substance misuse role.
  - Tier 2 training on managing and supporting patients/clients with lower level co-occurring conditions, to enable dual recovery. The target audience for this tier of training will be mental health professionals and substance misuse treatment staff who do not have a specific co-occurring conditions role.

- Tier 3 training on managing and supporting patients/clients with more complex co-occurring conditions, to enable dual recovery. The target audience for this tier of training should be specialised substance misuse staff and secondary care mental health professionals.

The above training programmes should not be seen as the sole solution to workforce development challenges, which in themselves do not guarantee cultural change in services. Additional learning opportunities should be prioritised with particular focus given to developing a long-term plan for rotational secondments between mental health and substance use services. Existing examples of these type of secondments provide highly encouraging evidence of shifts in behaviours and attitudes of staff, as well as raising confidence of staff to work effectively with both mental health and substance use issues. The aim of such secondments will also include promotion of greater levels and intensity of integrated practice between mental health and substance use services (which currently varies significantly across different areas of Gwent).

6.3.6 Meaningful involvement of people who experience problems with drugs/alcohol and their mental health, their families and advocates.

- **Recommendation 16: 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 be valued as equal partners. 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.

- **Recommendation 17: All services undertake family inclusive practice training within twelve months.**

  In terms of the experience of family members/carers, the evidence gathered during the needs assessment illustrated a predominant experience that they had of being judged and stigmatised, as well as the belief that support for families and carers is not considered to be a priority and is under-resourced. All services adopt and follow good practice standards for family inclusive practice[107] which include pro-actively seeking consent to involve the individual's supporter in their care, and seeking consent on an ongoing basis if it is refused at first appointment, as well as explaining the treatment/care process to family members, and encouraging family members to share information with the service, even if information cannot be shared back the way.

- **Recommendation 18: Develop a vision for a Gwent Recovery College.**

  Commissioners should work together with service providers to develop the local recovery model and look at how a recovery college approach might be developed for Gwent. In order to address this recommendation fully in the longer term, we suggest that a 'Recovery College' (or Resource

[107] Such as https://adfam.org.uk/files/docs/idf_toolkit.pdf

Centre) is established in Gwent, staffed and run by service user-educators and linked to the delivery of the local recovery strategy. The centre would train and support people with lived experience of mental health and/or substance use problems to tell their stories and to promote awareness of recovery principles among staff and other service users. It would also begin to train people as 'peer professionals' to provide direct care within the services. It would need to work with local education providers to ensure that the training is of a consistently high standard and begin to offer accredited courses. A beneficial offshoot of this development would be the general promotion of an 'educational', rather than a 'therapeutic', model within the services, which would place an emphasis on learning from one another and assist in promoting self-determination and self-management. [Further details and examples of 'Recovery Colleges' are provided in the **Part 2 – Supporting Evidence** report at **Appendix VIII**].