FIGURE 8
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GWENT CO-OCCURRING CONDITIONS NEEDS ASSESSMENT

PART 2 – SUPPORTING EVIDENCE REPORT

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

EVIDENCE INTO PRACTICE

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The research team was assisted by a small Advisory Group (below), which provided accountability, guidance and support. This group met on several occasions. The research team are grateful for the advice and facilitation provided by this group throughout the duration of the study.

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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. Each strand of data collection and synthesis – dataset reviews, interviews, stakeholder events, working groups, focus groups, and surveys – contains a box with key findings.

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APPENDIX I: LITERATURE REVIEW – KEY DOCUMENTS

Thematic Findings from Systematic Reviews

Prevalence and epidemiology

Lai et al's (2015) systematic review of 115 articles, included 22 epidemiological surveys. The review reported the comorbid prevalence of mental health disorders and substance use. Meta-analysis indicated the strongest associations were between illicit drug use disorder and major depression. This was followed by illicit drug use and any anxiety disorder, then alcohol use disorders and major depression, and then alcohol use disorders and any anxiety disorder.

Major depression and alcohol dependence have been found to co-occur at higher than expected rates in many epidemiological studies. Lifetime prevalence of alcohol use disorders in respondents with major depressive disorders has been reported to be as high as 40%. For those with a recognised alcohol disorder a prevalence of major depression as high as 35% has been reported. Anxiety disorders are highly associated with illicit drug use especially in those with lifetime drug dependence where almost 50% have a co-occurring condition.

All of the other prevalence studies reported significant associations between illicit drug use and dependence and any anxiety disorder. Major depression and illicit drug use have been shown to have the strongest associations based on surveys conducted in general populations. All of the 18 studies used in the meta-analysis reported significant associations between illicit drug use and major depression.

The authors conclude that comorbidity between substance use disorders, mood and anxiety disorders are highly prevalent across countries. The meta-analysis revealed that people with an alcohol use disorder were 2.1 times of greater risk of having any anxiety disorder compared to those without an alcohol use disorder. This association was higher for alcohol use disorders and major depression showing that the risk of having major depression is 3.10 more likely for a person with an alcohol disorder compared to someone without an alcohol use disorder. The literature shows substantial recent progress in investigating the patterns and implications of comorbidity between mental health disorders and substance use disorders. As such, the review confirms the strong association between substance use disorders, mood and anxiety disorders.

Hunt et al's (2016) systematic review and meta-analysis identified nine surveys of which two surveys were repeated ten years later using independent samples. The review shows comorbidity of substance use disorder and bipolar disorder are highly prevalent across countries. The meta-analysis revealed that people with an alcohol use disorder (abuse or dependence) are 4.1 times of greater risk of having bipolar disorder compared to those without an alcohol use disorder. The risks were even higher for illicit drug users where they were 5.0 times of greater risk of having bipolar disorder compared to non-users.

The authors found strong associations between co-occurring substance use disorders and bipolar disorder. Of the illicit substances implicated in this relationship, cannabis had the highest mean prevalence (17%) followed by cocaine (6.6%) and opiates (4.3%). The mean prevalence for any drug use disorder was 17%, for any alcohol use disorder it was 24%, whereas for any substance use disorder it was 33%.

The authors point out that comorbidity is important because it is the rule rather than the exception with bipolar illness and mental health disorders in general. Moreover, over the course of development, there are internalising and externalising disorders that modify and increase the risk of developing bipolar disorder. These include bouts of anxiety and depression during childhood (internalising) and exposure to trauma, deprivation and substance use (externalising) factors.

Kingston et al's (2017) review found that the prevalence estimates of current mental disorders in substance use treatment clients varied markedly. For example, eight studies reported data on the prevalence of any mental health disorders in participants presenting to substance use treatment services and prevalence estimates for substance use comorbid with any current mental health disorder ranged from 47 to 100%. Mood and anxiety disorders were especially prevalent, with the prevalence of current depression ranging from 27% to 85% and current generalised anxiety disorder ranging from 1% to 75%.

Depression was the most frequently assessed disorder. Current prevalence rates for comorbid depression ranged from 27 to 85%, and 12-month prevalence ranged from 40 to 55%. Current prevalence rates for co-occurring anxiety disorders as a broad category ranged from 12 to 91%, with 12-month prevalence ranging from 45 to 68%. In terms of generalised anxiety disorder, current prevalence rates ranged from 1 to 75% and 12 month prevalence ranged from 28 to 36%.

The authors illustrate that while a significant proportion of people accessing treatment for substance use also have co-occurring mental health conditions, there is considerable variation in the types of disorder, patterns and distributions of comorbid disorders seen across studies. Despite this variation, the lowest estimate for the current prevalence of any comorbid mental health problem was 47%, suggesting that comorbidity is a significant and serious concern which needs to be addressed by treatment services. In many cases, comorbidity may be the norm rather than the exception in clients presenting for substance use treatment. Thus, the high prevalence of mood and anxiety disorders in substance use treatment settings indicates a need for workers to screen and assess for these disorders as part of routine clinical care, in addition to being familiar with up to date evidence-based management and treatment policies.

Megnin-Viggars et al's (2015) review considered epidemiological data in order to understand the health and social care needs of people in the UK with a severe mental illness who also use substances. The authors report moderate evidence about the prevalence of co-occurring conditions obtained using a comprehensive *catchment area* survey sampling frame. The authors state that the evidence about the rates of co-occurring conditions are fairly consistent. For example, two large case-control studies found a prevalence of co-occurring conditions in the general adult UK population of 0.05-0.16%. Another three studies that restricted their comprehensive catchment area survey to people with severe mental illness found prevalence rates of 1.9-7.0% for current harmful drug use or

dependence and 7.0-15.5% for current harmful alcohol use or dependence. There is evidence from three case-control studies about differences in the rates of substance use problems between groups with severe mental illness and a group with no psychiatric diagnosis, no psychosis or compared to general population controls. Consistently higher rates of drug use were observed for children and adults with severe mental illness.

The authors also report evidence about the prevalence of co-occurring conditions amongst those in contact with *secondary mental health services*. This evidence was mixed with hugely varying prevalence rates across secondary mental health settings of between 11.7% and 61.2% for substance use within the past year. Evidence was found about the prevalence of co-occurring conditions amongst *those in contact with substance use services*. This evidence is mixed with estimates ranging from 5.7% to 38.8% for the prevalence of severe mental illness amongst individuals with substance use problems who are in contact with community drug or alcohol addiction services. There was also evidence that prevalence estimates of co-occurring conditions as 0.02% amongst individuals in *contact with primary care.*

Megnin-Viggars et al. (2015) also found evidence about the proportion of the co-occurring conditions population in secondary mental health services with different *severe mental illness diagnoses.* The evidence is mixed, however, the pattern is consistent across studies. The severe mental illness most commonly reported as comorbid with substance use was schizophrenia, with estimates ranging from 35.9% to 92.3% of the co-occurring conditions participants, followed by bipolar disorder which was the diagnosis made in 10.3% to 13% of co-occurring conditions cases. Substance-induced psychosis was also reported with estimates of 37.5% and 48.7%, however, this was an exclusion criterion in some studies. There is evidence from one cohort study about the proportion of the co-occurring conditions population in substance use services with different severe mental illness diagnoses. The severe mental illness most commonly comorbid with substance use amongst adults in contact with addiction services was severe depression with an estimate of 73.1% relative to schizophrenia and bipolar disorder which were the diagnoses in 7.4% and 3.7% of co-occurring conditions cases respectively.

The authors also found evidence about the proportion of the co-occurring conditions population in secondary mental health and substance use services *using different substances.* The evidence, again, is mixed, however, the pattern is consistent across studies and services. The most commonly reported substances that were used by people with severe mental illness and substance use problems were alcohol and cannabis, with 50.6 to 84.6% and 29.0 to 78.5% of the co-occurring conditions populations using alcohol and cannabis respectively. The percentage of the co-occurring conditions samples reporting problems with other substances are: 9.7 to 23.8% for cocaine or crack, 6.0 to 20.8% for stimulants,10.5 to 12% for amphetamines, and 0.9 to 10% for opiates.

In terms of *gender variation,* Megnin-Viggars and colleagues report evidence for a preponderance of males in a co-occurring conditions group relative to a group with severe mental illness-only. A meta-analysis of six studies found evidence of a lower proportion of females in the group with comorbid severe mental illness and substance use.

There is evidence about *ethnic variation* in rates of co-occurring conditions or between cases with severe mental illness and co-occurring substance use and controls with severe mental illness and no recorded substance use. However, the evidence about the direction of this variation is mixed.

Health and Social Care needs of people with co-occurring conditions

Garcia-Guix et al (2018) reviewed evidence that women with a substance use issue present with more psychiatric co-morbidity than men with a substance use issue and women without; the most frequent psychiatric disorders being depression, anxiety and Post-Traumatic Stress Disorder. Garcia-Guix and colleagues found that women with substance use issues also have a greater risk of experiencing **intimate partner violence** and report more sexual and injecting risk behaviours associated with HIV and HCV infection.

Megnin-Viggars and colleagues (2015) found evidence suggesting that people with schizophrenia and substance use have a significantly higher level of *met and unmet needs* than people with schizophrenia only. Furthermore, there is evidence suggesting that this is also true of people from a drug and alcohol service who also had a psychotic disorder when compared to people from the same drug and alcohol service who did not have a psychotic disorder.

The authors also found evidence about differences in the *duration of the severe mental illness.* No difference was found in between people with a co-occurring condition and those with schizophrenia only for the duration of untreated psychosis. When measured dichotomously or continuously there was also no difference in the number of days from the onset of psychosis to first contact with mental health services for psychosis for individuals with schizophrenia and cannabis use compared with those with schizophrenia only. Furthermore, there is evidence about differences in psychiatric symptom severity between people with a co-occurring condition and those with severe mental illness only. For example, there is a higher rate of relapse or non-remission amongst a co-occurring condition group. Moreover, there is a greater severity of positive symptoms in the co-occurring condition group. These differences appear to be specific, as no evidence was found for a difference in negative symptoms or symptoms of depression between people with co-occurring conditions and those with severe mental illness and no reported substance use problems.

There is evidence from that there is no difference in the rates of *attempted suicide* in co-occurring conditions relative to severe mental illness-only groups, whereas in terms of *medication adherence*, the evidence is strong about differences in medication compliance between people with a co-occurring condition and those with severe mental illness-only, with a significantly greater medication non-adherence associated with co-occurring substance use in individuals with severe mental illness.

There is evidence about differences in met and *unmet treatment needs* between individuals with severe mental illness with or without co-occurring substance use. In a study comparing self-reported levels of need between Community Mental Health Team (CMHT) clients with substance use and CMHT clients without substance use, and between drug and alcohol service patients with a co-occurring psychotic disorder and drug and alcohol service patients with no co-occurring psychiatric disorder, higher levels of need were found in the co-occurring conditions groups.

There is evidence that there are no differences in *education* between co-occurring conditions and severe mental illness-only groups. A meta-analysis of 2 studies found no difference in the number of participants leaving school by age 16 or with no qualifications between those with severe mental illness and co-occurring substance use and those with severe mental illness-only.

There is evidence for differences in *unemployment rates* between a co-occurring condition group and a severe mental illness only group. A meta-analysis of three found a greater number of people who were unemployed in the co-occurring condition group.

There is evidence for differences in *housing* between those with severe mental illness with and without co-occurring substance use. A meta-analysis of 3 studies found an increased probability of a history of homelessness or housing problems amongst the co-occurring conditions group.

There is evidence about differential rates of *violence* in co-occurring condition groups. The evidence shows inconsistent results when comparing the effects of co-occurring substance use (among those with severe mental illness) relative to the effects of co-occurring severe mental illness (among those with substance use). A meta-analysis of 3 studies found an increased probability of a recent history of violent behaviour for those with co-occurring conditions relative to those with severe mental illness-only. Moreover, another study also suggested a higher probability of violence in those with severe mental illness and co-occurring substance use relative to those with severe mental illness only as a higher prevalence of co-occurring conditions was found in patients attending a CMHT with a history of violence relative to a comparable group with no history of violence.

There is evidence about differential contact with the *criminal justice system* amongst those with co-occurring conditions. A meta-analysis of four studies found an increased probability of a recent history of contact with the criminal justice system in a group with severe mental illness and co-occurring substance use relative to a group with severe mental illness only.

There is evidence about the effects of substance use on *social functioning* amongst those with severe mental illness, however, evidence was mixed. A meta-analysis of 2 studies found no difference in social functioning between a group with co-occurring conditions and a group with severe mental illness only. Conversely, another study compared social functioning between CMHT clients with substance use and CMHT clients without substance use and found poorer social function in the co-occurring conditions group.

Current configuration of health and social care community services for people with co-occurring conditions

Megnin-Viggars et al (2015) report evidence from 12 studies of national, regional or local reports, assessments or evaluations describing current service delivery structures of community services for people with co-occurring conditions in the UK. The authors point out that the evidence highlights great inconsistencies in the configuration of co-occurring conditions services within NHS trusts across the UK. Moreover, these inconsistencies lie in a number of areas including sources of funding, structure of services, type of staff members, services delivered and coordination of care. However, notwithstanding the inconsistency in findings, the services can be separated into five wide-ranging

categories: (a) separate co-occurring conditions services which accept referrals and provide interventions (b) integrated services run by staff members from mental health and substance use services who accept referrals and provide interventions (c) integrated teams who provide support and advice to existing mental health and substance use services acting as consultants and ensuring adequate service provision for co-occurring condition service users (d) groups providing opportunities for networking (e) educational courses and skills training.

Characteristics of treatment options for co-occurring conditions

Morisano et al. (2014) report that, for the most part, treatment research has been conducted in high-income countries, focusing on the use of pharmacotherapies. The authors highlight three treatment models that have emerged from the literature as promising methods to manage clients with various combinations of co-occurring conditions.

Sequential/Serial Treatment. In this model, the individual is first treated for one issue (substance use or mental health), followed by treatment of the other. The authors point out that some have suggested that it is more important to first address the substance use issue as further compliance with psychotherapy and pharmacotherapy is unlikely without bringing the substance use under control. Also highlighted for concern is that some treatments for certain mental health disorders, for example CBT homework and exposure therapy for anxiety, might trigger anxiety, and therefore substance use, if attempted before substance use was under control, however the authors stress that no empirical support is provided for these claims.

Simultaneous/Parallel. This model allows for treatment of both conditions at the same time, but separately by service providers working in isolation from each other. In some cases, treatment for both disorders is provided at the same time in separate but closely linked systems. Citing a review of models for treatment of co-occurring disorders, Morisano and colleagues note warnings have been expressed that due to frequent problems in communication, cooperation, and logistics coordination between substance abuse and mental health treatment organisations, parallel treatment is a risky approach to take as responsibility often falls on the client to follow through a treatment plan involving both systems.

Integrated. Integrated treatment aims to target co-occurring mental health and substance use simultaneously within one agency or treatment programme, with service providers either coordinating care or providing treatment as a team. The authors point out that it often involves a flexible combination of treatments for a client depending on severity of symptoms and substances used. Integrating services requires that professionals from multiple fields learn to work together and in general, interprofessional dynamics play an important role in the process. The evidence suggests that among clients being treated for co-occurring mental health and substance-use-related issues, outcomes are improved when these "separate" treatment modalities are offered in combination within an integrated treatment plan that addresses both substance use and other mental health problems simultaneously.

Bibliography

Garcia-Guix, A., Mestre-Pinto, J.I., Tirado-Muñoz, J., Domingo-Salvany, A., Torrens, M. 2018. Psychiatric co-morbidity among women with substance use disorders. *Advances in Dual Diagnosis, 11*(1): 1-3.

Hunt, G.E., Malhi, G., Cleary, M., Lai, H. M., and Sitharthan, T. 2016. Comorbidity of bipolar and substance use disorders in national surveys of general populations, 1990-2015: Systematic review and meta-analysis. *Journal of Affective Disorders, 206*: 321-330.

Kingston, R. E. F., Marel, C., and Mills, K. L. 2016. A systematic review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia: Comorbidity in substance use treatment. *Drug and Alcohol Review, 36*(4): 527-539.

Lai, H.M., Cleary, M., Sitharthan, T., Hunt, G.E., 2015. Prevalence of comorbid substance use, anxiety and mood disorders in epidemiological surveys, 1990-2014: A systematic review and meta-analysis. *Drug and Alcohol Dependence, 154*(1): 1-13.

Megnin-Viggars, O., Brown, M., Marcus, E., Stockton, S., Pilling, S. 2015. *The epidemiology, and current configuration of health and social care community services, for people in the UK with a severe mental illness who also misuse substances: A systematic review.* Available at: https://www.nice.org.uk/guidance/ng58/documents/evidence-review

Morisano, D., Babor, T.F., & Robaina, K.A. 2014. Co-occurrence of substance use disorders with other psychiatric disorders: Implications for treatment services. *Nordic Studies on Alcohol and Drugs, 31*(1): 5-25.

Additional literature

As part of the review of literature for this study the research team identified a number of key articles (in addition to the 'Review of Reviews' which is presented in **Chapter 2** of the **Part 1 – The Report** as well as the section above) which highlight important learning points and practice limitations for commissioners and practitioners across Gwent. These key articles are presented in the tables below:

Facilitators and barriers in dual recovery: a literature review of first-person perspectives

Source	Advances in Dual Diagnosis (Emerald Insight)
Author(s)	Ottar Ness, Marit Borg and Larry Davidson
Year	2014
Retrieved from	http://dx.doi.org/10.1108/ADD-02-2014-0007

Key learning points	• The aim of the study was to identify and discuss what those experiencing dual-diagnosis describe as facilitators and barriers in their recovery process. • Three overarching themes identified as facilitators of dual recovery: (1) meaningful everyday life; (2) focus on strengths and future orientation; and (3), re-establishing a social life and supportive relationships. • Two overarching themes were identified as barriers to dual recovery: (1) lack of tailored help and (2), complex systems and uncoordinated services.
Practice implications	• It is important to not only focus on individuals' dual diagnosis but also that those who are have a dual diagnosis have a life and have an interest in having work, being cared for, caring for others and having a sense of belonging.

A Qualitative Study of Barriers to Care for People With Co-Occurring Disorders

Source	**Archives of Psychiatric Nursing (Elsevier)**
Author(s)	Minna Sorsa, Tim Greacen, Juhani Lehto and Päivi Åstedt-Kurki
Year	2017
Retrieved from	www.elsevier.com/locate/apnu
Key learning points	• This study was based on service providers views on the barriers to care with those with co-occurring disorders. Barrier identified: • 'Definition and understanding of the problems: clients and professionals' perspective often differ, and both can be out of step with what the care system proposes.' Client based barriers: • Client motivation • Several problems co-occurring • Own choices in the use of services Staff based barriers: • Emotional burden • Complex care needs in changing organisations • Knowledge and training • Personal working models Barriers to care related to service organisation:

	• Focus and prioritisation in different services are not adapted to dually diagnose clients. (e.g. Mental health services only work with individuals with mental health problems, not with those with alcohol and drug problems.) • Responsibility of the whole system to include or exclude clients • Access to care limited • Allocation of resources
Practice implications	• A holistic approach should be utilised when working with those with a dual diagnosis – considering both their mental health and substance use. • Increase training and knowledge of staff surrounding dual diagnosis to enable better working and increase staff confidence when working with this group. • Make services more flexible to make access to treatment easier. (e.g. evening and weekend opening times)

"Walking alongside:" collaborative practices in mental health and substance use care

Source	**International Journal of Mental Health Systems**
Author(s)	Ottar Ness, Marit Borg, Randi Semb and Bengt Karlsson
Year	2014
Retrieved from	http://www.ijmhs.com/content/8/1/55 (open access)
Key learning points	• The aim of this study was to identify key characteristics of the ways in which mental health practitioners collaborate with service users and their families in practice. The three major themes identified which are related to practitioners' experiences of collaborative practices were: • (1) 'Walking alongside' a service user was one theme identified. This requires an agreed between the practitioner and the individual on the destination. It is was noted that it is important to consider a person's 'life situation, hopes and dreams' and discussing ways in which to work together 'maintaining human relationships, and • (2) Continuity and consistency were mentioned as key to maintaining relationships as well as having time.

	• (3) There are many different systems and people that an individual need to collaborate with. A large majority of time is spend supporting individuals to manoeuvre through the system.
Practice implications	• A practitioner should aim to build a good relationship with service users and establish trust in the relationship. • Informing service users about their rights and the nature of the assistance which they can expect from services.

Stigma in Dual Diagnosis: A narrative review

Source	Indian Journal of Social Psychiatry
Author(s)	Yatan Pal Singh Balhara, Arpit Parmar, Siddharth Sarkar and Rohit Verma
Year	2016
Retrieved from	http://www.indjsp.org (open access)
Key learning points	• This review looked at various aspects of stigma in the context of dual diagnosis of psychiatric disorders and substance use disorders. It looked specifically at stigma experience by either those with psychiatric disorders and substance use disorders. The authors identified three types of stigma when considering these groups: • Self-stigma (internalised stigma) 'Self-stigma is defined as a subjective process that is embedded within a social context and is characterized by negative feelings about oneself, maladaptive behaviours, and stereotype endorsement' • Structural stigma 'Structural stigma is defined as the stigma created by the structures (institutional policies and practices) that surround a person (e.g. media).' • Stigma in Dual Diagnosis There is not much research surrounding stigma and how it impacts on individuals with a dual diagnosis, but this study suggested that individual may experience similar discrimination as those who either a mental health disorder and a substance misuse order. • Approaches to reduce stigma associated with psychiatric / substance use disorders - Education

	- Protest (protesting the inaccurate portrayals that exist of mental health and substance user disorders) - Contact with individuals that have mental health and substance use disorders can help to diminish stigma.
Practice implications	• Developing an understanding into the stigma in the context of dual diagnosis is important to help those who are directly affected by it such as the individuals, their family members and caregivers and treatment providers.

Dual Diagnosis in Older Adults: A Review

Source	Issues in Mental Health Nursing
Author(s)	Adam Searby, Phil Maude and Ian McGrath
Year	2014
Retrieved from	https://www.researchgate.net/publication/271600915_Dual_Diagnosis_in_Older_Adults_A_Review
Key learning points	• A key finding from this paper is that there is a hidden population of older people with a dual diagnosis. This could be due to a reluctance to attach such a diagnosis to an older individual. Furthermore, consequences of substance misuse such as falls, and confusion are attributed to other medical disorders.
Practice implications	• It is important that that the older population receives timely assessments and identification of substance misuse to allow for effective engagement and treatment when presenting to mental health setting. And identification of a mental health disorder if presenting to a substance misuse service.

Treatment Access Barriers and Disparities Among Individuals with Co-Occurring Mental Health and Substance Use Disorders: An Integrative Literature Review

Source	Journal of Substance Abuse Treatment (Elsevier)
Author(s)	Mary Ann Priester, Teri Browne, Aidyn Iachini, Stephanie Clone, Dana DeHart and Kristen D. Seay
Year	2016
Retrieved from	https://www.researchgate.net/publication/283501906_Treatment_Access_Barriers_and_Disparities_Among_Individuals_with_Co-Occurring_Mental_Health_and_Substance_Use_Disorders_An_Integrative_Literature_Review

Key learning points	There were two main barriers identified within this study: • Personal characteristics – This includes personal vulnerabilities such as symptoms of MH and SUD. For example, COD including psychosis where substance use often worsens MH symptoms. There are different ways in which this can impact a person, such as their motivation and which can make it less likely that a person would seek treatment. Additionally, a person personal belief about treatment providers, cultural beliefs and stigma relating to MH and SUD could as a barrier. • Structural barriers- Some of the structural barriers that are highlighted include - Service availability – Example: Lack of specialised services to treat COD - COD ID – Research indicates that practitioners do not always diagnosis substance misuse or MH together, usually it is one or the other. - Provider training – Staff dealing with individuals with a dual diagnosis lack of enough training to identify MH and SUD. - Service provision – 'Service provision includes service barriers such as organisational red tape and barriers related to treatment provision, such as the way that treatment is provided. The service barriers an individual encounter during their pre-treatment phase has the potential to impact the accessibility of treatment services.'
Practice implications	• One way to reduce the barriers to treatment is to offer a pre-treatment program while clients wait for intake and treatment. • Increase effective training in identifying MH and SUD among staff that work in these services. • Provide flexible services, making services available during the evening and at weekends.

Young adults with co-occurring disorders: substance use disorder treatment response and outcomes

Source	Journal of Substance Abuse Treatment (Elsevier)
Author(s)	Brandon G. Bergman, M. Claire Greene, Valerie Slaymaker, Bettina B. Hoeppner and John F. Kelly
Year	2014
Retrieved from	https://www.researchgate.net/publication/259516199_Young_Adults_with_Co-Occurring_Disorders_Substance_use_Disorder_Treatment_Response_and_Outcomes
Key learning points	• Young adults (18-24) are vulnerable to the development of both substance use disorder and psychiatric disorders.

	• Young adults presenting with SUD and psychiatric disorder or co-occurring disorders to a residential SUD program presented with more severe clinical profiles at treatment entry. • *However*, results show despite this; COD patients responded just as well to treatment as their SUD counterparts. COD patients also had similar post-treatment outcomes to SUD only peers. • High quality, multi-disciplinary and psychiatrically-integrated residential treatment program may have helped neutralise COD patients' great psychological burden and poor prognosis. • It is important to point-out that it may be possible that young adults with more severe pathology including histories of psychotic and/or manic episodes may not respond as well as those with SUD or with less severe co-occurring disorder.
Practice implications	• Residential programs (with an integrated treatment approach) maybe better equipped to assess and address the needs of those experiencing COD.

Taking the plunge: Service users' experiences of hope within the mental health and substance use services

Source	Scandinavian Psychologist
Author(s)	Sælør, K. T., Ness, O., & Semb, R.
Year	2015
Retrieved from	http://dx.doi.org/10.15714/scandpsychol.2.e9
Key learning points	• The following study explored first-person accounts of how hope is experienced by persons with co-occurring mental health and substance use problems. In addition to this, another aim was to develop knowledge which is relevant to clinical practices within the mental health and substance use field. • 'Hoping for change' Hope within this study was strongly associated with change and hope promotes the possibility that change can occur. Hope was not enough but needed to be followed by action. It also required reinforcement and support to flourish. • 'Trust as a foundation for hope' Distrust and suspicion could represent obstacles to seeking support from others and were also barriers when it came to hope itself. Distrust can stop individuals getting the support and treatment they need to move forward.

	• 'Taking the plunge back into life – hopes of being an average Joe or plain Jane.'
Practice implications	• The findings of the current study emphasised the need for there to be a trusting relationship between the practitioner and servicer user. • There should be effort made to counter stigma as this could be an obstacle to services users and believing that change was possible. • Services need to have a holistic view of recovery processes and support individual strengths and competencies.

The concept of recovery as experienced by persons with dual diagnosis: A systematic review

Source	Journal of Dual Diagnosis (Taylor and Francis)
Author(s)	De Ruysscher, C., Vandevelde, S., Vanderplasschen, W., De Maeyer, J., & Vanheule, S.
Year	2017
Retrieved from	http://doi.org.10.1080/15504263.2017.1349977
Key learning points	• This study addressed the question 'What does personal recovery mean for persons with dual diagnosis?' The following themes were identified: • 'Feeling supported: social relationships' was one theme identified. This included family support, peer support and community belonging • Looking 'beyond the symptoms': treatment was another element highlighted in this review. This aspect includes having a holistic and individual approach to treatment, good therapeutic relationships and the role of medicine in treatment. • 'Building a positive future: personal beliefs' is the third theme identified by the authors. Hope, regaining a sense of identity, building self-responsibility and self-determination and spirituality where all included in this sub-heading. • 'Having somewhere to be: meaningful activities' was the last theme identified. Example of meaningful activities included: physical exercise, creating art, reading and writing, education, employment and cultural and religious activities. All the above was deemed important to the recovery process by those who had a dual diagnosis.

Practice implications	• A holistic and individualized approach should be taken when working with those with a dual diagnosis, this includes adjusting to the pace and unpredictable nature of the recovery process. • Medication is helpful in the recovery process if the dose is according to the individual's personal needs and used for therapeutic purposes.

Dual diagnosis competencies: A systematic review of staff training in literature

Source	Addictive Behaviour Reports (Elsevier)
Author(s)	Petrakis, M., Robinson, R., Meyers, K., Kroes, S., O'Connor, S.
Year	2018
Retrieved from	http://doi.org/10.1016/j.abrep.2018.01.003
Key learning points	• This research paper was regarding approaches to staff training in Dual diagnosis competencies. • One of the findings of this research was that service users who were treated by staff with lower levels of self-rated dual diagnosis competency were significantly more likely to drop out of treatment. • The way that training is implemented into organisation has also been associated with dual diagnosis competency by staff (I.e. prioritisation of training) • The organisation has a role to play in how competent staff are when working with dual diagnosis. For example, organisation structure has impact on competency (i.e. staff turnover, training) • It is also suggested that changes to organisations mission statements and policies should include dual diagnosis service user care. This would have a positive affect for access to the service, the identity of the service and helping to make service users feel that they belong.
Practice implications	• One of the recommendations of this study is supervision. It is suggested that supervision is necessary to ensure staff feel more prepared to work with those experiencing dual diagnosis. • There should be more effective and sufficient training delivered to staff and it is highlighted that there should be competent leaders in services. • Additionally, attempts should be made to address organisational barriers such as an organisation's willingness to change and to change policy to make it more inclusive.

Building trust and recovery capital: the professionals' helpful practice

Source	Advances in Dual Diagnosis (Emerald Insight)
Author(s)	Topor, A., Skogens, L., & von Greiff, N.
Year	2018
Retrieved from	https://doi.org/10.1108/ADD-11-2017-0022
Key learning points	• The following paper analysed professionals' perceptions on their contributions to a person's recovery. Four themes emerged. They were: • (1) 'A base to build on' - This was described as building an 'alliance'; building a good relationship between the practitioner and service user. It also mentioned that a person previous experiences (i.e. relationships with family) may impact on this relationship as well as their mental health negatively influencing this 'alliance'. • (2) 'Building trust' – Part of building trust was aiding a person to build a positive self and view of others. Other elements include: acceptance, accountability, trusting the professional and learning to trust themselves. • (3)'Managing a fragmentised organisation' – This included continuity and time which was often reported as lacking and how professionals need to navigate this whilst support individuals. Furthermore, there appears to be a 'division of responsibilities between diverse organisations with different aims, responsibilities and cultures created difficulties for persons in their recovery journeys and entailed a need for cooperation between services with different agendas.' Additionally, some treatment was structured (which is not necessarily viewed negatively in some instances) however it is suggested that it should view people as 'individuals' with differing needs. • (4)'The Importance of societal conditions' - This is in relation to the societal conditions that are created due to political decisions. Two of the sub-themes which dominated were: Resources (financial) and housing.
Practice implication	• It is important to building an 'alliance' between a practitioner and service user. • Building trust is about acceptance by the practitioner of the individual (including the aspects that appear problematic) and

	accountability (e.g. 'the professional proving the existence of a connection between his/her words and actions').

APPENDIX II: REVIEW OF SIMILAR (RECENT) NEEDS ASSESSMENTS

Introduction

In line with the research objectives, the team undertook a review of previous co-occurring needs assessments. 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. 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 have been included. This is not an exhaustive list, however it presents an overview of a number of relevant issues and in terms of supporting people with co-occurring conditions which helps to situate the current report into the wider context.

A summary of key themes and messages to arise from this rapid review are presented in **Chapter 4** (**Table 4.1**) of the **Part 1 – Main Report**. Full details of this evidence review are provided in tabular form below.

Source	Kirklees Mental Health and Wellbeing Needs Assessment
Author(s)	Elliott, R., Wearmouth, L., and Richardson, O.
Year	2018
Retrieved from	https://www.kirklees.gov.uk/beta/delivering-services/pdf/HNA-report.pdf
Key findings	• Anecdotal evidence at a local level has shown that co-occurring conditions is an issue for service users; they are experiencing a disconnect in the service they receive because their substance misuse issue has to be treated before the mental health problems and vice versa. This is impacting on service users who aren't necessarily getting the right support or treatment to help them, when both issues often need to be treated at the same time in order for the service user's health to improve. • Between January 2012 and November 2014 there were 1,093 hospital admissions for Kirklees residents with a primary diagnosis of mental and behavioural disorders due to psychoactive substance use. • The majority of these admissions were males (69%); of the overall number of admissions in this category, 82% were for mental and behavioural disorders due to alcohol, 4% due to cannabinoids, and 8% due to multiple drug use and other psychoactive substances. • There were 37,902 hospital admissions for Kirklees residents with either a primary or secondary diagnosis, between January 2012 and November 2014. Of these, just over half (51%) were males. • The number of concurrent contacts for mental health and drug misuse has increased from 17.7 per 100,000 in 2014/2015 to 24.2 per 100,000 in 2015/2016. The number of concurrent contacts for mental health and alcohol misuse has remained relatively stable across the 3 year period. • Improve information sharing practices within the NHS and beyond in order to improve care and outcomes and to avoid missed opportunities in relation to patient safety.
Practice implications/gaps (i.e. relevance to Gwent services)	• Highlights that there is higher demand for a co-occurring service than can be managed by the number of staff. • Accessibility to dual diagnosis service can be perceived as challenging and can vary dependent on the needs of the service user.

Source	Derbyshire Co-occurring Conditions Needs Assessment
Author(s)	Figure 8 Consultancy
Year	2018
Retrieved from	Not in public domain
Key findings	• People with co-occurring conditions are very vulnerable and have complex needs relating to health, social, economic, and emotional

	stressors or circumstances which can often be worsened by their substance use. • There is very limited data available to assess the trend in prevalence rates of dual diagnosis either nationally or locally, but there are suggestions that co-morbidity is being increasingly recognised over time. • Flexibility is lost when services face drastic cuts, as both mental health and substance misuse services have. • Mental health services exclude people with a primary drug or alcohol problem and substance use services exclude people who have a primary mental health problem; leaving the client stranded. • 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. • There is a 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. • The issue of different agencies and professionals using different databases was identified as a barrier to information sharing. • Training opportunities in relevant mental health related topics and co-occurring conditions for staff working in specialist alcohol and drug services is minimal or even non-existent.
Practice implications/gaps (i.e. relevance to Gwent services)	• Acknowledges workforce development barriers. • Joined up working between specialist mental health services and specialist alcohol and drug services for adults is sporadic.

Source	**Better Care for People With Co-occurring Mental Health and Alcohol/Drug Use Conditions: A Guide for Commissioners And Service Providers**
Author(s)	Public Health England
Year	2017
Retrieved from	https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services
Key findings	• Mental ill health and alcohol/drug use are both associated with physical health problems and early death, with smoking a significant contributor to morbidity and mortality • 'Everyone's job' Co-occurring conditions are the norm rather than the exception, and commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to work collaboratively to meet the needs of people with co-occurring conditions.

	• 'No wrong door' Providers should have an open door policy for people with co-occurring conditions, supported by commissioners that enable services to respond collaboratively, effectively and flexibly to presenting needs, offering compassionate and non-judgemental care centred around the person's needs, accessible from every access point. • Carers (including young carers) have needs in their own right. As part of delivering timely, compassionate and effective care to people with co-occurring problems, practitioners should identify carers and family members who may have unmet needs, making appropriate referrals for carers' assessments and/or to family support services. • Delivering effective care to people with co-occurring conditions requires a workforce with the requisite values, knowledge and skills. People working in mental health and substance use services will require different levels of skills and knowledge depending on their role and seniority. • People with co-occurring conditions are often unable to access the care they need from both mental health and addiction services.
Practice implications/gaps (i.e. relevance to Gwent services)	• Describes what improved care would look like, underpinned by the principles that there is 'no wrong door' for anyone accessing support. • A key aspect of the 'no wrong door' principle is that providers should make every contact count, taking every opportunity to reduce health harms by offering advice and support to stop smoking, eat healthily, maintain a healthy weight, drink alcohol within the lower risk guidelines, undertake the recommended amount of physical activity, and improve their mental health and wellbeing.

Source	**Norfolk Dual Diagnosis: Health Needs Assessment For co-existing mental ill-health and substance misuse (A dual diagnosis recovery approach)**
Author(s)	Edwards, D., Habib, S., and Pereira, A.
Year	2015
Retrieved from	https://www.norfolkinsight.org.uk/wp-content/uploads/2018/09/Norfolk_Dual_Diagnosis_Health_Needs_Assessment_FINAL_V2.1.pdf
Key findings	• Dual diagnosis is a common complication for people with mental illness, often following self-medication with alcohol or other substances. This complicates a patient's treatment and recovery and can contribute to a breakdown in family relationships, social isolation and exclusion. The end result can be severe mental health and substance dependency often with a chaotic lifestyle, possibly with antisocial behaviour sometimes spiralling into criminality. • Co-existing mental ill-health and substance misuse is far more common than routine data from drug and alcohol services suggests. Feedback from a wide variety of stakeholders in Norfolk highlights the challenges faced by people with dual

	diagnosis in accessing mental health treatment and also how disruptive people with complex 'dual diagnosis' can be for public services and wider society. • The Kent and Medway Dual Diagnosis Care pathway has liaison between services as a key component. The liaison between services is underpinned by information sharing, which requires seeking informed consent from the service user at the earliest opportunity. This is in line with the Kent and Medway Information Sharing Protocol. • There is a lack of suitable accommodation for homeless people with dual diagnosis. • Improving the quality of communication and joint working between services was identified as the main priority by staff.
Practice implications/gaps (i.e. relevance to Gwent services)	• Acknowledges that lack of training has resulted in mental health staff, as a well as some other professionals, stigmatising people with mental ill-health who misuse substances, leading to such patients being readily excluded from evidence based treatments, in particular psychosocial therapies. • Mental health staff are often poorly trained with regard to the management and treatment of patients with mental ill-health and co-existing substance misuse. • In practice patients with co-existing mental health and substance misuse issues do not have access to a joined up service which takes ownership of their care • Mental health services won't provide support to clients who use alcohol or other substances.

Source	**Dual Diagnosis Needs Assessment (West Sussex)**
Author(s)	Figure 8 Consultancy
Year	2014
Retrieved from	https://jsna.westsussex.gov.uk/assets/living-well/dual_diagnosis_needs_assessment.pdf
Key findings	• The term dual diagnosis is a general designation used to describe those individuals who suffer from co-morbid substance misuse/dependence as well as a psychotic, affective, behavioural, or severe personality disorder. • This client group are very vulnerable and have complex needs relating to health, social, economic, and emotional stressors or circumstances which can often be exacerbated by their substance misuse. • Research has shown that service users with a dual diagnosis typically use NHS services more, cost more and are less likely to comply with treatment than those with single mental health or substance misuse issues. • The Department of Health 'Good Practice Guide' (2002) remains the most specific national policy document pertaining to dual diagnosis, the central tenet of which is a policy referred to as 'mainstreaming'.

	• The nature of the relationship between mental health and substance misuse problems is complex and co-morbidity can occur at any level of severity. • Using alcohol or drugs to reduce emotional distress (self-medication) has been proposed as an explanation for the high co-morbidity rates between non-clinical anxiety, depression and substance use disorders. • The current lack of an information sharing protocol is seen by stakeholders as extremely problematic, a priority improvement area; one that is easily achievable.
Practice implications/gaps (i.e. relevance to Gwent services)	• There are no routinely available national or local data on the prevalence of dual diagnosis, and because the definition of the term varies widely, so too do prevalence estimates. • There is very limited data available to assess the trend in prevalence rates of dual diagnosis either nationally or locally, but there are suggestions that co-morbidity is being increasingly recognised over time.

Source	**Dual Diagnosis Needs Assessment (Brighton & Hove)**
Author(s)	NHS Brighton & Hove; Brighton & Hove Council
Year	2012
Retrieved from	http://www.bhconnected.org.uk/sites/bhconnected/files/Dual%20diagnosis%20needs%20assessment%20B%26H%20FINAL.pdf
Key findings	• People with dual diagnosis are a very vulnerable group, and this complex condition is associated with significant clinical, social, legal and economic problems. • The prevalence of mental health problems among clients of drug and alcohol services has been estimated at between 50-85%. The most common problems are depression and personality disorder. • Brighton & Hove has a high prevalence of mental ill health, drug and alcohol use, and also has high rates of self-harm, suicide and drug related deaths. This suggests that the rate of dual diagnosis in the city is also high. • Data from mental health and substance misuse treatment services give a perspective on the level of dual diagnosis being detected and recorded by services; however this only provides a minimum estimate of the need relating to dual diagnosis in the city. • Between 10-50% of clients within Brighton & Hove mental health services have a dual diagnosis recorded. This is below national estimates and is likely to reflect issues with data quality. The highest proportion of recorded dual diagnosis is among clients of the Assertive Outreach Team.

	• At least 15% of people in drug treatment have a dual diagnosis. This has increased from 3% in 2005/06. Again, this is below the number suggested by national estimates and may be due to data quality. • A high proportion of people living in hostels report a need to manage mental health and substance misuse issues – the proportion varies between hostels but is up to 60% in those which take the most chaotic clients.
Practice implications/gaps (i.e. relevance to Gwent services)	• There is limited recording of dual diagnosis within NHS services in the city, in part due to the complexity of defining the condition. • There are no routinely available national or local data on the prevalence of dual diagnosis. • The definition of dual diagnosis varies widely and therefore there are wide variations in prevalence estimates.

Source	**Warwickshire Dual Diagnosis Needs Assessment**
Author(s)	Warwickshire County Council
Year	2012
Retrieved from	https://www.warwickshire.gov.uk/health-wellbeing-board-1
Key findings	• Dual diagnosis is a challenging problem for both mental health and substance misuse services. • People with mental health problems, who also suffer from substance misuse are at an increased risk of suicide, as well as experience financial and housing problems and are less likely to engage with treatment interventions • The term dual diagnosis is a general designation used to describe those individuals who suffer from co-morbid substance misuse/dependence as well as a psychotic, affective, behavioural, or severe personality disorder. • In NHS Warwickshire, the local definition has recently been agreed upon: Dual diagnosis is "the co-existence of mental illness with substance misuse which has an adverse effect on an individual's biological, psychological and social well-being." • Alcohol can exacerbate pre-existing mental health problems, relationship problems, problems at work, college or school, or violence.
Practice implications/gaps (i.e. relevance to Gwent services)	• There are difficulties in estimating the numbers living with a dual diagnosis. • Recognises that dual diagnosis is a challenging problem for both mental health and substance misuse services.

Source	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
Author(s)	Strathdee, G., Manning, V., Best, D. W., Keaney, F., Bhui, K., and Witton, J. et al.
Year	2005
Retrieved from	https://pdfs.semanticscholar.org/26dc/cf40f8ad8cb9866c82ff4009ea3ae0f182df.pdf
Key findings	• The most common mental health symptoms reported by substance use clients were depression, generalised anxiety disorder and panic attacks. • In terms of socio-demographic characteristics, those screening positive for dual diagnosis were more likely to be young, male and unemployed. • Dual diagnosis clients demonstrated significantly more complex and multi-axial needs in relation to elevated likelihood of personality disorder, physical health problems, risk / violence, lower quality of life and overall level of disability. • In terms of illicit drug use, clients from mental health and alcohol services were using mainly cannabis and cocaine powder. In contrast, substance misuse clients were using primarily opioids, crack cocaine and cannabis. • The development of inter-agency assessment and intervention care pathway and protocols were seen as pivotal to efficient use of resources and as a communication tool between agencies.
Practice implications/gaps (i.e. relevance to Gwent services)	• This research aimed to develop a screening and assessment tool to identify dual diagnosis for use in routine clinical practice by using an educational outreach training model, and to use this to assess the prevalence of dual diagnosis and related health, social and lifestyle needs across a range of treatment services • The assessment classifies dual diagnosis cases, i.e. those with concurrent substance use and mental health disorder as well as related social, health and lifestyle needs • The high prevalence rates of dual diagnosis across addiction, mental health and related services necessitate the prioritisation of training practitioners in both voluntary and statutory services in the identification and assessment of dual diagnosis.

APPENDIX III: STAKEHOLDER EVENT AND WORKING GROUP SESSIONS

Introduction

Two key Stakeholders Events were held at the front end of the research (4th December 2019 in Ebbw Vale and 5th December 2019 in Newport) to gather views and themes for consideration during the main fieldwork phase of the project. From these events the recruitment of two small working groups took place. The Working Groups each met twice (in January and February 2020) to consider the key messages that arose from the initial Stakeholder Events. Additionally, following discussions in the initial Stakeholder Events it was agreed to set-up a third working group to look specifically at the needs of older adults with co-occurring conditions. This group also met twice (in January and February 2020).

The purpose of these qualitative elements of the project was to find out:

- Views on current provision of interventions, help and support for those with a dual diagnosis;
- Any gaps in current provision;
- Views in relation to the nature and extent of future requirements; and
- Assets (groups, networks, individuals, etc.) across Gwent.

The notes recorded at both the initial and final Stakeholder Events and all three sets of Working Groups have been combined in the sections below.

Please note: The comments below reflect the views of attendees at the stakeholder events and working groups, and not necessarily those of the research team.

Key Stakeholders Events – Ebbw Vale (4th December 2019) and Newport (5th December 2019)

The first section of each Stakeholders Event involved small group discussions focused around the following five key areas of investigation. Each event had three small groups.

1. WHAT WORKS WELL - What support and services currently work well for people with Co-Occurring Conditions across Gwent?
2. GAPS/DUPLICATION - What are the main gaps and areas for improvement in support and service provision for people with Co-Occurring Conditions across Gwent? Are there any areas of duplication in support and service provision for people with Co-Occurring Conditions?
3. CAPACITY AND INEQUALITIES - Which groups/geographic areas are currently well served across Gwent and which are not well served?
4. ACCESSIBILITY - What are the current facilitators of and barriers to support/service accessibility for people with Co-Occurring Conditions across Gwent?

5. TRANSITION - What are the current strengths, weaknesses, opportunities and threats of transition arrangements for young people moving to adult support / services, and adults moving to older adults' services?

During the second part of the stakeholders event, each of the small groups discussed the key priority areas they believed should be taken forward for consideration by the proposed working groups. The five key priority areas were discussed in depth. Once the five key areas were identified at each table, all stakeholders were then allowed to vote for their top four from all key priority areas identified from all table. Themes were combined between the two Stakeholder Events, and the results are presented in the table below:

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.

Following discussions with Stakeholders at the December 2019 events, the following list of **six** priority themes/issues/messages were agreed as being 'essential' for the 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 (see **Chapter 3** (**Table 3.1**) of the **Part 1 – Main Report**).

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.

Working Groups

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.

Participants for the two adult-focused working groups were recruited primarily from those who had attended the Stakeholder Events, with additional recruitment coming through an email request to all local services and key contacts.

Participants for the older adult focused working group were recruited via conversations with the Clinical Director for Older Adult Mental Health and a Consultant Clinical Psychologist (Older Adult Mental Health).

Details of working group sessions and attendance is noted in the table below:

Location	Working Group session	No. of Participants
Ebbw Vale	Older Adults working group session #1 – 29th January 2020 (am)	5
Ebbw Vale	Working group sessions #1 – 29th January 2020 (pm)	10
Newport	Working group sessions #1 – 30th January 2020 (am)	10
Ebbw Vale	Older Adults working group session #2 – 19th February 2020 (am)	4
Ebbw Vale	Working group sessions #1 – 19th Febuary 2020 (pm)	11
Newport	Working group sessions #1 – 20th Febuary 2020 (am)	9

Each of the working groups focused on covering the six priority areas identified via the Stakeholder Event sessions, namely:

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

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'[1,2]:

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.

[1] 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

[2] 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.

Adult-focused working groups (Ebbw Vale and Newport) – summary of discussions

A summary of the discussions from the two adult-focused working groups held in Ebbw Vale and Newport during January and February 2020 are presented below, under the priority headings identified above.

Equity and accessibility (of services and supports) and pathways for defined populations

There was a lot of feedback from the working groups that people in need of mental health support were being denied it because of their substance use:

> *'From my end, it's always been very frustrating that as soon as it's substances, it's, "Sort that out and then come back to mental health services," and it's not black and white. If someone has gone through trauma, how are they supposed to do that?'*

> *'I would say, from what I hear from the mental health ward, and from the doctors, is exactly what you're saying. They push them away initially to say, "You've got to sort out your substance misuse before we can assess your mental health."'*

> *'I've worked with clients who've said, "I'm scared to mention my other substance issue, because it'll be black and white, and go sort that out then."'*

As demonstrated by the quotes above there were some who hid their ongoing substance use so that they could access mental health support.

Those who can get mental health support were often offered a very small number of sessions:

> *'Just primary care, but a lot of people miss primary care, don't they? Even if they go there, they can only be seen, is it six sessions, or whatever isn't it... in primary mental health? Sometimes that's enough for people. They go there, they have six sessions of whatever, they're assessed and whatever.'*

There was a discussing within the working groups about the barriers which stopped those with more complex or specific needs from accessing services. One person recounted an upsetting case of a woman who was experiencing domestic violence but whose complex needs trapped her in that situation:

> *'I'm just thinking of a lady that I used to support, and she was a drinker. There was domestic violence at home and things like that, and she was an older person with quite complex disabilities. She needed support, and it was very difficult to get her out of the property, to get her support within the community, because a lot of services that I tried to access, they said they needed her to get there and self-refer, which obviously was really difficult for her.'*

This case reflected a wider issue of those who were unable to self-refer or to comfortably express themselves in order to access support:

> *'I think unless it's specified, maybe, that individuals like that are going to slip through the net, because a lot of assessment clinics are in the hospital. So, unless it says the person cannot come out of the home, then they would expect that person to come in.'*

'People with autism as well, because I know there's a misconception that people with autism like to repeat things, but I know that people with autism, when they've got to go through an assessment and then another assessment, they're like, "I haven't got to say all that again, have I?"'

There was a general feeling that there was a lack of access for those who were older. This information did not come from the working group which specifically discussed older people, rather from the groups which were discussing a general approach:

'How do we approach people over 50? Why are they not coming to our services, because they have issues as well? That's how they were selling it. When we go to these events, for either ones, alcohol, substances, people don't want to come and talk to us or be seen to come and talk to us. So, sell it as a wellbeing thing. Wellbeing, education, all under the same umbrella, which is what is needed. People drink to help them sleep, to de-stress, unwind after work. All these everyday things. Everybody has these problems, don't they? Sell it that way, a wellbeing thing. Yeah.'

The barriers present to those who were older were amplified for those with other needs. For example the working groups discussed the intersection of disability and age, acknowledging that there was not enough support for helping people navigating these two factors access support:

'What about older people with disabilities that really struggle to get out of their property? They might want the help, but they can't access it, or carers that work long hours that want support, but it has to be when they need it, not within the nine to five hours. You might have discussed it at the last meeting, sorry, because I wasn't at the last meeting. So, just wondering what facilities we've got for those.'

For those who can access support there are issues with communication and the barriers that are in place when it comes to supporting those who need ongoing contact:

'What we've found is about 70% of all urgent assessments are discharged with no follow up. Someone's come in, met a clinician, had some advice, had some information on self-care or they've been referred somewhere else, but they generally don't come in to services in CMHT at least.'

'If you know somebody is using on top but they're coming to see you regularly and you're talking about that and you're able to do the harm reduction work and talk to them about what that means and why it's happening, then that feels safer than if you know somebody is using regularly and they're DNAing you all the time, not getting in for their appointments, then you'd hold a script to get them in, to have a conversation. If holding the script didn't work they might end up being discharged. But you try really not to… You try to engage them and work with them to try and get to the bottom of what's going on.'

Multi-disciplinary and partnership working (to better provide a holistic approach to care and support)

The lack of communicative and healthy partnership working was a major theme in the working group discussions. It was noted that it can sometimes be unclear which service a person should turn to or which is best suited for their needs:

> *'Sometimes people don't know where to turn, do they? When life's falling apart, where do you go? Who can help you? So, when you've got services that are very confusing, and then you've got services who say, "That's not our criteria, you don't fit our criteria," it's left to fester. Where do you go? They give up, and the problem continues, doesn't it? So, it's finding a responsibility for everyone, isn't it, to do something about it?'*

> *'So, I manage a support team, and they basically pick up a lot of these people who seem to fall between every net. So, social services, doesn't fall with them. Community mental health doesn't fall with them. Police will usually deal with them and we'll usually deal with them, and we're just trying to hold them up and find a service that's most appropriate to them, and then we get sent via the GPs a lot, but it's hard to get people to a GP. So, actually, they could come to us, but then we can't get them the help they need because we have the difficulties ourselves getting them to GPs, or getting into mental health services or into social services and that kind of stuff. So, they're knocking on our door. Yes, we're trying to help them, but actually it's a hell of a lot of work to get...'*

> *'The treatment workers will be working on the substances and if there's an identified issue with mental health, they then get referred to the dual diagnosis service. It's like, "Oh, mental health. Let's refer over to here because we'll deal with the substances, they can look at the mental health side," and then I have had it working with clients where I understand the capacity issues with mental health because someone will clearly have complications and issues running alongside their substance use, but they're not quite extreme enough or they're not in enough of a crisis moment for that intervention to quite take hold yet, so the advice is, "Try to minimise your substance use a bit more and then come back to us when you've stopped using. If you still feel bad after you've stopped using, then come back." And I do think it's a capacity issue of sometimes not complex enough, but then too complex for perhaps other services, and then there is that vacuum in the middle.'*

There was also a noted lack of engagement between the services. While this is discussed further in the section on communication and information sharing, it was noted in relation to holistic care too. Services were generally felt to be divided and unable to always communicate appropriately with a lack of meeting points:

> *"You've got GDAS that covers... It sounds very good, as in it's a... I say one-stop shop, but you don't have to be referred out for criminal stuff, for substance misuse. There's a lot of stuff in that. Then you've got mental health, your service, that joins in with GDAS, and you've got the children's service, and you've come to Tal-Y-Garn in the mental health unit. But what I don't see happening is a lot of communication from mental health services to yourselves. When I was*

there, you don't... Not you, it's us, to come and meet in the middle, but there's no meetings between mental health and GDAS. There's no meetings between mental health and GSSMS."

"That's probably our biggest frustration as a housing provider, so we're not statutory, the mental health services are probably the ones that we've struggled the hardest with in terms of the information sharing side of things, it's very, very difficult. Most other services, you can get around it, and when you've explained that you are able to share in your partnership, they're on board, and they will share. Probably mental health services are probably the hardest."

Some solutions such as service mapping and physically closer working were suggested:

'There's quite a lot of services out there, so sometimes it's mapping them out so they can work better together so that you don't get duplication, because sometimes you do have too many people in a situation.'

'It feels like we need everyone in the same building. You and I were having this conversation earlier. So, everyone in a lovely, welcoming building. You've got your colleagues there with all the specialist knowledge to support each other, whether it's mental health, substance misuse, whatever, and assessment hubs and all that kind of... And anyone can come and be assessed, like the service in Gloucester. You don't need a GP to refer you. If you've got a problem just ring up and we'll see you.'

The lack of holistic care was felt to be detrimental to those needing support who were often left feeling that they were being passed around different services:

'I've had clients say that to me. "I feel like a tennis ball being passed from one service to another," and feeling more and more worn out with their life, and seeing no way out because they don't feel supported by services.'

One of the explanations for this lack of joined up working was the difficulties with resources and funding:

'It'd be great if you could get someone who could do a lot of the methadone prescribing and things from a GP surgery but a few of the GP surgeries in the area have closed down as well because they just can't get the GPs."

'What happens is organisations are pitted against each other just for their own survival … what you'll see is organisations going, "I'm going to give it a go, just so I can get a pot of money," and it all becomes diluted then. You have so many of them set up and it's piecemeal and people aren't communicating, it's not joined up, so it becomes ineffective in itself. As you so rightly say, if you set up a project, it takes a year and a half to fully embed it. You've got to recruit staff, and then within a year you're then dismantling it.'

There was a feeling though that the introduction of those with lived experience into different services was helping combat this issue:

'The whole co-production, I think that will help shift that balance of power. The more people with those lived experiences that are involved in the decision making and shaping the services.'

Workforce development

It was recognised that there was a lack of workforce development opportunities. In some instances there was a feeling that staff often lacked the tools to support those who came in with complex mental health needs or more specific risks of harm:

> *'Investment in staff as well. I suppose that comes back to the... You know from earlier… You know, providing them with the individual tools that they need, whether they be mental health, or they be drug and alcohol workers, you've got the skills there to actually give the advice in relation to either area. The advice and support, I suppose.'*

> *'Maybe educating staff as well on tier one, the basic things, minimising harm. That just takes a discussion … Now, the GP should be doing that anyway. It's probably a money thing, they're not doing it, or maybe they don't even realise. That's an important thing. That could stop, maybe, somebody... It might minimise the effects of ARBD, dependency, having that conversation with them, "What's really going on?" and referring them. Just that tier one, minimising harm. How are they eating? How are they sleeping? That can take conversation from anybody, can't it? More training, maybe.'*

> *'Fundamental training right at the beginning. We do work with* [name of University]. *They've got a good mental health research institution attached to them, but what they worked out, and they only worked it out in the last few years to be fair, that it isn't until year five on their programme that you get the option of working in mental health if you're training to be a doctor, but you have to choose between mental health or paediatrics. You can go your entire seven years without doing any mental health.'*

It was argued that this workforce development needed to reach beyond the "immediate" or commonly recognised workforce to include everyone who came into contact with service users:

> *'I think people don't really know what they're doing on the other side in their workforce as well, because we were saying about how some of the substance misuse and statutory services are saying, "I don't feel confident dealing with somebody with mental health." But, they might be an RGN, rather than an RMN? That is, people don't realise that the workforce isn't just mental health staff. It's also general nurses or people from other backgrounds. They're only going to have limited training on mental health and a lot of it's on the job as they go along.'*

Finally, it was recognised that part of the problem with workforce development was a general overworking and overloading of those who were already in the workforce. While development is undoubtedly a good thing it was suggested that this too needed to be tackled.

Data availability/usage and Information sharing/communication

The working group discussions revealed that information sharing was a significant barrier to collaboratice working:

> *'I think particularly for us that's a massive issue, is certainly sharing of information, particularly the adult... As much as you want to be nice about it, it's mental health services where it's the*

hardest to actually get any information directly from. We've got a case at the moment, and in terms of a partnership response, to get everyone around the table, the only people who are invited to the meeting that don't attend or don't say anything are mental health services. Pretty much I can say that probably happens in every case where you know that there is an issue with an individual's mental health. I think largely, particularly then where we're a housing provider, so we're not a statutory service as such, so we can't directly refer to mental health services, which is a problem, then we could be giving all the information in the world across to them, but we won't ever get anything back without a lot of difficulty to find out what then is happening on that side. I think we've already said, if you're going to work well with somebody, all the services have got to be working together. But there's definitely that breakdown there.'

'Sorry, I'm just going to raise a concern about that. Totally agree, we need to assess whose responsibility it is. It sits with everybody as you talked about with child protection. I think there's still a huge issue around sharing information, because child protection legislation is broken down because people still don't share information.'

'For those that are in service, like you say with the pathway they've got to establish through diagnosis or co-occurring problem, then the difficulty you have sometimes is that some of those are really, really difficult to manage, or they may engage in mental health but not substance misuse, and the mental health are left then likely holding this very chaotic and risky individual. So, I think sometimes that causes barriers to come up in terms of criteria and whether you accept a referral or not. It's like, "Oh God, I don't want to see that one because we had a nightmare with the other one." Again, to me that comes down to partnership working, how you engage your colleagues with the specialist knowledge.'

Again some of this seemed to come down to a lack of staff or an overworking of the existing workforce:

'That's the crux as well. We're talking 10 per cent, 15 per cent where we're not doing any education. We've got a remit and you've only got so many hours, and you can't do it. Things have expanded, but we're staying static. That's the data, and I understand that. But why do you need data when the fact is that referrals for psychology can be up to two years?'

Others noted that challenges came with the changing of how admin was managed, especially after GDPR:

'But the other thing I think that's changed a lot since I've done this job is that we have to evidence everything. When I first came to this job it was a breath of fresh air. 70 per cent clients, and then it was a bit of paperwork. Now, it's the other way around. We have to evidence it, and they say, when you're saying take it back, "Oh, we can't do anything about that. This is what the commission want, the government want, they want to see what you're doing with the funding," and then you have to evidence there to keep winning the bid. So, instead of having more time to do the real work here, you're evidencing all the time. You're stuck in front of the computer, and there's a lot of duplication. The system's slow, so you've got that on top of it as well, and while all this is happening things are festering. You've got a knock-on effect.'

'...around the domestic abuse services in Gwent, with the police, but then that was pulled because of the information sharing and the consent to share and that side of it. It's almost like we've taken a backwards step, and that's because of GDPR, is what was given as the reason. Even though it was safeguarding.'

'It's even the small things like... I had an email from them six months ago, saying, "Great news. We can now send emails basically safely to social services staff." We've been an integrated team, social services and nursing for ten years. It's like, it's only now we can send emails across without confidentiality being breached. It's like, "Really?"'

In particular, communication issues were noted between services and the NHS:

'It was to do with people being discharged, no fixed abode, from a hospital. That happens a lot. People get discharged in their pyjamas and taken to a one-stop shop. The message is, "Well, that should never happen." It's like, "Okay, what's your pathway, then?" Nobody could tell me. So, I was like, "Give me the pathway and I'll promote it," because obviously nobody wants to see anybody discharged from general or mental health... It doesn't tend to happen in mental health unit, in fairness. More general hospital admissions, or discharges. "What's the pathway? Let's get it out there then." So, it's a lack of understanding I think sometimes from a health perspective about housing, and it's quite a complex process sometimes.'

'Over the space of... It was supposed to be, initially, quite urgent. He got the appointment quite quickly, but it's now been going on for about two, three months now trying to find where this person fits, because one person is saying no real evidence of psychosis, but then what he's describing is different. It's where does he fit, because different services are saying, "Not quite us, and I can't quite see this yet." At the moment I think he's under, from my understanding, he's under a period of assessment because they're still trying to be, "We're not quite sure."'

The police were also noted as an institution with which there were significant communication issues.

There were however some positive examples given where communication worked smoothly:

'So, GDAS is the single point of contact, so people can drop in there. We have meetings on a Monday morning then, every Monday, and we see referrals from GDAS, and we take people who need to step down.'

Prevention and Early Intervention

The working groups discussed the importance and challenges of early intervention, noting that it could be difficult to engage young people.

'We try and engage from 17 onwards it's quite difficult, though. They don't get many people who do engage. The figures are really low, thinking about young people transitioning into adult services.'

'...engage young people in the substance abuse side of things as well. We try to get into schools to talk about drugs and everything else, hammering on the door, and it's like, "Oh, don't talk about that."'

It was acknowledged that early intervention was also about awareness raising:

'So, prevention things to support in that. Wellbeing, education for people. Even today, people don't know about dependency and that you can die drinking. People don't know something as simple as that. GPs don't give clear advice to their patients. That's a really important thing. They're not doing it. It's a lot of educational work, I think, and tier one - for everybody.'

'I think that's a national thing, though. They should be putting more things on TV. I had one client, she watched... Was it Chiles? He did a documentary, and that stopped her drinking. Just seeing those things, talking through liver damage and seeing things, honestly, that was enough. That stopped her. So, we need more things like that on the telly instead of being encouraged, and all the adverts, isn't it? And supermarkets, where you can buy four boxes for £20 as you walk through the foyer.'

'This is why we've managed to get funding for an education support officer to work in schools with the children. What we're finding, once we're finding out the issues with the children, it actually then goes back and finds out what the issue is at home, and from there you can offer support to the person who's struggling at home, whether that's Mum, Dad or whatever.'

Counselling was also something that was noted as being key for early intervention:

'Before they get to the problem, before they become... All those issues, maybe they wouldn't come in. But they've got that opportunity to have some support, because at the moment it doesn't seem like that's happening. The counselling's something I came back to. I know with yourself, with a psychologist as well. Some people just need to talk. They need someone... Just by coming in, "God, I feel better now." Not having that opportunity, and sometimes you need to be more professional. It's a big gap, to me, with counselling. I don't know what everybody else thinks. There's just nowhere to talk now, and they self-medicate with alcohol.'

Housing issues

The pathway into housing support was often a complex and confusing process for those who needed help:

'Then they've got every service there, so that people can access, because what they were finding in primary care was that a lot of people were going to their GP, but it's not really for a physical health issue or a mental health issue. It's perhaps loneliness, or they've got a housing problem. They've got the damp coming in, but they don't know where to go to.'

'I do wonder sometimes, and I know I wasn't in the room, but a guy knocked the door one time of our centre. He was in tears. He was absolutely distraught. He said, "I've just been over to my housing, and the woman said, tears won't work in here. Just leave." He's going to be living on the streets. He said, "I had to prove I have a mental health issue for them to help me." I was

thinking, "My God, this poor man. What would I be like? I'm going to live on the street, and then I've got somebody going, get out." It's sometimes employing the wrong people, the wrong attitude. You know, he had to prove... Do you feel like you could live on the streets? What an attitude to have. It's wrong. It's wrong.'

The working groups noted that these complications extend to working with those who need housing as there are often complex needs and complex situations that must be engaged with:

'There's a lot of people like that who you find out for other reasons, don't you, but they're not willing to leave the house for whatever reason. So, as a housing provider, we pick up these things through somebody's renting in the area and we hear the property's in a horrendous state. Then actually getting those people out is horrendously difficult. If you can't get services in, then you're kind of all stuck. As you said, there's places where it will happen, and then the fact that it's different everywhere is a minefield for people working.'

'I've noticed recently, coordinating a hoarding disorder ... I've just realised really that there's not a workforce that's necessarily that well trauma-informed, because there's this idea that has been mentioned about the three strikes and you're out, and a lot of the attitude within that group has been... We've had to unpick it a little bit, but, "We can only do so much. We can declutter, we can go in, we can address the crisis, get it to a manageable level. If they don't then want to manage it after that, it's up to them. If they want to be a hoarder, they can be a hoarder." But what we know is that the long-term psychological intervention cases, where they've had nearly two years-plus support, they've been the most successful cases, where there's been a multidisciplinary approach. But unfortunately the housing association, and I see where they're coming from, they say, "Well, we have to manage it from a business side, and if we need to evict that person, we need to move them on, or it's causing environmental health factors..." I get that, but...'

'I think probably different housing providers are on different journeys, but sometimes you're then forcing perhaps the legal result, because we've potentially got this other option against somebody you know has already experienced massive trauma, has got major complex issues going on, but we cannot get anywhere so then we have to look at dealing with the issue, and sometimes have to try and get rid of somebody. Ourselves, we're trying our very best not to do that, but then there will be different experiences of different housing providers, because I think we're probably on different journeys.'

'It's like, the government are looking at trying to end evictions into homelessness, and this is eventually where these people are pushed if we are forced to get rid of them. So, people with these issues can cause lots of different problems within the communities, so then we can't get the access or the assistance these people need.'

It was noted that there have been moved to make the housing services more equipped to deal with some of these however:

'Depends which housing association you're working with, but most... We're trying to be more trauma-informed, and we're doing our psychologically informed environment training and all

that, but there are some compliance lines where it's a legal cert. But most of it is about the reduction of health and safety issues and you manage those risks, rather than...'

There were also barriers in terms of how able services were to take on and support people. This varied greatly by service and by area:

'There would be varying differences where you would have perhaps issues around... It's probably more homelessness, or people perhaps in Newport compared to... Monmouthshire's got less accommodation for people in temporary accommodation and things like that, and I guess...'

There was a link made with the working group between mental health and homelessness, one which was not always dealt with well by services:

'Sometimes within housing, if you mention that they've got mental health, that can be a huge stigma, but to say they've got alcohol and substance misuse as well is a double whammy for housing. Obviously Housing First is looking at that, but for mainstream housing associations, it's still a big thing, and we do have people turned away, and we do have housing associations in the past that we've had individuals get to the top of the housing list, but then they cherry picked.'

'Yeah, and social crisis as well. I see lots of people referred to mental health in a social crisis. "I've been made homeless, therefore..." They may be having a mental health crisis of some description, because obviously if you've been made homeless then you're going to be quite upset and anxious about that, but then mental health services will... "Well, actually you're not mentally ill. You're in crisis because you're homeless."'

Veterans were a group who were identified as being at high risk:

'When you're leaving the military and you've got to give so much notice, they would go into housing and some of them wanted to be on the social housing register. I was in Caerphilly council one day and they said, "Well actually, we need your discharge papers." They said, "Well I'm not discharged yet." The difficulty is there. They said, "Once you've got your discharge papers, you can go on the list." I said, "Actually, no, you're not doing that to them. When I left, I had my discharge papers physically three months after I physically left. I got sent them in the post. Now you're waiting for them to be homeless before you can even put them on any list." And to be fair, it wasn't because they didn't want to, because they changed it literally there and then, it was because they didn't understand the process, or there's a distrust. Somebody's saying, "I can't do this. I can't do that," they think, "Well are you really telling the truth?"'

The working group noted that there were challenges with getting housing support to those who were rough sleeping:

'Originally, to house anybody that was currently rough sleeping you'd have to go through a quite extensive pathway of them being recognised on the streets rough sleeping, identified by ... whoever's doing the assertive outreach within a local area. They'd pick them up; they'd get them referred through ... They'd come through into supported accommodation. Whilst in supported accommodation they'd have to engage, they'd have to abide by certain, kind of, I don't want to use the word rules but kind of rules."

'We identify people who are rough sleeping. We work with them with what their need is. There's five principles of Housing First looking at choice, looking at… I should really know this, but this is all written down. Looking at the individual needs, looking at choice, looking at what kind of… Their area of need, as such, whether that be a co-occurring need, whether it be an individual need, it's not often the case. Picking them up, placing them into their own tenancy, and putting that wraparound support then around them to maintain that tenancy. Everything else is down from their tenancy, whether you're looking at involvement with GDAS, or engaging with substance misuse services, even things like registering with a GP, it's all done from the safe environment of their own tenancy.'

'We've approached numerous people that are sleeping rough. There's 34 people at the moment sleeping rough, give or take, in Newport. They've all been identified. They've all be approached. Some are like, "No, not ready for it yet, don't want it." Some are chomping at the bit, "Let me get in there." It's having them go, "Yes, I'm ready for this. I feel that I'm there," or, "I'm ready and I want to but I have doubts about this, that and the other," and it's relieving it that for them. We've settled three people so far. These individuals range from a gentleman who had to stop his transitioning from male/female whilst sleeping rough, the implication that brought for him. Another gentleman who's had severe groin injury through intravenous drug use.'

While accessing or providing housing wasn't always the issue there was a recognition that sometimes the housing available wasn't suitable for the person's needs:

'But it's also us being realistic. I meet with the housing providers on a Monday, I meet them every fortnight. We had a conversation today about a lady in town at the moment who's got a dog. There's a lot of stuff about the funding of the dog, the dog's behaviour. We've even got to look at training with the dog, training with her about picking up the dog mess, stuff like that, before we say, "Okay she's ready, let's get her in and this is going to work." It's not putting a restriction on her as such, it's just going, "Let's get this done." It's playing ball with everybody.'

'We've been offered some lovely properties, we were offered a two bed, but it just wasn't right for that individual. We were offered a flat in a block of flats where there's a lot of known drug use and it's a bit like a rabbit warren, there's a lot of dealing with the youths going running through and they can't be seen by the police. This individual at the moment isn't clean. He's still very actively using but he can get his amount that he uses daily. If we had put him in that flat, potentially, with the greatest respect, you look at him and you know he's using substances, he's going to be cuckooed.'

Older adult-focused working group (Ebbw Vale) – summary of discussions

A summary of the discussions from the older adult-focused working group held in during January and February 2020 are presented below, under the priority headings identified above.

Equity and accessibility (of services and supports) and pathways for defined populations

In terms of equity and accessibility to services and pathways for defined populations it was felt that accessibility for older people wasn't always good. It was noted that older people might often have more complex access needs and that it was often unclear which service best suited them:

> *'I also see younger people who come through [name of service], who aren't 65, who actually have cognitive problems that may not meet the criteria for a dementia, have physical health problems and frailty issues that you think actually they would be... And I think it feels to me, this issue about what is a substance and what isn't, and what is a mental health, is another take on that. It's where do people best fit? My sense is, in Blaenau Gwent we have quite a lot of people that struggle with alcohol and other substances, and they don't quite seem to fit anywhere.'*

Multi-disciplinary and partnership working (to better provide a holistic approach to care and support)

This uncertainty about where older people were best suited to get support was reflected in the discussions on partnership working and holistic approaches to care:

> *'Because the system is encouraging that you signpost on to the appropriate service, but that comes with challenges because that service might have a slightly different criteria and a slightly different view. There might be quite a wait, and this is my personal view, is that the people who are either struggling with these issues, or have struggled in the past … if they're asking for help that way, to say, for example in psychology we have, at the moment, not in older adults, it's less, but the Welsh Assembly Government has 26 weeks referral to treatment.'*

It was noted that there needed to be a clearer, more emphasised focus on rapport building and one-to-one support:

> *'No, support workers would be great, because they can link in. If you put a key worker in a substance misuse service, then they can feed back and monitor the person's alcohol. Bit of more rapport. That's a very important thing, just having that link with somebody, gaining trust with everything. You'll get more out of them about their lives than just the odd clinic visit, which I don't know how often they see people. But I think that one-to-one support would reduce relapse, definitely. That's why our support workers go and see people with depression. Having that social link as well.'*

Workforce development

There was an acknowledged need for workforce development for those who worked with older people.

> *'Yeah, it would be good to have a few more skills, just to feel a bit more confident in maybe supporting somebody, but certainly linking in with the specialised service, but as you say,*

working together, really, and how you go about that, and making it quite clear that that's part of, I suppose, our and their roles, that we work together rather than separately.'

There was a feeling that the care offered could vary and that there needed to be more clarity on how to approach and discuss things with older people:

'It's more the individual person who assesses them, rather than having a set of... I hate the word criteria because that again becomes an all or nothing. "If it's four pints it's okay, if it's five pints it's a problem," and as a psychologist I hate that. I guess some guidelines about what you might think about. I wonder if that would give us more confidence in the decision making, so rather than have a set, "You must," give us a kind of, "These are the type of things, when you're deciding, to think about." That, for me, would feel helpful."'

'We've got this … app yeah? So, that's helpful as well, about the training and how to approach people, the way you discuss it. See it from their perspective. They want to change. You don't put your views on them, sort of thing. But it's difficult when someone doesn't want to stop, or if they are drinking at least find out the reasons why they're drinking. Like, most people say, "It gets me to sleep at night." Then you can just get some alternatives for then rather than using the alcohol.'

Data availability/usage and Information sharing/communication

There was limited discussion on information sharing and communication but as with the discussion in the other working groups it was acknowledged that the NHS and the police were complex partners to communicate with. There were barriers to communication with both and a lack of clarity:

'Well they can sometimes. They can. We've got a primary care service in Wales, so in mild/moderate conditions they may go under the... The GP may refer to the primary care service. But if they assess and feel that it's more secondary, they would refer direct to us as well. So, I suppose the GP's got some options as to which way he goes. We'll get crisis situations that take priority, but even moderate conditions that may come to us, they'll get seen very quickly.'

'Well, just with our client group, the police as well, it's difficult to get any information off them. I know they've got their own team within police. We had a gentleman, me and my colleague were waiting for about two hours for them to get back to us. The police had their own little meeting, and they decided it wasn't... This gentleman, day before, he was fine. They didn't tell us. So, we were there for hours waiting for feedback, and when we did speak to them, they would give me little titbits of information. They wouldn't give me anything. I thought this person was a missing persons. So, it's very difficult to get… I've had it a few times, getting information off people.'

Housing issues

Housing issues were noted as being particularly important for older adults and the needs of older adults around housing were more complex:

'I suppose neglect is probably one of the things in housing. That's not a housing issue per se, but keeping safety in that environment is a big issue for us. Yeah.'

'I think it's different for older people because I think you raised a very valid point. It's not necessarily about having housing per se. It's about as they age, and perhaps their physical health or their cognitive health declines, that that housing might well be unsuitable for their needs. So, rather than it be again what you might stereotypically think of, your homeless person, not so much that, but often they might be housed somewhere that's perhaps quite inappropriate for their needs. One thing I've come across is that if you've got somebody perhaps who overuses alcohol and they end up in an over-55s, a sheltered complex, then often their neighbours aren't necessarily too amenable. So, not necessarily services, but other members of their peer group, aren't always very amenable to having somebody living in that complex. Would you say that's...'

It was felt that there were services out there that could support the housing needs of older people however and there was good partnership working in this area:

"If they come to us, then maybe they need rehousing. Then we're very fortunate in that we've got an integrated social services team in Monmouthshire. So, we've got social workers in the office next door, mental health social workers. So, we work really closely together, so if somebody is in a rehousing situation then we're fortunate to be able to... "

APPENDIX IV: KEY STAKEHOLDER INTERVIEWS

Introduction

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 and coded prior to independent analysis of responses by two members of the research team. The analysis has identified the following high-level consistent themes and messages and a summary analysis of these is provided in **Chapter 4 (section 4.3)** of the main **Part 1** report:

- Equity and accessibility to services.
- Multi-disciplinary and partnership working.
- Workforce development.
- Data availability/usage and information sharing/communication.
- Housing issues.
- Provision for specific populations.
- Moving forward.
- Care co-ordination.

The research team are keen to detail the richness of the qualitative data, so below are the extensive set of key quotes that were extracted from interview transcriptions and used to identify the wider set of sub-themes for our analysis.

Strategy and Leadership

'There has to be some system change in terms of... there has to be a review of this issue around the Mental Health Measure. What is it in the Mental Health Measure that says that somebody has to be in this treatment system before they go to another treatment system? Knowing tha it's impossible to get them to... almost impossible to get them through the first step.' (CO8)

'I don't think that it would be good to have these services as most specialist services. Like substance misuse at present is considered like a... when I say adult and specialist services. So, the Gwent Substance Misuse Service comes under a specialist service category, and I think that that by itself then alienates and encourages difference. And if we want to try and work together to bring about improvement, I think it's very important that this service is then pooled and becomes a part of the main service and so we kind of deliver care alongside as two colleagues trying to work towards the same patient. Because I do have patients that I see and they're seen by [name] as well, but we don't tend to see these patients jointly. I believe what would be really nice is if we could do more joint clinics so that this patient understands that, "Look, it's the same set of people who are treating me." It's okay, everybody has different areas of expertise, but it doesn't mean that you can't come together and deliver it. I understand that, and I'm not saying that there's any reluctance on [name] part or my part. That's not the case. That's just how the services are organised.' (CO9)

'So, in Wales because we don't have really commissioned services as such, I think it's very much up to every individual Health Board to try and understand what the needs of the population are and what needs to be done in order to deliver what is required for the population. The good thing is, we are really not bound by commissioners. If anything, we have the liberty to try.' (CO9)

'It's difficult to compare, because obviously I don't know what goes on in other areas. I think we are quite joined up. I think you know, since I've been in post, the senior nurse specialist services also covers some of the community teams within Newport. So, there's a broader understanding. Obviously forensic services is involved within the adult directorate, but as much as you endeavour, I guess, to make it a seamless service there's always that silo mentality, and if I'm honest there are blockages. Frustratingly, there are still blockages.' (CO10)

'I don't think it was professional responsibilities, I think it was more of people protecting their service more than anything, and I think that was always a challenge. There was always the suspicion... and don't get me wrong. I'm not going to big myself up massively, but we've tried within the leadership team we've got to break down those barriers and it has improved significantly. But it's not just secondary mental health, well health board services that are at play here. You've got local authorities, you've got third sector services, you've got charitable organisations. There's loads. And in some respects, and this is substance misuse and mental health, I think there's a degree of arrogance from secondary services that, "We're better than you," and I think from third sector services, and I'm probably very controversial here, I think from our end there's a degree of arrogance, and I also think from some third sector services there's a degree of, "We are an alternative way. We shouldn't be aligned to the health board." You know, go back to the sort of liberal socialist views of the seventies. You know, when Mind first came out

and it was kind of anti-establishment in terms of, "We offer a different way," and I think in some quarters that's still also prevails. I've got no proof of that. It's just my perception. I think it's quite easy to say we'll be joined up, but people have got their own values and their own beliefs.' (CO10)

'It's interesting. It's compounded by each different local authority has different needs… It goes down to the clinical leadership within those areas. If someone's got a specialist interest in co-occurring, they're obviously going to be more sympathetic to those referrals coming in. The more we've spoke this morning Andy, it's all about education and training and increasing awareness.' (CO10)

'Well, I think in terms of the substances, we do link in with Gwent Substance Misuse Service and the third sector. I think it's improving. Certainly, it's been a bit of an issue in the past. Again, it's about resources isn't it, and whereas previously, they would tend to only start to work with people when they were going to be discharged, that's now changed.' (CO11)

'This is going back to… I suppose, in Wales, we didn't have the troubled families programme in quite the same way. So, in Torfaen this was, we led an organisational development programme that was basically… and I look back on it now and I think, we could have come up with a much better title. It was around the 'Don't Walk By' thing. It was about, actually, this is everyone's responsibility. If you see somebody needing any kind of support, then actually, we've all got a role in providing that support and there is no wrong way of accessing that. You just need to be clear about what's your role in that system. So, I personally sign up to that way of working as the strategic direction for joining up services. I also know from that experience that is incredibly difficult to embed and that you'll get… no surprises here, you'll get a whole range of responses to that, ranging from the, "it's okay, you would say that, wouldn't you, because you're not the people dealing with the actual… you're not the nurse on the… ", all the way through to "yes, actually, we'll sign up to this, but actually, we won't make this happen in practice". So, actually, there's a whole range of responses to it. But as an inclusive way of going to improve the intent of joining up the services, I think you've got to make it really easy for people and I think actually, summarising it down to… we try to say, 'Don't Walk By', and then we put in place a series of organisational training packages to make that real. What does this mean if you're a level one worker? What does this mean if you work in more complicated services? But it also is a massively time consuming and leadership heavy agenda. I think it would be… I know from your privacy notice that this is a confidential interview anyway, but for me, we've got to start thinking about… I mentioned to you in passing, I'm two to three days a week and I drifted in to this. I do think the leadership of the APB needs a look at in the light of the next three to five years. We're setting ourselves on a path of trying to do much more joining up over a longer period of time. The intent is to have a ten-year outlook. We may not have a ten-year contract, because I think ten-year contracts become difficult for all the people that need to commit funding and all the stuff about factoring discretion and all that good stuff. I get all that, it is an impediment. So, I think that strategic direction in terms of my articulation, 'Don't Walk By', your articulation, there's no wrong front door, this is where we need to be on it. I think my caveats and concerns around that, I think we've got a massive strength in Chris as a leader in the mental health sector. His services, his commitment personally, his engagement with the board is good. If we go down that approach

about trying to make this… I think we want to make the whole joint endeavour the whole theme of the next contract, but my concern is about, how do we service the leadership of that given that essentially, it's seen as something that we do. Maybe this is something for us to reflect on as well, about how do we operationalise that intent. One of the things that we did last year, and I'm not sure it was… we did it with the right kind of intent behind it, but I'm not sure it's not led to an unintended consequence, is that we try to reduce the number of formal meetings, because they were a little bit business heavy. They were a little bit… and when you get a multiagency partnership, it's very difficult to get an agenda that does engage everybody. So, there wasn't any real disconnect from that but I was just very conscious that people's ability to understand access regularly, attend service, engage with the APB's agenda, is probably not where it needs to be for the next phase of their development.' (CO12)

[succession planning, isn't there?] 'Yes, absolutely, and of course, COVID cuts right across that, as do the busy agendas of all the partner agencies. So, we've had a disconnect. We've probably had three or four police representatives in the last three to four… well probably more than that. Three to four police representatives in the last two years I guess. There is some continuity of other memberships, but that … It doesn't help and it doesn't help that… again, you'll have to… when you play these things back, you'll have to just… I don't know about your experience researching, I think the police see it as a place where they can blood talent in terms of partnership working. That's not necessarily the same as somebody taking ongoing accountability for the improvement and systems improvement that the police are such a big part of… So, there are a few issues.' (CO12)

'One of the strengths around that is around… so, one of the strengths around Gwent is that actually a lot of the senior public service leaders, so taking this out of the context of the APB, have been… they work very well together. They are genuinely collaborative. So, there is an informal set of arrangements that brings together the G10. So, that's the Gwent ten public service organisations. And interestingly, they've asked for a presentation from the APB sometime towards the end of September. Now, that's… I say interesting, because that might be… I don't quite know what the focus of that is at the moment, but whatever. That's a platform for us to not… it's a platform for me to be a bit more active and actually there are some things here that you guys can help with… Absolutely, so I think strategic direction is… in my words, the 'Don't Walk By' approach, everybody's business… the endeavour behind that to make that real is huge and the leadership that requires needs to build on some of the strengths we've got, in Chris and across the process more widely I think.' (CO12)

'It goes back to the point I was saying about public services in Gwent and some of the leadership is good between organisations which is obviously a good foundation for that kind of work. I think the other thing I'd just throw in to that is that maybe one of the things that we need as well as the mandate or the commitment, one of the other things we maybe need is, as well as the leadership, the mandate and the commitment, which are kind of conflated together. I think there is something around… in commissioning teams at the moment, we've got a traditional set of commissioning skills. I don't mean that in any way, shape or form to be anything other than what it says on the tin. Those are very good. They're very helpful. Maybe, and this is a blooming

battle that I've played out once at the APB and lost. Maybe we do need to start thinking about, how do we supplement that so actually there's some specific improvement capacity in that team, that is around the… "if you two want to do join clinics together, I'll take away the burden off you and organise that for you."' (CO12)

'I think we want to make the whole joint endeavour the whole theme of the next contract, but my concern is about, how do we service the leadership of that given that essentially, it's seen as something that we do. Maybe this is something for us to reflect on as well, about how do we operationalise that intent.' (CO12)

'I think the difficult has been is that over… so, we've had years and years and years of not much happening in that area, and when I joke about the third incarnation of the treatment framework, I was around with the other two and basically they never went anywhere because there wasn't buy in, and in particular there wasn't buy in from mental health services, and in particular it was, I would say, the medical side of it. So, the first incarnation we couldn't get anybody to get involved, second incarnation we had a few of the senior nurses that kind of got involved, but we could not get consultants on board at all. What you then find is that you get the people at the top of mental health, so the divisional and directorate level, understand it and are fully paid up members of the, let's do the co-occurring properly club. But then the guys on the coalface, at any level, whether that be a consultant stuck in Rumney or a CPN in Lower Monmouthshire, it doesn't percolate down to them quite so well and they still then work on what they think about co-occurring. So, to still come across consultant letters saying, 'We're referring this person to GSSMS, and they can sort the problem out and deal with the psychosis,' and we kind of bounce back, 'We're not a dual diagnosis service. Have never been a dual diagnosis service.' So, we still get kind of that issue as well. The flipside to that as well is, I think one of the biggest difficulties in all of this, and if you want to get to the crux of the ones that we fall out over, is what is mental illness? So, if you look at what the CMHTs talk about, they talk about severe and enduring mental illness, and severe and enduring mental illness is that which can be diagnosed using ICD10 or 11 criteria and that for which we have treatments. What colleagues in substance misuse services are often dealing with is distressed people that behave in a way that is risky. That is not always mental illness, but it's still something that has to be dealt with, and I think that's where these kinds of crises of personalities occur, because you will then have substance misuse treatment agencies.' (CO13)

'Strategically, [Housing] *are quite well joined up, but there is still work to be done. We have developed strong regional links with mental health colleagues and the area planning board. That involved making sure there was representation from the supporting people programme across the various groups. I also attend the sub-groups to represent what will be Housing Support Gwent going forward. I've sat on the minimum unit price group. Quite well-developed links.' (CO16)*

'If there was a review of how leadership has been stablished in Newport, because it's here where it is at its strongest, and get this be established over Gwent… I am thinking of the co-occurring group and the rough sleeper group, how can these be expanded across Gwent? Also, finding out

if these groups are fit for purpose. Furthermore, ensuring that ensure at a regional level that we go forward… strong links with the APB.' (CO16)

'I would like the Welsh Government to provide a Gwent-wide budget. It's a bit of a past-code lottery in my opinion when it comes to substance use and co-occurring.' (CO17)

'One challenge is that on the ground a staff member may identify that rehab is the best course of action for an individual, however when it goes further up things get a bit sticky in terms of funding. Then all your good work underneath goes out of the window a little bit as people try to find out who is responsible from a financial point of view. What I struggle with is that in terms of finding a rehab place for someone, then you have GSSMS fighting with complex care for funding, and for me there is a big gap in the agreement in terms of co-occurring about who is contractual, who is the commissioning body, is responsible for the funding. All those sort of things. That's when it gets tricky. It usually gets sorted out by email war. Sometimes we actually pay for it, the local authority, it goes up the channels then, its not without these challenges.' (CO17)

'I think one of my observations from the beginning really is the governance structure in relation to taking some of this forward from a strategic perspective. So it feels to me, my personal view is I guess that we've got the substance misuse area planning board which is pretty divorced from the regional partnership board. So I think that's quite interesting and I think that in itself is probably something to reflect on… well I guess it's made me started thinking that if the area planning board was… would there be benefits of the area planning board being brought under the broader regional partnership board agenda. It just made me think about what would be the pros and cons of that. I could absolutely see some pros. It would be really interesting to talk to colleagues about whether there would be any reasons why it wouldn't be a good idea. But I think in terms of the regional partnership board structure locally, Wales has really, really pushed that. So we've got quite a significant structure there now which goes from having the leaders of the local authorities, your vice-chair of the health board at that regional partnership table. Underneath that a significant sort of leadership group where you've got directors of social service, some of the key execs from within the health board and then underneath that we've got a number of strategic partnerships that we describe them as. So one of those is a mental health learning disability strategic partnership that I'm the current chair for. But it's interesting. That gives a really robust; a pretty robust multi-agency way of thinking about how we support the needs of our population. And interestingly what doesn't come into those conversations at regional partnership board, what doesn't come into those conversations at leadership group are really many conversations around substance misuse. So I just think that's an interesting point.' (CO25)

'Well I think there needs to be more. There needs to be more focus on it and I think that the strategy documents often come out but I'm not sure how high a priority they're given. I mean I sit once a fortnight on a safeguarding and concerns panel and we've tried to pull some of the learning into those groups about how we try and identify themes and although there's lots of other panels isn't there where with sort of like serious incidents or deaths are reviewed, but I'm not sure how that then all ties in.' (CO27)

'It's just my personal view of it is often when I sit in forums and you have a conversation is you get the representation of this is what we can do, this is what we can do, but the patient sits right in the middle of all of those services, so when you're talking about developing services, we don't seem to get to the point where we have a conversation about "Right, how do we all sit in the middle here with a patient?" as opposed to, "We can give you this bit, that bit, that bit and unless you meet that criteria, you won't get all of this." To me it's just that bit about how you enable someone to navigate their way through it. I mean I've been doing it for 35 years and I'm still struggling to navigate my way through some of it. I think if you're in a level of distress or intoxication or crisis then people are not going to...' (CO27)

'I feel like adult mental health is drowning in a mixture of possibly, not the most robust leadership but also just drowning in... it's saturated and it's got quite an old-fashioned view, I think. I don't think CMHT's have had a lot of national leadership either and national strategy that's supporting them. So, they've had lots of operational and policy change, but no real leadership of the core basis of services. So, I think the difficulties that leadership need to grab hold of, some of this... how we operationalise national strategy...' (CO32).

'Because you know what, if I've got cancer, I want NICE-based care. I want what the NICE guidelines say I should have. So, why wouldn't we do that for mental health patients? And we still cannot evidence in most services that we offer NICE guidance and care for even depression and anxiety, because it goes back to the Vanguard thing. If you say, well what do you need to offer? You need to offer CBT and medication, behavioural activation and blah, blah, blah, and people go, "well, we've got a waiting list for CBT". Why doesn't every member of your CMHT know how to deliver CBT? If someone can't have... why aren't occupational therapists labelling that they do behavioural activation? I just think, my gosh, it really is about clinical and strategic leadership. So, the top should be saying, what are we trying to deliver in accordance with what values, and then how does that manifest in each of the teams in the clinical leaders and the teams to be audited against that? But what you've got is managers who have been around for 25 years, which... actually, I've been around for quite a long time, but who come to work, and they do their job and they don't read policy, and they don't read research, so how are they going to know?' (CO32)

Langage / terminology

What are the issues/challenges around the language/ terminology and how should we refer to this issue. Are you aware of an agreed definition of 'Co-Occurring Conditions' in Gwent? If so, what is it? If not, would this be helpful to have in place?

'I think you're never going to get it right. I think there's always going to be some discrepancy around it, but I think the term dual diagnosis isn't sometimes always helpful.' (CO1)

'I think when you talk about co-existing conditions, I think it's important to recognise that there's an interplay, and this is always a circle rather than... this is not a flowchart of one against the other, this is a circle where there is... literally you start off with substance misuse, whether it's

drugs or alcohol, you have adverse childhood experiences, you have low incomes, you have low social economic problems, and then whether that's homelessness or it's partnership breakdowns or whatever, alcohol feeds into that as a sort of non-virtuous circle if you like.' (CO2)

'I think the short answer, before I give you more details, is no, I don't think that we have a consensus agreement on what do we call as co-occurring, and I think this is what led to us running this pilot, because we wanted to understand. And I think we thought that because Newport is a typical inner city area, I think this might be the best place to do a pilot rather than the Valleys where the population... obviously the prevalence I would like to think is quite high over there as well, if anything, but we thought, "Okay, let's run this pilot," because I think GDAS always felt that a lot of, they call clients, we use the term patients, under their service really then they came to us, adult service, they were not getting a service. So, they said if we had a pilot at least that will give a sense of what does this gap look like? What is the prevalence? Does it mean that we should have a service that would cater for this individual group? And rather than waiting for people to become so unwell where they necessarily then need to be detained and then brought in and then go through the whole circle, wouldn't it be nice if we could pick them up earlier and make a difference in all manners of means?' (CO9)

'I'd be inclined to think that some of the connotations and terms we use are quite negative. I think substance misuse does say you're misusing something and I think it goes back to the conversation from Wednesday where within some setting there's some image or thought that people need to be abstinent or free of substances before they can start therapy from a mental health perspective. And the reality is, I think if you go back to sort of my approach, it's only a problem if it's a problem for that person…I would prefer that substance use is used as opposed to substance misuse. That old dual diagnosis, whilst it did serve a purpose at the time, there was confusion a lot of the time because dual diagnosis also meant mental health and learning disabilities and dual diagnosis went. And we were using within health boards loads of different abbreviations that were confusing. Co-occurring, I think that does give a brief description. I think that terminology is given by government guidance, isn't it in the document?' (CO10)

[I'm really interested in the language. I would agree with you about the word recovery, but I'm interested to know why?] '*I think service users understand recovery is a destination and for some of them, I think that feels invalidating because I don't think they think they'll ever recover from the things that have happened to them in their lives. I don't think you could ever recover from it. You might be able to adapt and be able to adapt in a healthier way than you currently do, although all behaviour is adaptive, isn't it? They're taking substances because their internal worlds are exhausting.' (CO32)*

[resilience] *'Increasingly that's falling out of favour with me. I think my absolute frustration is that we don't consider what human behaviour actually means, and by behaviour, I mean the internal experiences and what can be observed externally. You've only got to have the humility to look at yourself and understand why you don't want to change your own behaviour. Utter*

compassion and commitment to helping someone else change their behaviour, it's just… fundamentally, we're not at that level in services.' (CO32)

Thresholds / criteria

'It's very easy for them to bounce your referral saying they do not meet the criteria for their service… That's what it comes down to. "If they don't reach that criteria, we don't want to see them." But I'm never quite sure as to what the criteria exactly is that qualifies. Suicidal? Forget it. Especially if you look at CAMHS. They don't get too excited about suicidal ideation now, especially self-harm, but that goes back to CAMHS again. I think if you've got an acutely psychotic patient, they'll take that.' (CO4)

'So, because they're co-occurring, we've not made [criteria for the co-occurring conditions panel] it that rigid. They don't have to have a mental health diagnosis as such. As long as they are suffering in some way with their mental health, they meet our criteria there. So, it's people with mental health and co-occurring substance use. That can be alcohol or drugs and yeah, any kind of mental health, moods, mood disorders… I guess the service was set up because there's been that gap between services that have been noted where people kind of don't meet the CMHT criteria for them, or because they've got a mental health diagnosis they don't meet maybe substance misuse service criteria, so it's really for those people that are falling between the gap and finding it difficult to engage.' (CO5)

[For some services] *'the criteria is that you have to have a complexity and mental health being one of those complexities, but in order for that complexity to be present they actually have to also be being cared for by the CMHT. So if they're not being picked up by CMHT they also won't be picked up by GSSMS either because they won't be classed as having that mental health.' (CO5)*

'I understand that the system is the system. So for GDAS, the system is that you have to be engaged in the treatment programme and seeking recovery from your substance misuse or issue. But that is a system that excludes people who need support and might need prescribing and need our help, but I'm not at a place yet to hold the homeless population. So, I understand. I work myself within an imperfect system that actively excludes people who need that support. The system excludes them. The system says "We are not for you". There isn't even a system for them and a lot of them will have the severe and enduring mental health issues. So if you look at our homeless population, they have no access to substance misuse support, they have no access to mental health support. But the mental health system has always, in my view, always been extremely difficult for people with substance misuse to access, always.' (CO8)

'I think it possibly would be helpful if you had a standardised set of descriptions, but I think for me it's that joint working, and joint working can mean many things, but it's that clear understanding of, yes, okay, someone's caning a couple of slugs or lager down him every night. That doesn't mean it's caused his mental health problems. He could be blotting out his mental health problems and just to say, "You've got to stop drinking before you have therapy," it's a very subjective stance to take. I think we've got to look at the individuals and at the skills and

knowledge and like I was saying the other day about being in the same room together, having that conversation to do some formulation. So, when that referral comes in to have that... you've worked in services Andy, you've seen a referral. You're automatically making some formulation in your head of what could be going on for that person, and quite often you're right, quite often you're wrong, but I think it's useful to have that expertise in the room.' (CO10)

'I think it's down to people's... whilst everybody is a highly professional skilled clinician, in theory, I think people bring their own agendas to any assessment. It's very difficult sometimes for a lot... I think personally, people bring their cultural norms and values when they come to assess, and their own perceptions and we can't change that. I think it's about our self-awareness, what we're bringing into that assessment, and I think that's partly a reason why some people react in a certain way with people with substance use. And there's also, "We've got 25 referrals this week. We can't manage this." ... Yes. Well, we've got five different patches, local authority areas within Gwent, which you probably know. That's how services are configured into, and I've been in post for a couple of years and one of the things we'd like to aspire to is a standardised service. Because whilst a lot of it is standardised, different areas have gone off and done subtle, little different things. So, for example, 70% of referrals to the Torfaen CMHT are usually batted back... batted back is probably not the right word, but signposted elsewhere.' (CO10)

'I've sat in a room and someone was arguing for a service user to be discharged because they had drug induced psychosis. It wouldn't take a rocket scientist to realise they didn't have drug induced psychosis, they had a psychotic episode, but that was bad enough, but the fact was we knew this guy was using buckets full of amphet every day and stimulants. So, it goes to the fact then, well if it's a drug induced psychosis, he's using drugs every day, he's psychotic. You know, he's just like...and you see that mentality of, "Well, we're not going to work with them because they're making choices..."' (CO10)

'Sometimes we get referrals through for patients requesting HCR-20 and joint working with forensic, and you look at it and you think it doesn't fit... it's that understanding. Or we'll get, "we need an assessment on this patient", so two days later you're actioning it, and you find out they discharged the patient. You're like, "hang on a minute, you only referred him two or three days ago, and you want this done because he's such a risk", what's going on?... Some of it is about pressure of beds and, yes, I think it's something we need to think about Andy, because I think generally speaking, talking to colleagues myself as well, we'll talk about substance misuse, alcohol dependence, yes. But I think we miss a lot, and also, you're talking about the particular client group that we work with, and people talk about the women, the personality disorder, but actually we know full well that the vast majority of our clients have had traumatic childhoods, have got personality disorder traits of one form or another but that is a gap that we're missing.' (CO11)

[Is that where you would focus your attention as the main priority for better meeting the needs of this client group?] *'I think so because one of the things we come up with is... the meeting I've just been in is our weekly kind of GDAS, GSSMS meeting where we look at referrals and stuff like that, and what you get is somebody contacts GDAS, they go to the GDAS building, they have an*

assessment, it comes up that they're a drinker but they've got epilepsy. So, it's, "Oh, shit, they're going to need inpatient detox." They now need to go to GSSMS, so they get referred to GSSMS. They come to us. They do another assessment going over the same shit that they did with GDAS and then they're in the system. Sometimes there are ones who turn up and say, "Yes, I've got depression. I'm on this medication, blah, blah, blah," and the GDAS worker doesn't know whether they're with the CMHT and subject to secondary mental health services, in which case they should come to us, or they're not. So, they see them, they assess them, they then refer them to us. We see them, we assess them, and we say, "No, actually the GP's looking after their depression," and we bounce them back again. If you had one building with those two people in...' (CO13)

'From the mental health services, the CMHT in particular, are extremely busy. They have a lot of referrals, a lot of services and people referring in, so it's always a difficult balance for them. From their perspective, if substance misuse seems to be... If substance misuse is in the mix, then obviously quite often they will look to refer that person, or signpost that person to a substance misuse service to be able to do the work, and I think sometimes, the whole thing of... A person's ability to engage in services, if they've got a co-occurring issue, I just don't think they have the... Not necessarily the skills, but it's that lack of understanding and there's a specialist service there. If there's a specialist service there, we'll let the specialists deal with it. But then, from the opposite side of that, and coming from a substance misuse side of things, if there is an identified mental health need, then that person, on the mental health side of it, should very much be managed by mental health services. I think there's always that tension. Although, having said that, I know, just from the discussions I have with the team here in Newport, they have a large number of people that they are working with, with co-occurring needs, that have very little involvement with substance misuse services. That's usually by choice. They will signpost, and they will encourage involvement, and they will offer to make referrals but the individuals, quite often they don't want to engage, or they don't want to admit, or they don't want... They're quite happy with their current lifestyle, they just need...' (CO14)

'I think it's a little bit of both really. I think confidence is a difficult one. Because I know that every CPN, and OT, and social worker within the CMHT has complex co-occurring people on their caseload. They work very well with them. I don't think... I think sometimes it boils down to, "Actually, we're up to our eyeballs. There's a specialist service for this. They're nurses, psychiatrists, they're mental health trained. Maybe they might be the best service to deal with them." But I do see lately, in particular since Charlie's role on the duty desk, there's lots more joint assessments going on. With the COVID situation as well, we've done... Darren's done joint assessments with GDAS, GSSMS, and obviously he's looking from a mental health perspective. I think we're seeing lots more joint assessments going on, or people being called in at point of referral, rather than just going back and saying, "I don't think this is us. Send it to GSSMS," or in the worst case scenario just forwarding it on to GSSMS so that the person invited and doesn't even know they've been sent to a substance misuse service. That doesn't tend to happen anymore thankfully.' (CO 14)

'I think it's a bit of both, and I think there is always that pressure with specialist services, because again I think they develop a little bit in isolation because funding becomes available, or there's a need. A need is identified, "Let's put this in place." But, it feels at the minute, whatever you put in

place, it just creates more demand, or a different demand, the demand changes, because everyone's got their criteria, and it's like, "Well, that's not us. That won't be GSSMS. That'll be GDAS. That won't be eating disorders…" whichever specialist service it seems to fit with or whatever primary care service it seems to fit with, the criteria comes in and then it's like, "Oh no, that's not us. That's so…" It always feels a bit clunky then, and not very patient focused. I mean, all they're asking for is some help, so to have to go through multiple points of either referral or assessment just doesn't feel right. I think sometimes there's just that bit of tension, between core services and specialist services. People don't really talk about it, but it's there. That tension where, "Well, you're the specialists in that so deal with it."' (CO14)

'I know at high level within the Health Board, they've done a lot of… They've gone out and… They particularly liked the Gloucester mental health where there is no… People just ring up and book an appointment. There's no referral required. There's no… Then, when they come in and you speak to them and then you get an idea of what their needs are. It's not, "You have to meet this criteria before we'll see you." It's just like, "Right, let's see you and let's work out what you need." And I know there's a fair bit of passion for working in that way at a higher level within the Health Board, and the divisional manager is very keen on exploring how that might look, particularly with all the crisis liaison work and the crisis assessment unit stuff that's going on, and the support…' (CO14)

'I always get a really fast response to any type of referral that I tend to send over. And depending on the person that you are referring to, I mean if you've got a good rapport, and you get a lot of joint work in, and more so now COVID has hit because we've all got to be kind of fluid in the way we work, and that seems to have made a massive difference, having this different approach… Because everybody's had to evolve their outlook on how we need to work, and how we successfully help the people that we need to.' (CO23)

'Meeting the grade for Primary Care Mental Health Support Services, it just feels like each team we create, we create a gap and invariably that impacts on the patient and any criteria that we look at and certainly, if you're a relevant patient under the measure then that opens the door to services whereas the vast majority of people do not meet that criteria. But they still have significant psychological needs or trauma that may lie in the background. And with any - not with any, but with a lot of individuals who have substance misuse issues and trauma-related and as you've described earlier, they're using some of these substances to sort of manage the way they feel, is that you then have this, well certainly if it's primary care mental health support services, is that they're not willing to engage or unable to engage, so they're sent an appointment, don't turn up, therefore it doesn't count, or they've been taking substances, therefore they're not in a position where they can engage in therapy at this moment at time, so you've got no access to services because of what you're doing when what you're doing is probably, do you know what I mean? It's almost like a domino effect isn't it?' (CO27)

'Yeah. It comes through CMHTs, basically. We sit behind the CMHTs. The CMHTs have their criteria, which all rely on secondary service need, and in Wales, it's the Mental Health Measure, that's it. Those are the people they take on. You need to be unstable enough, unwell enough,

however you put it, to come into that sort of service, and then, you will get a CMHT response.' (CO30)

'So, generally our eligibility is severe and enduring mental illness, usually with risk associated with that. Unfortunately, there are lots of individuals with co-occurring substance misuse problems. I think it's... There has to be a threshold at some point. We get a lot of referrals through for individuals who need trauma work. So, trauma work that's more intensive or over a longer period of time than can be met in primary care. The difficulty with that is, it's kind of the chicken and the egg. So many individuals look to substances to cope with or to block out what they've experienced, but if they're that under the influence and, I suppose, committed to their substance misuse, it's very difficult to effectively assess them, for one, because all substances affect your mood, affect levels of anxiety, can cause psychosis, but then you've got to look at, how effective is any intervention going to be? So, that I would say is one of the biggest issues, and so we often have discussions with... I only had one recently with members of the substance misuse side who were saying that the massive barrier to them tackling the substance misuse is what they would deem as their mental health problems. Some individuals, to us, that wouldn't be severe and enduring enough.' (CO31)

Prevalence / needs

How confident are you that the full extent of Co-Occurring needs amongst the Gwent population are properly understood and evidenced? Are current/future data collection systems 'fit for purpose'?

'I think we're shocking. I think we're quite poor. It's only anecdotal. It's like I touched upon the other day, 20 years ago we would have a lot of people coming in for first episode psychosis, and they're not coming in now and I think the EIS have pulled a lot of those out of the system by starting work with them early, but they tend to be the ones with good family support. And I think there's a lot of young folk in particular, when I say young, 18 to 24, even 25, who are probably experiencing a lot of possibly first-rank mental health symptoms that's being clouded and diagnosed as substance use, drug induced psychosis. And I think these people are struggling, and they go back out and they continue to use drugs and I don't think we've really got a grip on that.' (CO10)

'There's two or three bits to that. One bit for me is the fact that we've got some interesting dynamics going on at the moment around criminal justice and their commitment to a joint contract. Part of that comes from the fact that if you look at their cohort, mental health and substance misuse are massively over-represented. I think part of the dynamic is, they are a little bit critical that some of the outcomes that have been achieved by the drug and alcohol services for their clients aren't where they'd like them to be. Equally, I think that's a little bit naïve in the sense that well, we're accepting clients here that have got longstanding, undiagnosed, untreated, unidentified issues that actually, they've been in your service or with the service for quite a long period of time. So, actually, that understanding about who needs to be doing what… if you want the better outcomes, then there are changes that you need to make further upstream that will help steer those better outcomes and I don't think that bit is… I don't think it's properly understood or evident. So, that's one of the things for me particularly. I think generally speaking, the other

reason, although we didn't know it at the time, was that I think we generally thought that ten years of austerity is going to be a fairly hostile environment, low level mental health. Throw COVID in to that as well, then that's probably going to generate a bigger level of need. So, it might not be about evidencing all of that need. It might just be about actually understanding those general dynamics and keeping this under review. So, I don't know about known service gaps. I think there are some gaps in criminal justice and I think that's some of the things we're seeking to try and engage and change at the moment, other than that Andy, I'm not as well…' (CO12)

How would you describe the prevalence of Co-Occurring conditions across Gwent, and what makes you say this?

'I think from memory, you know it's something like a third of patients are presenting with mental health issues to ED, not all hospital sites, but presentations to ED, it's something in that order. So you know that's quite a considerable overlap isn't it?' (CO2)

'I think a lot of people with mental ill health will be using substances, and vice versa. It's always difficult to know which occurred first. There's a lot of self-medication out there, as we know. It's difficult really, to be honest. Looking amongst the patients I've got in the practice, I've known them a long time and there's a couple that I've got no doubts that the CMH team should be more involved with, but they're not, but then they're reasonably stable at the moment because they're on large doses of methadone which is keeping them calm.' (CO4)

'I would say at this end of the spectrum, early intervention work, I'd say you know probably, and this is just a guesstimate – it's really about 50% of our caseload, you know I've got substance misuse issues that contribute to their first episode of psychosis, we're a first episode of psychosis in the intervention service.' (CO6)

'I'd like to say that now I think we can honestly say that at least 90% of the patients we see in our services, within current services, do use substances, okay.' (CO9)

'We actually did an analysis… I think it was about two years ago, of our wards and Pillmawr came up with substance misuse… poly-substance was about 73%, Ty Skirrid… I'm reading it; I've got it on the wall, 80%. Pillmawr then, substance misuse generically was 100% and Ty Skirrid was 90, I think that says, yeah. So, it's a huge problem for us.' (CO11)

'I would say in terms of the patients who are inpatients, just off the top of my head, I would say probably two-thirds of them will have an ongoing drug and/or alcohol problem, running alongside their severe mental health problems. It might be more than that, it might be five out of six. There's six patients there and pretty… there's sometimes one of them that doesn't have a drug problem, let's put it like that, and those drug problems can be really significant. In fact, actually they can be the major destabiliser of the person. For example, there's one individual who was with us for a couple of years, she's improved to a point at which she's been able to be moved. She moved into a supported house in the community. Her mental health deterioration was significantly contributed to by cocaine use, such that she could not leave it alone. It was a daily

thing, and it resulted in her entering into a very, very severe psychotic mental state really, and it's taken some years to help her, as an inpatient, to get stable again.' (CO30)

Current services / supports

Can you please tell me a little bit about the range of services and supports that are currently available in Gwent for individuals who experience co-occurring mental health and substance use conditions?

'CMHT are covering the whole borough and our staff are receiving training on co-occurring conditions and there is a co-occurring nurse employed by GDAS, and there is GSSMS and there is some good joint working going on there. There is a drop-in centre provided by Platform in Cwm Coch psychiatric unit. There is that linking of services I suppose and recognition that people do have co-occurring conditions. The housing are coming on board in terms of co-occurring conditions also. We also have services from a social care point of view. Lots of things from preventative point of view. We do have to join up more.' (CO17)

'I mean I do wonder with… there are gaps, certainly for older adults to have because I mean I know my wife works on an older adult ward and when they've had somebody who's admitted for a detox who's been difficult for them because they're not used to dealing with it, but certainly when somebody comes in and they've been using other substances it's almost like they're starting to see the results of the '60s now and that culture. But again, just the mention of some of those things it's like, these are old people, they don't do that and then suddenly you're finding they are. And it's a real culture shock for the staff when they're trying to deal with that, because they're not used to it. I mean this is not specific to older adults, I think it's that part about how people navigate mental health, physical health and housing systems is that I think there is some mileage in us trying to develop roles that enable people to access services because what tends to happen is people are referred. For example, they see the GP who says, "I'll refer you to GSSMS", or "I'll refer you to Primary Care, they then send you an appointment". The reason they went in the first place is probably… it may have diminished the need to see somebody so they don't engage with that, then they get a letter saying, "You didn't respond so you're…" or they see somebody who assesses them and says, "Well actually, what you need is you need to see so and so over there and so and so over there", so they might provide something around housing, they may give someone benefit advice.' (CO27)

Can existing services and supports effectively meet the local needs?

'It all comes down to resource and money and everything at the end of the day. The other thing, I think there's always been that split between… With GDAS, the funding through the public body, NPP or whatever, more through a criminality route, as opposed to GSSMS, which is a health route. I think that did create a little bit of tension, although I think that all settled down a bit.' (CO4)

'Limited is what I would say. Within GDAS obviously we have a Co-Occurring Nurse that advises us, and we have the COG Panel and the Bridging the Gap Project which is a very new thing really… Yeah, and that's sort of arisen really around the lack of services or the lack the access. That is supposed to be a kind of gateway, a bridge between. So, within GDAS those two things

exist. Then you've got the Gwent Specialist Substance Misuse Service which is supposed to be the prescribing service for people with co-occurring issues, and then you have a smattering of small projects I suppose; things like Growing Spaces, that are not projects that exist solely for that purpose but are projects, and Mind who will take referrals from us and offer support to people who we refer…So I suppose there are those things, and things are set up in GDAS specifically for our clients who have co-occurring issues. Then there are actual services set up, and the only one I can think of is the Gwent Specialist Substance Misuse Service that is there; and then there are services for people with mental health issues that will take referrals from services where they are working with people with substance misuse. Sometimes that can be limited, but there are several services, Mind and some of those have taken a little bit of persuading and pushing. At one time they wouldn't take referrals from us and now they do. But they will take the referrals, but it is quite a patchy thing.' (CO8)

'I think in an ideal world I would like to say that yes we are offering everything within our means, but I think I also at the same time have to acknowledge and accept that perhaps that is not happening, only because obviously there are lots of different teams, lots of different human beings involved in vetting every single referral. And obviously everybody's views or takes, because it's not… and we don't ever want to have like a policy or a standard procedure that says, "Look, this person, if they meet, one, two, three, then they come into our services." You can never ever have a service, or rather we shouldn't have a service that works on those simple mathematical kind of sums whether should one be in or out. And because, as I said, there are so many individual staff involved, one can never say with confidence that, "Yes, we are not sending people away, and that we are keeping everybody who should be and that we are going above and beyond to make sure that we're doing everything." In an ideal world, we would like to but at the same time what I was hoping is that if we worked more jointly, if we had some referrals where we could sit down jointly and have discussions to learn more of what can be done, or how can this person be helped, I think that really would go a long way in helping this population.' (C09)

'One of the big challenges we've got and that is really frustrating is people with ASD. So, increasing problem. We…So, what we tend to find, they might have a dual diagnosis, they might have schizophrenia for example, young males and they've been on acute wards, struggled on there. Quite often then they'll be sent out of area to a provision where to some degree it's managed, but then things might unravel. But then they come back to us and generally speaking… we don't have staff who are skilled in looking after them. They are on a mixed ward. I've had several cases when I was on Ty Skirrid, as well as LD… we're not talking mild LD. We're talking somebody with like 58 IQ, and he was on Pillmawr. We had to find him a bed. The placement was closing. They struggle…' (CO11)

'Obviously in Wales now from the point of mental health systems we've got the great WCCIS Miami coming on board, whenever, which obviously substance misuse services will be part of. So, it won't just be NHS and social services. My understanding is the third sector are coming onto that as well, but then I guess within that people will have levels of access. So, it might be that support workers in GDAS don't have access to the mental health records of people, but they just have the… I don't know how it's going to run. From our point of view with the physical health side

of things, our physical health portal is just for ABUHB, but I've got patients on the border who would go to Prince Charles Hospital in Merthyr Tydfil and I have no access to any of that. So, it's still a pain in the neck to get that information. Our current mental health system, ePEX, I don't know whether Anvita spoke about it, it's the worst pile of nonsense I have ever come across.' (CO13)

'Our biggest struggle, and I've had two sons of the same chap phone me up today to pester me about their dad, is that we have one ward in Gwent where we can do detoxes in older adults, and it's run by a lovely but old fashioned consultant who has to have a consultant to consultant letter requesting a bed each time. And once they're on there... because we have an advanced nurse practitioner who goes onto the wards, that's his role is to cover the wards when they go on and support the nurses. Once they're on there, brilliant, but it's getting people in there, and the difficulty with older adults with an alcohol problem compared to younger adults with an alcohol problem is that they fall over more, they are unwell much quicker and they have a lot of family pushing and advocating for them, and it becomes frustrating that you're waiting weeks and weeks and weeks to get a bed. So, I think that's the...' (CO13)

'Over the years of my involvement, at least in Gwent, there's been a lot of changes, I mean, going back to tendering the new service with Kaleidoscope and now GDAS, and obviously that tends to adapt every time the tender goes out. There'll be additional roles or responsibilities or things will be changed in order to try and meet the needs. The GDAS side of things, obviously they've got the dual diagnosis nurse. They brought that role in, in terms of trying to meet some of those co-occurring needs, because it's always felt like there's a bit of a distance between the mental health side of things when it comes to substance misuse. I think, in part as well, sometimes it's the way specialists, or the way new services, or a specialist services, or additional schemes and projects, the way they develop, to me it feels a little bit... Sometimes they develop in isolation a bit. I think from a CMHT perspective, obviously... I didn't really have, other than the contact I used to have with CMHT in my previous role; I didn't really have a foot in the door of the mental health side of things. Now I have and I can kind of see it from the other side.' (CO14)

'No. I think we need to be more realistic, increase the supply of detox beds. More rehabs. Better provision on the ground around the wet dry accommodation. We can probably look at this from a strategic level, we could ensure that this is a strategic priority for all partners.' (CO16)

'We do not have a specific service for those with co-occurring conditions, but what we are finding is that the people who do have co-occurring conditions are falling through the gaps. For example, psychiatric services will say you may fit our remit, but we cannot help you until you address their drinking problem. But then GDAS for example with say you have to address your psychiatric history. This is not helpful. I would say that a huge number of people I speak to say they drink too much to cope with their mental health condition. I am also speaking with more carers who are drinking too much to cope with their caring role. One person said to me, "I know going down to the garden shed with a bottle of wine is not the solution", but they know it is getting them through. Who am I to say no, if it is helping them to cope?' (CO22)

'I think there is a gap for those with dual diagnosis where they can bounce between service, that's because there hasn't been a service purely for those with dual diagnosis. People are advised to sort out their drinking before they address their mental health conditions.' (CO22)

'I think there's been some good developments in physical healthcare and there's a huge group of these people who are hidden homeless, where they may not be declared as homeless but they are sofa surfing and for all intent and purposes are homeless, is that they will have varying levels of mental health need or psychological need, but they do not necessarily fit into a primary, secondary and that tiered approach. I don't know. Like I say, there was some good physical outreach work that has been done by some of the physical healthcare and I do wonder whether there's opportunities around us developing those types of services or those types of roles to support those people who are in psychological need out there to enable them to access services.' (CO27)

'Most of our acute inpatient wards have fairly newly qualified staff on and their experience of undertaking detox and the CIWA scores and the rest that goes with it, is very limited. I guess, to me it doesn't feel right anyway is that someone's level of psychological distress may not be that they require an acute inpatient ward and some of our wards, a 24 bedded ward where there's high levels of activity and not a lot of it specific to alcohol or drugs, and I guess that's where the positive bits around some of our in-reach and we've got Gary Phillips is doing a...because of the lack of that availability, often the acute presentations on the inpatient wards take a priority. So, whilst we have tried varying ways to try and manage that, it is really difficult when you're looking at a planned admission as opposed to a crisis admission and we know that the sort of crisis admissions or ad hoc admissions around alcohol and drug detox doesn't really work. So, to me it would be better if we did have that type of facility. And whether that could be a shared facility with other health boards I don't know, and maybe geared up to cover a wider area certainly makes more sense to me.' (CO27)

'I'd say for example, we've had… so, as part of my role, I attend the ward round every week as well, at Adferiad and obviously there's a lot of people who come in with substance misuse, so obviously we say, "get yourself referred to GDAS", which is the Gwent Drug and Alcohol Service. A lot of people don't do that and then that's our advice… I think the difficult part of it is, they're on an acute ward with staff who don't have the understanding around drug use for a start. Again, this is the part that I think would be helpful, because for a short while, there a guy working on the ward for a short while, because he was doing an ANP role, something like that, and I felt him being on the ward was so valuable to them because he would be able to talk to these people in a lot more detail about the drug use, why it started, what it makes them feel like, how do they feel without it. Because obviously, when they're on the ward, they're not taking anymore. So, there's a degree of abstinence on the ward, but then the minute they go, it's back to their original pattern of behaviour. He was able to do that work, and I feel he was able to have more of an impact in that. But the minute he got taken away, it's not available anymore.' (CO29)

'I think I always have concerns about forming lots of specialist teams, because I think we can become so black and white and tunnel vision that so many more people miss out. I think having link staff or staffing with extra skillsets within each team.' (CO31)

'For me, the closest we ever got, one of my great sense of loss, and maybe other people have referenced this in Aneurin Bevan. A few years ago, we had Vanguard in with us and they did some systems thinking with us and we ran a pilot project that had no silo that was really about… an observation was phase one of our services and our systems, and the patients that wanted to use them. And then phase two was really this systems thinking where instead of handing off people, you would pull in the resource and the skill that you need, and that really recognised that if you have a psychological formulation of people that understood them from a biopsychosocial perspective, then actually what you got, you would be pulling in a housing worker and a [audio lost 05:06] worker and you'd be understanding their roles in helping stabilise that person so they could make better use of mental health skills, you know, the skills of a mental health worker. That was… I think it was possibly one of the greatest things that could have happened and it just never happened.' (CO32)

Is there anything you think that is working well and whatever we do we want to preserve this?

'You've got the GDAS, haven't you, which are kind of quite broad, aren't they, in their guidance, but they have the majority of substance misuse services, and then there's that dual diagnosis service that's within that, isn't it? It's very much at a support level, isn't it, rather than a... I don't know. It's whether it would be more effective with also some buy-in from health around it.' (CO1)

'So we set up the service here in 2017 with pipeline money from the Welsh government via the Wales liver disease implementation plan, to try and set up an alcohol service, because what we find is, as I'm sure you're aware, there's mental health services embedded in A & E, but those are around mental health specific issues, and although a lot of mental health attendances to ED are alcohol-related, there's a lot more alcohol attendances that aren't mental health-related, but the impact on other parts of the system where… and there were no services for those people to head towards…. So what we work hard on is, because there was no service until we introduced it … we've worked hard on engagement with ED's, to get them to understand that we're not there to provide… they're providing sort of… often psycho social support, and often mental health-related support, but it's filling that gap for those patients who don't necessarily have an acute mental health issue, and don't get seen by the mental health liaison services in ED, but recognising those people who have got alcohol-related admissions, so that we can try and intervene, prevent further deterioration of an existing health problem, prevent the development of other health problems that they haven't yet developed related to alcohol, whether that's liver disease, or cardiac disease, or whatever. And also to try and prevent re-admissions. So one of the big things we've done working with ED staff, is a lot of training.' (CO2)

'Yes, we link in with Mind, we link in with CAB, we link in with the community mental health teams, we link in with primary care, the GP's, with debt and welfare advice we link into, with Advocacy Services; so it's about really trying to link in with as many organisations we can that can then alleviate the social issues…It does work well. I mean GDAS has been a great partner for

us to be honest, and we change participants, when people are ready to come off some of GDAS's activities they refer them to Growing Space and vice-versa really. The CAB service is really good, and the new commission service from the Health Board will be good, because there is no specialist strand in CAB for mental health… And then the Advocacy Service works well, I mean it's really good if someone's struggling to be presented with their housing issues, and they need to be represented in the meeting or tribunal; they are really good and supportive.' (CO3)

'There are some good things that happen, so GSSMS and GDAS work very closely together. We've got a really good relationship with their…There is some really, really good relationships that go on.' (CO8)

'The COG Panel idea is that we've got two mental health support workers who work our side, and they will pick up some referrals and then they are basically getting people ready who should be with GSSMS and should be with the Mental Health Service, but to sort of bridge that gap and to navigate the system for those people. So, in essence, it should work really well; it requires everybody to refer to the Panel, and it requires the Panel to engage with everyone and not set criterias that are too high, and I think at the moment a little bit of a thing with the COG Panel is we seem to be the only ones who are actually referring in. So although it works well, in essence, it's a really, really good idea to have all those people sat around reviewing everybody, it isn't functioning yet where it should I don't think. But it's still new.' (CO8)

'So, we did have one of the CPNs from the Gwent Substance Misuse Service who has been seconded to our inpatient service, and his role is mainly to kind of, obviously, help staff but also to help with detoxes, but also educate our nursing staff. And I think that has gone down quite well, and I think the nursing staff do feel… who really have never worked in the substance misuse service, but obviously when patients get admitted they see that this is a constant problem and they don't know how you do you manage, what do you do? So, I think this has definitely helped. So, I'd like to hope that moving forward the pilot would then translate into a permanent role.' (CO9)

'I have to say the support workers that we appointed as part of COG, they've been wonderful. Yes, they've been wonderful, and I think they're very dedicated, they're very enthusiastic and if only we could just have support workers of that same ilk in each of our services, I think that will make a massive difference. You don't really need professionals. You need people who have that ability to reach out to this very population and work with them.' (CO9)

'Yes, I think there's some pockets [of good work]. Gwent is a really funny area … the closer to the coast, the more tolerant, less risk-averse conditions you'd have, and then the further you go out the less tolerant and more risk…I think there's something about the services and the way the services were set up in terms of taking risks. Certainly I think within Newport there's a better working relationship, and Caerphilly there's a better working relationship, and a lot of that is driven by the tolerance of the consultant psychiatrists I guess in terms of… I guess the clinical leadership, you know?' (CO10)

'That co-ordinator post I think is really paying off massively for everybody really. People like GDAS, GSSMS, GPs, primary care mental health services, they have a consistent person that they

speak to, get consistent advice and consistent signposting or offer of assessment, or whatever it is that that person needs. I know Charlie who does the post, she's got really good working relationships with GSSMS and GDAS, so that's been a massive positive I think.' (CO14)

'The complex needs post … That post has been in place since April. He's been doing a lot of scoping work and working alongside. And with COVID then, the homelessness agenda changed completely and he's been doing lots of joint assessments and supporting the wider homelessness agenda. What seems to be coming from that pilot, because again it's only a fixed term post up until March next year at the moment, a lot of the stuff that seems to be coming from that is the psychological, unmet need for psychology really. Most of the people he's coming across don't really meet the criteria for secondary mental health services, but they're too complex and chaotic for primary care services. They're managing to achieve some stability with their substance misuse, which is fantastic with all the support that's in place, but what seems to be becoming increasingly apparent is the trauma side of things. There's lots of… And obviously, for that then you'd probably be looking at a referral into secondary care psychology which would be sitting on a waiting list for 18 months at the minute, if they managed to get through the whole process of being assessed.' (CO14)

'He's the leading, alongside two other clinicians, on the development of the LSU for the Health Board. Obviously an LSU would probably… The reason that I think Gary is involved in that, several people applied for it, is because the idea of an LSU would probably be around more complex needs patients, so they may well have a substance misuse history, current or previous. That's going to be really interesting to see how that develops. I think his role as well has broken down so many just preconceptions as well sometimes, certainly from a mental health perspective, "Specialist services are all a bit precious and you've got to jump through hoops to get there," but a4ctually him being there on the wards, being able to advise, consult, admit, discharge, work with patients, the fact that he's been so keen to support the wards as well, he's done all the PMVA training so he doesn't have to… With a difficult patient, he's not just sat there watching them get on with it. He's getting stuck in. I think he's really broken down a lot of those barriers as well.Yes. I think it feels like we need to do a bit more in reach from a substance misuse perspective with mental health because that feels a better way of working rather than expecting them to reach out to us, just because of the level of activity that goes on in mental health services. It's so busy. Not to say that substance abuse services aren't, because I know they are as well.' (CO14)

'We've got the assertive outreach team for mental health. That is very much… Quite often lots of those are substance misusers as well. But, yes, this is a new… It was looking at what resources were already in place, how it could be managed to be able to provide a bit more of a co-ordinated approach. Rondine is kind of leading on it from a GDAS perspective. It was looking at…' (CO14)

'The set up in GDAS is excellent, the development of the APB at a strategic level. It's a lot cleaner pathway with one route into services.' (CO16)

'One thing in Blaenau Gwent that we have is that the relationship with health and social care is fantastic. We understand the needs of our population. We know the staff need ongoing co-occurring conditions training, and not just the secondary care staff but also all staff so people are

aware of co-occurring conditions. Its just about changing the culture of teams, so they don't see substances as a total negative, and look at the history, I think culturally we are changing people's views. We are good at building up MDT meetings, and there is more joint working going on, I think its about bringing the third sector into that and working holistically. We have the platform drop in where there is a multi-agency support and I would like to see this expanded. We need to look at this from a co-occurring and preventative point of view. Out SW and CPN's have a good understanding of substances and good working relationships. However, the further up the structure it can be a bit more diluted.' (CO17)

'I've supported people to access GDAS which seems to be really helpful for people. That is if they can get there.' (CO18)

'There is the mental health triage service with Gwent Police. The triage service works from 8-2am in the Police control room in Cwmbran. Where we have a team of MH professionals and social workers and nursing staff who assist the police within the police control room. We have access to health and social care databases so we can look on the notes and see information about people in real time. Share information and offer advice. Key to our role is liaising with wider services, for example if someone if threatening to harm themselves, we will work with the crisis team so that person can be assessed.' (CO21)

'The direction and steer of the health board currently, there is a clear strategy in place around services, and especially services to meet the need. Out of the Housing Needs Assessment (CT), recommendations have been implemented which is great. I get the sense that there is a good steer coming from the health board and they are being collaborative with third sector organisations. That to me is a huge positive.' (CO22)

'I mean some of the people we are helping haven't had a tenancy for twenty years, and you know it fell flat. Now they have a beautiful flat, they are maintaining with the support of Pobl's Housing First, which is working brilliantly.' (CO23)

'This in-house working, or joint working then, we can see and pick that up quicker. It's like we couldn't locate somebody the other day, they hadn't turned up for treatment, and a message came out to me. I then messaged the Housing First group, GDAS, and then we all had this little outreach programme trying to locate one person, but it was effective; we brought them in for treatment. They wanted the treatment, they had a couple of personal things going on, and then we were able to help them with their social problems.' (CO23)

[Assertive outreach] *'It's an adverse way of working for these guys. But they do accept that, and they can see that it's working, because some of the guys here, they have patients that I see on a daily basis because of where I attend, and yet they wouldn't see them. So I'm like "right I've seen this chap; I know he's with a CPM." They said "I know, there's a massive decline in his mental health," and this is going on behind the scenes, which you wouldn't have seen, or wouldn't have heard of until he's hit crisis, and like "do you want support?" and they're going to see him, and off we go… that way of working would have been foreign, previous to COVID.' (CO23)*

'Right, so with being the glue that I have had, because I feel what the glue… all this highlights is myself as a small cog in a big clock you know, and it is an important part to keep it working okay? What I tend to find the need is, that within this role I am stopping a decline in mental health. We are pulling people into treatment faster, and improving quality of lives. We are saving money by less admissions to A&E you know, and the police attending their residence, because of the level of support they are receiving. However, I think as a service we fall very short on the link between trauma, whether it's childhood trauma, adult trauma, it's psychology we are massively, massively…' (CO23)

'So there's loads of work in Gwent around sort of the more broader sort of… so integrated wellbeing networks, the whole sort of addressing people's financial needs, housing needs, all of that, sort of those broader, I guess, psychosocial determinants of wellbeing in its broader sense. Then more recently the work we've been doing is saying, so in addition to that, what are the specific, I guess, evidence based interventions we need to be delivering in terms of supporting people from a mental health perspective. So some of the Jim White stuff. So all of that sort of stuff really. So that's another piece of work we're trying to really, really beef up. So things like ACTivate Your Life. Things like the SilverCloud supported CBT-type work. So thinking within that space as well what might be the particular interventions we might need to offer from a substance misuse perspective. And I know for example, one of the modules in the SilverCloud stuff, I think is around alcohol isn't it?' (CO25)

'So I think there's been some really rich learning through COG. I think it is showing us there is a different way of being able to work with people with this complexity. What I'm hearing is there's a real willingness of the partners coming together in that space. You know, housing was around that table, voluntary sector, statutory agencies. So really good from that perspective. It feels like we're doing it in one borough and we're doing it with a small number of people. I guess the bit that I'm interested in is, is that something that we'd want to scale up and for what sort of numbers of people?' (CO25)

'So, what the local authority have got are two separate - hostels I guess they are, for homeless people in Caerphilly County; you may already know, Maes Y Dderwen and Ty Idris Davies House? Yeah. So, they call them units rather than beds, so it's a bit of a strange language. But there's 18 units in Maes Y Dderwen and I think it's 12 in Idris Davies House and these are people who present as homeless and they're there temporarily. There's no maximum time that they can stay there but they're put there temporarily in kind of bedsit-sort of situations. Whilst they're there the team work really well with them actually; I visited the other day. They focus on all kinds of skills with them, employment skills, self-care skills, managing a tenancy. There's a qualification that they do as well, which I've forgotten the name of, but it proves that they can sort of manage their own tenancy. So, it's those sorts of skills that make them more attractive to private landlords in the future. So, what they are looking to do is to have a hub model of mental health professionals providing support to the people who are the tenants then, in these places. We're still ironing out the details of what the role would be. I can tell you about the CPN role though because… so it's going to be split into a few different things really. Firstly, the staff there, although they have some basic awareness of mental health, substance misuse etc., they would like more.

They would also like some more awareness of our services. By that I mean sort of secondary mental health services such as the CMHTs, the wards etc. So, part of the CPN's role - and it's only going to be one day a week, is going to be psychoeducation really for the staff there but also for the tenants. So, it's going to be kind of a drop-in clinic model where… because it's only one day a week is the thing, so they're going to be there for one day a week, almost to sort of set up their stall and say "What do you want to talk to me about?" They can advise people on the side-effects of medication. They can provide assessments themselves. So, they could do kind of an initial assessment of somebody and then they would have the power if you like to refer into our services. I think that's really important actually because part of the problem they were finding in the homeless services was that they would have people often with drug abuse issues or alcohol issues, but they would get a sense that something else wasn't right as well, but they don't have any training on anything else.' (CO26)

'A few years ago I was managing a crisis team and I was able to make some links then with the local kind of charity that had been tasked then with helping the homeless population in Caerphilly. The way that we first linked in with that was actually just hearing them on Radio Wales talking about the night shelters and saying "We have this huge population of homeless people who don't receive any help from crisis mental health services." I was like "What?" and immediately made contact. Like how is this happening? It was the same issue. He said, "Well we can't refer to you guys because you don't think that we have enough knowledge, but our clients won't go to the GP, so they're stuck." … The risk then is that people are left either to get better themselves or to go through unnecessary suffering, or to deteriorate to the point that they need Mental Health Act detention and none of those are ideal situations are they? So, we would much rather know about things further on. As a result of kind of making those links we've had some successes in Caerphilly whereby we get more appropriate contact now from the homeless service themselves and we will accept their referrals and things, from that charity link for example.' (CO26)

'One of the other positives I forgot to mention sorry, our crisis services assess a lot of people and signpost them on other places. We don't take them on. You know, a lot of people go into crisis for all kinds of normal reasons that are just an unfortunate part of life aren't they? And we're able to sort of signpost them to the relevant people who can help them. Luckily for them they don't have a serious mental illness, they don't need anything else. We think we know what's available locally. And Maes Y Dderwen are doing the same thing in parallel and actually a lot of these services that they know about; we don't know about, and vice-versa. So, there's going to be a lot of shared learning about the third sector as well which I think is really useful.' (CO26)

'We have a lot of dealings with Solas, the accommodation, Solas, in Newport. I find… we've tried to do a bit of work with them as well with some of the people they're managing because again, Solas is a place that put up a lot of people. It's like a hostel-type place. Excellent staff and they do such an amazing job there. But again, what you've done, you've bunched all these people in

one place with a lot of similar problems. I find what that does, unfortunately, it just perpetuates their lifestyle and it doesn't really change.' (CO29)

'So, the new complex needs panel… I'm really excited about seeing the learning from that. Really excited… Massive drug and alcohol problems in that service user… in that kind of setting, in that service user population. So, we've been able to put some psychology in that to begin to test ideas where we embed psychologists in a community for psychologically informed environments, what changes? What is different? Can we find… it's a bit more convoluted way around, isn't it? But I think if we can get examples where this adds value and works, then we can feed that back up in to…So, I think these mini pilots are really helpful with the onus being put on people like measuring. Don't just chat about it, don't just say, that was a nice experience, I'll pop that on my CV. So, measure it, celebrate it, make it public.' (CO32)

Equity and accessibility to services

Is there equity of provision across Gwent – or are some areas better served than others?

'Yes, and I think the population… probably Newport and Caerphilly are fairly similar. Those are our largest populations. It is around somewhere like Monmouthshire, that people tend to be maybe more isolated because often their extended family… people have retired to Monmouthshire or the younger members of their family have moved away. And so older people tend to be more isolated in somewhere like Monmouthshire. Issues around Blaenau Gwent are that we seem to have – and I think this is common amongst a number of different health conditions, is that we have… people tend to present quite late. So people that we might see in our memory services are often more cognitively impaired.' (CO7)

'I mean there's issues around loneliness with older people. I think that in mental health, there is often a lot of focus on younger adults in terms of investment but… There is a focus on dementia but you know there is more… maybe older people who have other mental health problems beside dementia and cognitive impairment and they sometimes get forgotten and don't have access to similar services you know, to crisis home treatment-type services. There will be a number of older people who drink alcohol, who have excess alcohol use and substance misuse, but who don't have cognitive impairment but will have other mental health problems – they will have the depression and the anxiety.' (CO7)

'I think without a doubt improvements always have to be made, because also I think Gwent is… the biggest challenge with Gwent is it's geographically so spread out, and I think that in many respects poses a massive challenge because the amount of workforce that you would need, whether it be from the National Health Service or be it from the voluntary sector, would have to be immense in order to then pull it all together. I don't know whether we'll ever be able to say that, "Yes, we've got enough people in order to meet this demand," because whilst we constantly keep employing staff, but I think the number of patients also keeps going up. And I think before, what used to happen is… you know, it used to be an exception where you saw people using substances after a certain age. By 40s, 45 you would see that the whole lifestyle would kind of

change, but it's amazing now. We see people even in their 50s and 60s who are still going strong. So, I think that is, again... as I said, it's no longer a problem just within the working-age adults. I think it's become an issue even.' (CO9)

'I think for me, it's been a bit of an issue in that; we don't have an equitable service for women in Aneurin Bevan. I'll probably get shot down for saying it but... so, if you're a woman with a forensic history, who has also got a personality disorder, you might be on Bellevue and you'll get a lot of support. You then get discharged in to the community, have a bit of a wobbly; you need to come back in to hospital. If you are a male equivalent, we'll probably have you back on our rehab bed, because we try to keep a respite bed. But if you're a woman, that's not available, so you'll go to an acute ward, and the likelihood is, the stress of that will exacerbate your health, or you may not want to come back in. So, it's a resource thing as well.' (CO11)

'No, it's okay. So, I think rehab generally is not considered as much of a priority. My personal opinion in mental health, is that it should be. We tend to be crisis fighting a lot of the time. So, I look at my colleagues on the acute wards, and what they're dealing with, and I understand when we're talking about priorities, of course I understand we won't be seen as a priority. However, in terms of the longer term picture, we are an essential part of that wheel. So, I hope with the LSU Project, the rehab wards there, I'm hoping that will change. One of the things that I've also done... so, our open rehab wards, our criteria is anybody with a mental health diagnosis who has an offending history, but we do also take people from acute wards, so, non-forensic patients, and increasingly... it does vary, but increasingly on Ty Skirrid, the open ward, we have taken more patients from acute who aren't technically forensic. It's not to say they haven't got risks, they've just never been charged formally.' (CO11)

'The group of co-occurring that we're not helping are going to end up being a group that we don't have anything at the moment to help them with, because the CMHTs are set up to deal with schizophrenia, depression, bipolar. They're slowing getting there with personality disorder. Yes, slowly. What they're not set up to deal with is people who've had shitty childhoods with multiple traumas who started using substances to deal with their emotions when they were teenagers, therefore they fucked up their reward system in their brain... So, I think that's maybe what we're going to discover, that we have not so much a class of people with mental disorder as we define it currently. 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.' (CO13)

'In Newport, there is a well-defined set of groups such as the rough sleeper group and co-occurring groups, which links substance use, housing and police etc.' (CO16)

'The main crux of services is in Newport ...' (CO16)

'Some areas are better served than others financially and budget wise. We have one social worker for the whole of Blaenau Gwent for the whole of substance use. From a provider point of view we have good relationships, but when you compare Blaenau Gwent to Caerphilly, there is no comparison; there are more opportunities in Caerphilly and they have a bigger budget and more focus there on co-occurring conditions.' (CO17)

'There are few services for those with dual diagnosis, so provision is patchy across Gwent. In terms of carer or family support it really depends on the local authority. Monmouthshire, a key priority in their strategy is to support family members and carers so they put money into that. Newport, although they acknowledge this, they are so strapped for cash, thy have to prioritise their funds elsewhere. It does mean that is inequity of provision.' (CO22)

'I think the organisation needs to have an understanding that the way it has worked in the rural area is different than the central Newport. So, providing addiction service in Newport, for example, is different to providing addiction service in Monmouthshire or in Blaenau Gwent, or even Torfaen, but obviously we've got Monmouthshire and Blaenau Gwent, they're very clearly rural, more spread out areas. So, there is a different way of working. The second part is the nature of the patients. The nature of the patients are different. So, in Newport for example, they're more city, they can more easily walk to access to a service. From where they're living they can go to any substance misuse service by walking all through, even it was like an hour and a half or an hour for example. But in the North it doesn't work like that. It can cost them £8.00 to £12.00 just to come for an appointment…' (CO24)

'Buvidal, which seems to be a much easier substitute kind of drug which seems to be rolling out across the board at the minute and people can access very, very easily.' (CO28)

'I think it's also, you know, we don't have enough staff, ever. We're always fighting fire. So, to add something else in, something else you're asking staff to do, something else that you're asking them to take their time out, there has to be some recognition from those above that you either replace that time, or you expect us to do less because we physically can't do everything, or we don't do it very well and then there's absolutely no point in doing it. We either do an effective, efficient job that truly is the best for the individual, and you have content staff that can manage the risks that they're trying to deal with, some of which are immense, otherwise you've just got a failed service, poor outcomes.' (CO31)

Generally, how would you describe the identification and assessment process for Adults with Co-Occurring Conditions in Gwent e.g. are people identified early and continually assessed in a seamless partnership to meet changing needs?

'About three or four years ago we invested in a system called Lamplight. And that system records a participant's journey from start to finish. It also has a Warwick-Edinburgh for recovery built into it. … But also, it's got all the partners and interventions that's happened for the individual. So if you want to see one of our participants, we can take you from the day they started, all the way through to whether they finished or they're still with us or whatever, but also you can see every intervention from partnership agencies. … And the great thing is then that Lamplight also has a dialogue system built into it, so what intervention they had, and the result of that intervention is also recorded with the outcomes… S it is really comprehensive; it's just a great system.' (CO3)

'I mean speaking honestly, I know that Mind for example, if somebody came in and they even thought that they had drunk some alcohol or whatever, then they wouldn't be allowed to participate…We try to use an approach where we judge everybody as they come in on what

they're actually like, but then of course, where things can tip over the edge, if all of a sudden you can see that they are intoxicated, or very high on drugs or whatever, then of course it endangers the other group. So it's a fine balance, but the problem is, unless you try to do something, these people will just be going round in a circle constantly.' (CO3)

'The learning disabilities, it's very much under-represented. I think there's probably more than we actually know of, because there's a lot of people with learning disabilities that aren't, again, involved in any kind of services. From what I've spoken to from learning disability psychology leads that cover the areas, they haven't really got a handle of what they should be doing with people with a substance misuse problem, and it's around their training. Probably homeless population, there's a lot of people with underlying mental health issues and underlying learning disabilities.' (CO1)

'I would say certainly it's about… it's really strange, but if you look at the main social issues like housing and benefits, it all depends really on the personnel in those areas. I worked in Newport and we've had a really good relationship, and they're really supportive, and yet there's other areas where we work where we wouldn't have the same rapport, and I think DWP is a good one. In Newport for example, they've got a very strong team, and [Name redacted] in Pontypool who runs the team is really supportive of mental health. If you go further up the valley, Caerphilly for example, it's very difficult to go in and speak at the Job Centre, and we say to them now "we're here to help people who have issues; we can help with that." I think that it's still a lot to do with that people don't understand mental health. And you know, it's the usual type of thing, what people do is, or what we do is, to make all our staff understand about mental health, we put a mental health first aid course on. But there's a heck of a difference between going on a course and dealing with somebody who is experiencing crisis in front of you.' (CO3)

'You look at Kaleidoscope. There was a visit to Kaleidoscope many years ago, and next thing Kaleidoscope was being provisioned for Newport or whatever. The one advantage across Gwent is there's maybe a little bit more consistency across the patch as regards third sector, voluntary sector type care, because you've got the All GWENT Partnership as opposed to you used to have Kaleidoscope, Drug Aid, there used to be a whole load of different things across Gwent as regards third sector provisioning. I think the fact it's all come under one umbrella helps, although… Maybe it's not quite the same, not always the same with health. I think there may be a little bit of a difference in the way they work between north and south, but that's a bit anecdotal to be honest.' (CO4)

'We're constantly looking out for a spare bed on the ward. People who are going in for detox are placed on a mental health ward where people are in severe mental health situations, and I guess for people who are just going in for an alcohol detox that might be quite scary to be put on a ward where people are in psychosis, and quite off-putting as well. And I guess the experience there of detoxing perhaps aren't as experienced maybe? And also just the kind of care that follows on from that… So, I went to Cardiff and they have their own Detox Unit, and they basically do a psychology pre-group and then they go into detox with the same group of people that they did

the pre-group with through the detox and are able to come out of the detox and go into an after-care group with the same group of people. So, just that kind of continuity of care.' (CO5)

'Like we've got one [individual] that has got cardiac issues, physical health issues and needs to be seen by a specialist physical team but is refusing to stop his substance misuse and we're trying to help facilitate their appointments and help him to understand the importance of looking after his wellbeing, and the importance of looking after his physical wellbeing as well as his mental health. And you know they're very much, the two are quite entwined but he's – unwilling - I suppose is the right term to use, so you consider their period of abstinence from substance misuse to try and get it sorted and because he's so under the influence of substances – well he's ended up becoming floridly psychotic and admitted and detained as a result of it. And this is something that we see often, and we've tried and we've tried to get GSSMS involved, GDAS before that, but they don't attend appointments and then they get, you know their cases are closed and we've spent a lot of time trying to get people to recognise and develop motivation to change or just some insight but we can't sustain this, it's really difficult to sustain.' (CO6)

'I'm not sure about Monmouth if I'm honest with you again, but then I'm wondering if there's, not the need… because I'm not quite sure because I haven't been there that long and none of my service users have substance issues in Monmouth, but say in Blaenau Gwent there's quite similar services.' (CO6)

'We can't say "Well actually, we're not seeing you until you stop drinking" because they're often presenting with quite significant risks which will add to their cognitive impairment and that will need to be managed, and we have managed it, and we do try and will continue to.' (CO7)

'I'll give you a second example of a patient who was also in his forties. He was originally seen by the forensic team in the past, and to the point he... so, he was under the forensic team, had treatment, given a diagnosis of schizophrenia, given Olanzapine as an antipsychotic, but he needed to go to prison. Then after discharge from prison what we call the IRIS team found that he's too complex and preferred to be referred to GSSMS, and he was already on a methadone script of 60mg. So, GSSMS took it over and had a review with myself and one of the senior nurses at GSSMS. We referred him to CMHT on the basis of a background of the risk. He had residual psychotic symptoms and he was on oral tablets. We felt that he needed to be continued to be followed by mental health services. So, he was assessed by the CMHT, but he wasn't assessed by a senior clinician. So, he was assessed generally as a... a CTP assessment was completed. So, a senior clinician wasn't involved in terms of assessment. Maybe he was involved in the discussion, but as the outcome of the assessment they said they recognised that the patient has a past history of mental health, but the patient is stable. So, therefore he does not require secondary mental health services. So, he wasn't engaged. And to advise the GP to continue prescribing the Olanzapine. So, obviously we kept the patient on our caseload as part of GSSMS, but an incident happened. Part of his condition that he had residual psychotic symptoms in the nature of having voices and having fears that some individuals may harm his children, and obviously we were quite new in knowing this patient. So, actually he didn't fully open up, but he was very pleasant,

fairly stable I have to say, nothing intimidating or anything, but he did say that, "I have those voices." But, obviously within one session you don't expect for the patient to fully open up, but he did express that he had the residual symptoms. So, apparently what I have understood is that the patient went out, took some amphetamine, symptoms obviously got worse. I don't know actually what was fully the symptoms, but he went to the accommodation where his children were living and he was holding a knife, and our expectation is possibly holding that knife is to protect his children from the delusional beliefs.' (CO24)

'To them it's just bizarre behaviour and they don't know what to attribute it to. But because they're not healthcare professionals, our services in the NHS are designed such that we wouldn't accept a referral for them. So, they would need them to get that tenant to go… well, first of all to register with a local GP because often homeless people are not registered with GPs. So, to register and then to show the motivation and willingness to attend the GP and say, "I'm struggling with this" and then the GP to refer onto us. So, it's kind of loads of hoops and some of them aren't very reasonable for people in that situation. So, I think it will be really useful just to have somebody there, just to have eyes on and say "This person definitely needs a referral for a further assessment." Or "this person doesn't". So, a lot of signposting as well.' (CO29)

'So, we are separate. You've got the CMHT and you've got GSSMS which are in a separate building. We don't have much to do with them as such, but what I will say is that whenever we have a referral come in… well, it's quite difficult. When we have referrals come in for GSSMS pre-COVID, we would often ask them to join us for a joint assessment. But obviously that's changed a lot now because we do mainly telephone assessments, so it's not so easy to do them jointly. So, I think that has really impacted on our ability to tap in to information from their side that we would benefit from.' (CO29)

[Are you aware of any planning that's going on to try and deal with that, to try and improve that?] *'At the moment… I would say probably before last week we were working towards bringing people in again for assessments that we felt needed to be face-to-face, which felt like a step in the right direction. What I will say, I'm a big advocate to say actually, a lot of these assessments could be done on the phone, which is quite a positive thing to come out of COVID. But for ones that you feel that you need to see them because sometimes you get a lot of information, those visuals give you so much information about a person and obviously you're able to link it to other services to ask them to come in as well then. That's where you might contact the forensic team and say, "can you do this joint assessment with us?" GSSMS, "could you do this joint assessment with us?" We had a bit more flexibility but I guess depending on the next few weeks, we'll decide whether we lose that flexibility or not. But I will say that pre-COVID, I felt that we were accessing these services as and when we had the opportunity.' (CO29)*

'Because at the moment there's a discussion around the assertive outreach team. So, at the moment, our assertive outreach team is separate from the CMHT so it sits outside of that and it's not very inclusive. But in England and a lot of other health boards, they've reintegrated their ALT model, but back in to the CMHT but still kind of held under the key principles of what the model is. But it sits within the CMHT, so it feels a little bit more inclusive. So, I feel that perhaps if we

had more… for examples if GSSMS were more linked to here, and then went between the two bases, there's probably going to be more knowledge shared and more expertise shared, skills, all that sort of stuff would only benefit the service if you see what I mean.' (CO29)

Are there any clear pathways for those with Co-Occurring Conditions to move between services in an appropriate manner? (Consider pathways across the whole spectrum – from those with low threshold/multiple needs through to those with high threshold/multiple needs). What about transition issues (between C&YP services to adult services AND adult to older adult services)?

'My issue is that as soon as… If someone's got… Psychiatrists may disagree with this. If a patient has got a serious mental health problem, and they've got substance misuse, they're very… They tend to blame their mental health on their substance misuse not particularly on the fact they may have got onto substances to control their mental illness. It does blow a bit hot and cold and some consultants are better than others, but I think there is a certain frustration from my point of view, and I know from fellow GPs, as soon as someone's got a substance misuse problem and mental health, that really it's the substance misuse that seems to be the primary problem that needs to be addressed, and the psychiatrist will therefore refer them on to GSSMS to sort out…Because I know the system, it's pointless referring them to a psychiatrist. If they've got serious mental ill health with a substance abuse problem, I would go to GSSMS, but that's because I know the system. I think there's a lot of GPs and other health care professionals within primary care that would most probably say, "Over to GDAS, go and self-present to GDAS who will refer to GSSMS." I don't think… There's not many… I don't think there's a great understanding from a lot of my primary care colleagues with regard who is the best place for these patients to go to. They would, by default, just tell them. "Go down to GDAS, self-present," or, if they were very worried about their mental state, they may refer them on to the psychiatrist of course who would then… The CMH team would basically just bounce them back to their GP, and then they would have to go in to GSSMS. I don't think there's any clear… I feel amongst my general colleagues, there's no general understanding about where the patient should be referred to.' (CO4)

'So, I mean, going round to different services and talking about the [Co-occurring Conditions] Panel, so the professionals are really keen and on board with the idea of this service that can help people with those co-occurring mental health and substance use issues, but we're finding that people aren't actually making those referrals as such… And, it's what the barriers are to them making the referrals, and I guess that something that we've thought about is maybe that the referral forms are too long, and if we can overcome those issues, or they're just too busy…' (CO5)

'Yes. I mean in terms of their mental health needs, it's very clear that they would access the older adult mental health service and if there are cognitive symptoms, they would access our memory service that is embedded in our older adult mental health services. … So, the substance misuse service is supposedly age blind and so, we should be able to access an opinion from them. We have managed to, I think, most of the time.' (CO7)

'The biggest barrier is around access isn't it? It's about actually considering the issues that those people will bring. The level of access is totally limited, so in terms of… you know, if I think about it, it's like trying to, you know, the actual door to those places… it's very, very difficult to get in.

So, from our point of view in substance misuse, so I've worked here a long time, so just one thing that changed, that then decreased that access. So access is worse now than it's been previously, where even though we've tried to put in things to make access better, there have been changes to policy and decisions made on the basis of changes to policy that has made access worse. So, we used to have a system with GSSMS where if a person had a diagnosis of a mental health, of severe and enduring mental health issues. So they've only ever existed for those people with severe and enduring mental health issues and not people with lower level anxiety and depression issues. But the criteria at one point was that if somebody had a diagnosis regardless of whether they were receiving treatment from primary mental health services or secondary mental health services, as long as they had a diagnosis, we would then be able to refer them into GSSMS for specialist treatment, and then GSSMS would liaise with their other partners in Mental Health Services to get that mental health dual diagnosis happening. Then something came in that we were told about that I really, really don't understand and I've never understood, called the Mental Health Measure, and the Mental Health Measure meant there was a fundamental change in policy by GSSMS which meant that it didn't matter if somebody had a severe and enduring mental health issue, and it didn't matter if somebody was mentally unwell, because of that to be an enduring mental health issue, if they weren't receiving support from primary mental health services, we could not refer them to GSSMS.' (CO8)

'So, that was a fundamental change. Now, so that what it meant is that GDAS would be left with people who were diagnosed with severe and enduring mental health issues who could or could not be mentally unwell at that time, and in order for us to get them into the only specialist mental health and co-occurring system that exists in Gwent, we had to first get them into the mental health system. Not the drugs system, the mental health system, which for us was sometimes completely impossible. Because that mental health system has a system of, I don't know, 'two appointments missed and you were discharged', a benchmark of 'no, this is just about drugs', 'the alcohol issue is not a drug... not a mental health issue', 'you have to do the work around the drug or alcohol issue before we will see them'. So, we ended up left with some pretty ill people who we couldn't get into the services that were there for their illness. And our response to that and the general response to that has been to put in the COG Panel and to put in a mental health nurse, our side, to try... and all those things are there to exist. Those things exist to get those people into the services that exist for their benefit. So we've had to put in substantial investment just to get people through the front door of the services that exist for their benefit.' (CO8)

'I'd like to say that if anything general adult services are, I think, still the only service that really don't have any inclusion or exclusion criteria. So, if we receive a referral from our GPs or primary care colleagues or substance misuse, probation, criminal justice system, wherever, it can be any source, obviously it's then screened and if we feel that there is something that we can provide for this patient, then we'll definitely offer an appointment. And if not, at least we... you know, whether we take them on into our service or not is a different matter, but we'll definitely assess it to understand what the needs are.' (CO9)

'I think there is a lot of duplication, gaps in the system where it is quite disjointed at times, people are presenting to hospital in crisis in terms of their substance use but there are not being seen for

their mental health. So, there is not a streamline for co-occurring individuals. I wouldn't say there was a clear pathway.' (CO17)

'Breakdown in communication… collectively from Blaenau Gwent view, we need to have more equitable services. If we had a team, whatever that would look like, then everyone would have an equal service no matter where you are in Gwent.' (CO17)

'There is sometimes difficulty from mental health professionals in terms of supporting people. This is due to the substances they are using, and the assessing them correctly, to a degree. It seems that it is difficult for mental health professionals to fully assess someone who is using substances and properly treat that. Sometimes they need to address the [SU] issue before their mental health is looked at. That is not always the case but I have experienced that with clients.' (CO18)

'We do have a policy and pathway we are trying to develop with adult services and commissioners. Not many young people want to transition to adult services… they have the choice, but young people don't want it. But we have an understanding with commissioners, that we can keep people over the 18th birthday, but this is a case by case scenario. Very specific to their needs.' (CO20)

'Pathways are working well… joint adult allocation meeting and we can take the young person to this meeting in terms of transition- ideally we will get a name to contact to help us with the transition, this meeting is the key to a smooth transition. Ideally, we have three shared appointment with adults services until an agreed time when adult services would take over.' (CO20)

'The biggest challenge for us is the difference between the children's framework and the adult framework. There is a tight safeguarding framework for those under 18 … what we consider as a safeguarding concern when they are under 18 when cannot do that when they turn 18. We can't do that after the 18th birthday. This makes us uneasy in terms of supporting young people after 18. This makes me uneasy, it feels really unprofessional as a practitioner and challenging. We don't have the connections with adult services or local authorities, and this makes the process difficult conflict.' (CO20)

'So, to register and then to show the motivation and willingness to attend the GP and say, "I'm struggling with this" and then the GP to refer onto us. So, it's kind of loads of hoops and some of them aren't very reasonable for people in that situation. So, I think it will be really useful just to have somebody there, just to have eyes on and say "This person definitely needs a referral for a further assessment." Or "this person doesn't". So, a lot of signposting as well.' (CO26)

[anything else we need to say about the pilot] *'I'd like to think that we could prove that this is the missing link in the chain, maybe, and evidence that by working together we can create a better, less bureaucratic form of intervention. I hate that word, but for a person, support. We can support a person through a really bad time in their lives together without having to navigate that, let's be fair, horrific course of boundaries and eligibility criteria and levels and everything else that to us are barriers… the ultimate goal, I suppose, is a) to stop people coming through that*

door, the revolving door point of view, and b) the additional benefits that this hub will bring will hopefully allow people, not just to move on and be okay, but I think if these, for example, say somebody has gone through some trauma when they were young, by having all this mental health support whilst the problems that are occurring in terms of the housing will give them that boost, I suppose, to put it to the back of their minds and just keep developing and developing as opposed to doing just enough.' (CO28)

'So, when I get a referral, generally they're from the GP. So, if I look at that referral and I think, "Actually, that individual needs substance misuse services," I don't ever just say, "Back to referrer." I write a letter. So, I'll write a letter back to the GP and say, "I've screened the referral and, based on what you're telling me, I don't think we would be able to do an effective assessment or any long-term intervention. I would suggest you speak to the individual about being referred to GDAS or GSSMS." So, obviously GDAS is our first port of call, and then if it's more complex, so mental health problems, child protection stuff, physical health problems, they go to GSSMS. So, that I would do. I would never just not suggest that, if that makes sense. I would never just think, "That's not for us." I still would imagine that there are individuals that won't be picked up by either service, but I would say that's probably less and less, because GDAS take self-referrals. So, if someone... We're a secondary care mental health team, so we need more of an official referral route, but with GDAS I would have thought that, if you're motivated, you could make contact and you would have some type of assessment/intervention group work.' (CO31)

'Often, I think if you're not going to take a referral, or you're going to signpost it, like you say, it's all about communication. Because the number of times, if somebody just explains to me in person why that doesn't meet their criteria, or they don't think it's suitable, or I do that in return, you end up with just such a better outcome because the referrer really gets it, rather than passing it back to the individual and saying, "So, I referred you to the CMHT, but they've come back and said it's inappropriate, but I'm clueless." It just doesn't help them because it's making them feel like they're not wanted. "Well, the CMHT didn't want me, you're saying you don't want me." That's how people internalise it. That's of course not what we're saying. So, I think if someone then went back to them and said, "Well, first off we just need to do a little bit of work, get your alcohol down to however many units a week, then we could keep a mood diary and we could really take a look at what it is you're experiencing," and those type of outcomes, I think, are much better for the person, and people know where they're at. You know what you're working towards.' (CO31)

Are there any specific groups that are particularly excluded from services?

'It's become very clear that that is a gap, more so since the secondment started. Mental health acute inpatient units are where we try to do these treatments, but we can't book beds. We don't have any access to beds unless there is not a mental health need. A mental health admission will always trump drug or alcohol planned admissions every time…which is very frustrating for the patient. Only two weeks ago, we had a patient prepped and ready for detox. The bed was identified, approved by the ward; they want to be able to provide the service. The morning came for that admission and there wasn't a bed available. That happens pretty much across Gwent. We've got the five areas in substance misuse, and my secondment covers those five. I had two

admissions that week, with a potential third, and we couldn't get a bed for any of them at the time we'd planned, so we had to let patients know that.' (CO15)

'That's a hard one. However, addressing stigma around mental health, there is a slight danger that people misunderstand mental illness and wellbeing. So, some people think they need a psychiatric service when in fact its more to do with their wellbeing. Whilst that addressing stigma has been great it has created another set of problems in terms of capacity. It is great to raise awareness and talk about wellbeing, but there is a clear distinction between someone who is dealing with normal life events and someone who is dealing with a mental illness, I think we are in that in-between phase of what those boundaries are. Some people are looking for a psychiatric intervention when it is not required.' (CO22)

'The problem is, trying to get them… because unfortunately, everything becomes process-led. So… and it's kind of, "what's your pathway for this?" do you see what I mean? And what you're asking is more of a fluid process whereby you kind of give a lot of leeway to people because you understand that when they're in… when they're chaotic, they're not going to perhaps be as on-point as what we expect… If you book an appointment with your GP and you turn up an hour late, and you don't get seen, you understand it's because you're late, whereas they probably had something going on or forgot the appointment and the problem is then, they get quite irate and next thing you know, they get banned from the GP practice because they were abusive to the reception staff. You can see where it goes and I used to see these people on PICU all the time and it was about, "how can you manage when you're distressed, how can you manage when things aren't going your way, because life doesn't always go your way?"' (CO29)

'So, the wards are always so quick to discharge people as well, because obviously I guess COVID, pre-COVID, bed availability is always something we struggle with in the Health Board. So, there's always a rush to try and get people discharged and then it's kind of like, have they got capacity to make an unwise choice to take drugs? If they have then I guess we can't keep them in hospital and that's their choice. If they don't want to self-refer, that's their choice. In some respects I like the idea of trying to make them make decisions and put the responsibility on them. But the downside of it is, sometimes they do need to be… like I said, hold their hand to help them get there, to realise, "actually, I can address this".' (CO29)

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.

'So, from a clinical experience, there would be, for instance, because people have got a substance misuse problem, the mental health services will say, "You need to address that first, and go to GDAS or whatever third sector agency is the gateway into services." It's the fact that it's that self-referral kind of thing, and I guess urban myth that you can't refer people into services, and it's

that client group that we're dealing with. Probably not always going to be the best at engaging, and I think I mentioned before, one of the big barriers to engaging into services is about people's mental health. This is especially things like alcohol. It's a depressant. They're going to become more depressed, and the likelihood that they're going to have the motivation to engage in services isn't apparent. So, to be signposted doesn't work. Then, if they do get referred into secondary mental health services, it's very much like, "Well, you need to go and address this first, rather than it being addressed collaboratively.'" (CO1)

'Because I know the system, it's pointless referring them to a psychiatrist. If they've got serious mental ill health with a substance abuse problem, I would go to GSSMS, but that's because I know the system. I think there's a lot of GPs and other health care professionals within primary care that would most probably say, "Over to GDAS, go and self-present to GDAS who will refer to GSSMS." I don't think… There's not many… I don't think there's a great understanding from a lot of my primary care colleagues with regard who is the best place for these patients to go to. They would, by default, just tell them. "Go down to GDAS, self-present," or, if they were very worried about their mental state, they may refer them on to the psychiatrist of course who would then… The CMH team would basically just bounce them back to their GP, and then they would have to go in to GSSMS. I don't think there's any clear… I feel amongst my general colleagues, there's no general understanding about where the patient should be referred to.' (CO4)

'I suppose the biggest barrier is around access isn't it? It's about actually considering the issues that those people will bring. The level of access is totally limited, so in terms of... you know, if I think about it, it's like trying to, you know, the actual door to those places… it's very, very difficult to get in. So, from our point of view in substance misuse, so I've worked here a long time, so just one thing that changed, that then decreased that access. So access is worse now than it's been previously, where even though we've tried to put in things to make access better, there have been changes to policy and decisions made on the basis of changes to policy that has made access worse. (CO8)

The introduction of the Mental Health (2010) Wales Measure was cited by one interviewee 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 let to a 'fundamental' change in policy of GSSMS, which meant that - regardless of an enduring mental health issue - if clients weren't 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.

'So, that was a fundamental change. Now, so that what it meant is that GDAS would be left with people who were diagnosed with severe and enduring mental health issues who could or could not be mentally unwell at that time, and in order for us to get them into the only specialist mental health and co-occurring system that exists in Gwent, we had to first get them into the mental health system. Not the drugs system, the mental health system, which for us was sometimes completely impossible. Because that mental health system has a system of, I don't know, 'two appointments missed and you were discharged', a benchmark of 'no, this is just about drugs', 'the

alcohol issue is not a drug... not a mental health issue', 'you have to do the work around the drug or alcohol issue before we will see them'. So, we ended up left with some pretty ill people who we couldn't get into the services that were there for their illness. And our response to that and the general response to that has been to put in the COG Panel and to put in a mental health nurse, our side, to try... and all those things are there to exist. Those things exist to get those people into the services that exist for their benefit. So we've had to put in substantial investment just to get people through the front door of the services that exist for their benefit.' (CO8)

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.

'Yes, and I think the population… probably Newport and Caerphilly are fairly similar. Those are our largest populations. It is around somewhere like Monmouthshire, that people tend to be maybe more isolated because often their extended family… people have retired to Monmouthshire or the younger members of their family have moved away. And so older people tend to be more isolated in somewhere like Monmouthshire. Issues around Blaenau Gwent are that we seem to have – and I think this is common amongst a number of different health conditions, is that we have… people tend to present quite late. So people that we might see in our memory services are often more cognitively impaired.' (CO7)

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, in my view, always been extremely difficult for people with substance misuse to access, always. I think because there is this idea, and it still exists, and it will always exist, that the issue is their substance misuse and not their mental health. Even though when you look back through people's history, for a lot of the people I've worked with there will be a history of ADHD prescribed in their childhood. There will be a history of Diazepam prescribed in their childhood. There will be a history of psychological services being put in when they were very young. So, you know, these things existed before... so even where that history exists there's still that myth, and I think it's a myth, that you have to go away and sort out your drug use before you can... Because the level of self-prescribing around mental health issues is huge, you know. People suffer from anxiety, people suffer from panic, people suffer from schizophrenia, do lots of things to dampen... You know, so that is the one thing. The other thing is the system that says "you have to attend this appointment at this time". "If you miss this appointment…", or "if you don't answer this letter", or "if you don't..." – they'll drop out of the treatment. You know, there

is no Assertive Outreach element to any of these mental health services for people who are really chaotic. (CO8)

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 would say. Within GDAS obviously we have a Co-Occurring Nurse that advises us, and we have the COG Panel and the Bridging the Gap Project which is a very new thing really. Yeah, and that's sort of arisen really around the lack of services or the lack the access. That is supposed to be a kind of gateway, a bridge between. So, within GDAS those two things exist. Then you've got the Gwent Specialist Substance Misuse Service which is supposed to be the prescribing service for people with co-occurring issues, and then you have a smattering of small projects I suppose; things like Growing Spaces, that are not projects that exist solely for that purpose but are projects, and Mind who will take referrals from us and offer support to people who we refer.' So, I suppose there are those things, and things are set up in GDAS specifically for our clients who have co-occurring issues. Then there are actual services set up, and the only one I can think of is the Gwent Specialist Substance Misuse Service that is there; and then there are services for people with mental health issues that will take referrals from services where they are working with people with substance misuse. Sometimes that can be limited, but there are several services, Mind and some of those have taken a little bit of persuading and pushing. At one time they wouldn't take referrals from us and now they do. But they will take the referrals, but it is quite a patchy thing.' (CO8)

Multi-disciplinary and partnership working

How well do services currently work together, in terms of joint assessment, joint care-planning and joint review?

'So I think there's still a deficiency there. I think the decision on whether something should be funded along the lines of a complex co-occurring service, or alcohol and drugs, or alcohol and mental health, I don't know the answer to that. We've set up the service the way we have just to try and be as pragmatic as we can, and fill in the gaps as much as we can… The bottom line is, is that there isn't the resource to be able to meet the demand that's out there… And this is the NHS in a nutshell really, and social care. We've spent so much of our time dividing pathways, is due to the fact we've got huge waiting times. If you had additional resource, you wouldn't have to spend so much time and you could get on and actually see a lot of people.' (CO2)

'I think the hub-based service is mainly going to be for telephone calls. I think what we still really need is a service that enables more joined up working, and I can see how maybe even our nurses who've really not worked in substance misuse… so they feel, "Oh, you know, I really don't know what to do with this patient, because I've never dealt with these kind of problems. It's best if the CPN from the substance misuse service is involved." And I think what really would be nice is if there was more joined up working so that each of the staff learn from each other and hence can help their patients, and how…' (CO9)

[How would you describe that change within the team?] *'Initially it was like sort of a bit frowned upon, because I am working in a different way. And then they were saying "you seem quite isolated," because there's me as a CPN, and then I have a healthcare support worker. And normally I would be based primarily at Gold Tops, but then I've been off at places to work out within the third sector GDAS, and if I need a computer I can always pop then to Salvation Army; they've been fantastic. And GSSMS, I've got clinics out there. So within the team I don't really see them actually, because if you're based at Gold Tops, you're based at Gold Tops.' (CO23)*

'So, I had a patient, for example, who was in mid-fifties. He was complaining of delusions of infestation in his skin, and was detained and discharged, and obviously he's not engaging within the team. After he was discharged from the detention, he was sent in the community, did not engage with the team, as the nature, and from there he was discharged from services, which is the mental health services. Then he came back again, and he was then detained, and he was detained under Section and then got discharged and the expectation is for that patient to engage. Obviously the diagnosis was given that he had a drug induced psychosis. The term drug induced psychosis doesn't formally exist in ICD10, but that was kind of the impression that everybody around within the mental health team had the impression of. So, GSSMS started working with this patient, and this was in 2018 and I was in higher training at that time. So, GSSMS was working with the CMHT to convince the patient that the patient was actually not well and would require mental health input. Then the patient lately... I mean he was given oral antipsychotics. The patient less likely will take those oral antipsychotics because of the nature of the chaoticness, and then he was lately then put on a depot injection. For our side we needed to prescribe this patient, which is the buprenorphine. We were very flexible in the way of prescribing. As you know, with prescribing buprenorphine it has to be daily supervised. With this chap we took a bit more flexibility about how we dispensed. Then from there, as we were being flexible in the prescribing, we were able to engage the patient in terms of the nature how we were dispensing and ultimately we were able to put this patient on Buvidal, which he finds great. The overall process that I was just talking about, it took two years for this to happen. So, I was an ST5, so it was two years before I started this post, and by now the patient is fairly stable and is on Buvidal injections. So, you can see how much it can take for patients to be recognised from mental health services, and this is not critical about them, but it is more obviously that's the perception from their side.' (CO24)

'And I guess the other shift from a workforce perspective that you say in terms of making this everybody's business, I guess how we try and move towards some of system-wide leadership as well. So not just around that side of working within individual services or within individual organisations. And I think there was an experience very recently for me that made me realise we've still got a long way to go with that and I just observed it to myself. It didn't need naming. So people will talk about there's pretty strong relationships between statutory agencies and third sector within Gwent and they seem to... I take that for face value and they do seem to do a lot together. But there was just an example when we were trying to think through the Housing First initiative that we've been involved with. So we were trying to work out, so what is the wraparound support we need from substance misuse and mental health to enable that to really flourish? And what played out in a very polite way, but was statutory agencies, the health board; colleagues in

the health board and GDAS both trying to take their position and I thought it was really interesting. So we ended up… the money was there so I didn't worry about it too much, but basically we ended up putting in roles that were very similar from both organisations because neither would say, actually you're the best to do that. Or you do that here and we'll do this bit. It was really quite interesting.' (CO25)

'I mean I think in some of our areas where we've had clinics that are running in the same areas, I mean I guess we've had links where people have gone into the inpatient services where they may run clinics in some of our CMHT bases, so some of those, and the clear joined up where it is clearly for both services, it works really, really well. But it is that grey area one is that it can be really difficult for teams to associate where that person may be or where they may sit and I think that is still a challenge for us and I don't know…' (CO27)

'I've had a conversation with the directorate manager not that long ago about is there ways that we could – of linking into the CMHTs better and having, I don't know, for the want of a better word, a substance misuse worker within each CMHT so that they form part of those clinical discussions and those clinical conversations in MDT meetings, in day-to-day corridor conversations where they can advise and support everyone within that caseload. But that covers one end of it. Because we've also got a huge amount of people who would not meet the criteria under part two of the mental health measure to be received into a secondary mental health service, but they may have a need that could be dealt with at a primary care level, but there's no access to that. Primary care mental health services do not have specialist substance misuse or alcohol workers, they are fairly generic. It's almost like you can fill one gap but there's a void somewhere else. I don't know but the conversation needs to be with all really. Often GPs will refer – from a GP's perspective, if someone's got a mental health problem, they just refer to mental health, they're not interested whether it's primary, secondary, tertiary, do you know what I mean?' (CO27)

'It's almost like a one-stop shop thing isn't it, if you like, is that down in Lower Dock Street, our team down there where they've got the needle exchange, things like that, and they started doing dressing clinics there and [unclear name(s) - 39:05] has [have] done a real… a lot of good work there, but then it fringed on, well actually some of this stuff is really complex, the physical healthcare stuff, but you've not really got anyone from the physical side that would come and sit at Lower Dock Street, when maybe they should? We had some conversations about it. I mean Lower Dock Street in Newport, it's a perfect location for service users but it's a grotty building. And I guess the cultural thing sits both ways because then, when we talked about maybe it would be really good to share a base with the CMHT and Primary Care in the same building and by then that cultural thing came from the other direction, we thought well I'm not sure our service users will want to come to a place like this and would they want to come to a new building? Would they want to come and you're thinking, "Oh I don't know?" You'd think it would be better to have access to all the other services but also when you start having that stigma bit about somebody, they may need a separate entrance.' (CO27)

'Yeah and I think as a team we've probably pushed them into doing that without necessarily realising how far Pandora's box can go. Because as a team we've always been very adamant that there is no point just doing the bare minimum, doing the housing support and then saying "Everything is done, goodbye" because unless you dig a little deeper and get down to the actual root of the problem, whether that's somebody's mental health that's causing the housing problems or somebody's learning disability that's causing the housing problems or somebody's ACEs from when they were a child, and it all comes in, all ties in to PIE and TIA. So I think one of the things that I've definitely realised from pushing providers to open Pandora's box is that there is that... they are scared, like [Name] said, and now getting these staff in place in terms of the hub will help them explore Pandora's box further and not only explore it, hopefully come up with viable answers to help those clients not have to go through services like this ever again, but also it expands the staff's knowledge, techniques, et cetera where at some point hopefully, maybe some of the staff in the hub won't be needed at some point in the distant future because the staffing that we've already got will have developed those techniques. So, I think that's what it's about from us in terms of the staffing.' (CO28)

[Barriers to access I think isn't it?] *'We had a young lady in a young person's supported accommodation project, ligaturing constantly. In our view, that's a mental health issue. We took her to the services, they're all adamant it's behaviour. "No, it's behaviour. Her dad wouldn't talk to her, she's just kicking off. It's nothing to do with mental health" and yet time and time and time again, she was trying to kill herself with anything and everything. Mobile phone, the earphones, it was scary and I suppose that was a turning point for me. We met with AOT, Assertive Outreach Team, we met with CMHT, we met with like health sort of provisions in terms of Home Treatment Teams and stuff because me and Rhod we were just banging our heads against the wall really weren't we? ...And we were saying "What are we missing here? Why are these people, in our opinion, in our assumption, falling between the cracks? Is there not the correct service out there? Are we referring to the wrong people? What are we doing wrong?" So, I think that was the starting point really. The conclusion was that there are services out there but we are not accessing them at the correct point in time. They're overstretched. They're only dealing with high level eligibility. There's probably a better word to use than that.' (CO28)*

'Yeah, okay so basically somebody would be assessed through our homelessness department and then they would be allocated basically a placement in one of our emergency temporary accommodation provisions. When they go there, basically there's housing support staff there twenty-four-seven. So, they would initially be allocated a key worker, so that would be their sort of go-to person but there are other people on site and around that they can go to at any time. Lots of workshops and stuff going on, but they would have a key worker and they would be the person that maybe they would see more often or they would build a lot more of a rapport and a relationship with. So that's the housing support staff. So by adding the triage or hub staff into that building, we will be adding an assistant psychologist, a counselling psychologist trainee, a community psychiatric nurse and we also factored in some registered management time as well, so somebody that would be able to oversee those three posts, link them all together, make sure that we are doing what we want to do and achieving what we want to achieve, but more

importantly be a safety net or a clinical supervisory role for those individuals, especially now with COVID when we're working more in a virtual sort of manner rather than kind of face-to-face, so we did factor that in and I think a lot of people didn't and I think, so far we've seen that that role is going to be key.' (CO28)

'We have worked a lot with Care Aims. I'm not sure if you're familiar with Care Aims, which is looking at what the patient needs and how we can provide that for them without creating too many barriers, and also making sure that we're not being restricted in terms of intervention. But also making sure that we're offering it at a time that people are ready to accept it, because that is sometimes the biggest issue. We can see what needs fixing but sometimes, people aren't in a committed stage to fix. So, it's how do we manage that period, until that person says, "I am ready to change" and then making sure that you've got the services available to capture them when they're ready, rather than wait and then you miss that opportunity. Things like that.' (CO29)

'I think we've got quite a good relationship with GSSMS. I know that I can email the consultant or a couple of the nurses down there, and I would like to think... Well, I know vice-versa, because I know the consultant down there emails be about things. So, I think that's a positive. We do have a link nurse. We set that up many years ago. They used to come to MDT maybe once a month to discuss cases, and just over time that hasn't happened. I think it could be... It's difficult, because some weeks it could be really helpful, and other weeks it was an hour from their time that actually could probably be best used elsewhere, because we didn't have anything really complex to talk about. We could have done it over an email or a phone call. But it definitely makes a difference having a face to a name. So, rather than just flinging off emails, which we all can do very well, it's nice to talk to people, isn't it? It goes back to the basics of what we're about.' (CO29)

Can you identify successful partnerships that have worked well in Gwent around Co-Occurring Conditions?

'I just think it's the climate that we're operating in and they're pretty good actually. I think we're quite lucky, they're pretty good. I'm quite interested in how this project is going to go because they seem more assertive. I think they need, I just think there needs to be some sort of, I don't know, flexibility isn't it? I don't know, it's how you engage them, like in our Service we spend a lot of time that we're extremely flexible, you know early intervention work that's what we do, we will continue above and beyond then what a CMHT would do in engaging a young person, if they don't engage we just keep going and going and going, and I feel like there's the service need there for substance misuse services that almost, I don't know if that's the right thing or would that be a waste of resource, I don't know.' (CO6)

'Connection with other services is good, generally good working relationships with partners in health, and in social services. Frustrations include that the responsiveness is not always there. There is a new pathway which has not been signed off. With people who are a suicide risk, if they are intoxicated, sometimes thy will not be assessed. Two years ago it was a big issue and the

police officer was stuck. The crisis team would not assess due to alcohol intake. We would have to, almost, babysitting someone as they can't leave the person, but the crisis team would not assess them. We have slightly moved on and we are working with partners to get people assessed. But now we can take people to be assessed and the crisis team are using professional discretion. The crisis team are not just turning people away if they have had a drink, they are looking at this more on a case by case basis. There is a new backstop now where we can take people to A&E.' (CO21)

'So with GSSMS they work in one particular way; you know COVID's hit, and they're still quite restrictive within the way they work. I find them… it breeds that sort of… breeds error, or not meeting the patient's needs. And part of my role I thought was: we've come in, GSSMS and GDAS have started working collaboratively, which is something that kind of was a get together between everybody, and then we hit those boundaries and limitations between either service. And then by setting up these clinics together, and me being a part of that, I was able to smooth the transition between. It does work much quicker, especially for our co-occurring group and our homelessness guys. So whereas they would normally – one assessment and then they might not rock up for the treatment. And then a letter would be sent out, and sometimes it wouldn't get to the patient; we are very much outreach.' (CO23)

'So the concept of the psychological wellbeing practitioner is we want them to be embedded as part of the primary care MDT. So at the moment a lot of their work will probably need to be virtual. We were hoping they would be based in GP surgeries or community hubs close to people's homes. It'll need to be a mixture now I think as we move forward. But I'm really keen to make sure that those practitioners… our model is that they're able to have a really good conversation with somebody about their wellbeing and their mental health and really doing a really decent sort of biopsychosocial assessment and formulation with the individual and help plan with the individual around what are their goals and how do we support them to start taking some actions in relation to those things. So within there for me, absolutely we need to be able to have an awareness and be able to have conversations with people around substance misuse. And it may then be facilitating somebody into specialist substance misuse support through GDAS. It might be some other route for the individual. But really making sure that those wellbeing practitioners can do that.' (CO25)

'I think it's a good start employing somebody [New CPN] *because I think what we see is that there is somebody that can work across both teams. But I'd say we probably need to work even more closely again, because I would say that as a CMHT, we don't have enough information around the impact on substances. That information sits within the drug service. That's their skillset and knowledge. But I think we're working with people that… a high proportion of the caseload has substance misuse issues, whether it be drugs, alcohol or whatnot. So, I think there would be a way forward, probably more of an MDT; that would involve the drug service, perhaps training and stuff like that as well.' (CO29)*

[What would you lose if Darren's post goes?] *'I think we just become detached again. We just become two services that will try and work together where possible, but it will be on "what help*

can you give me", so they only contact us when they've got somebody that they're worried about mental health problem-wise, and we only contact them when we've got an issue with substances that we want to help with. But I think when you've got that constant communication, there's a lot of conversations that go on, that actually are really beneficial, that you miss.' (CO29)

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-Occuring 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 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.

'Our services is co-located with the mental health services with cross-token, cross-refer. They go to the joint allocation meeting which is the meeting with the community, which is the IAPP Funded Service, every Monday to talk about which patient should be in which service. And so, we work very closely with GSSMS, which is the NHS funded substance misuse service. We also have a pathway group for Gwent where we put that together as a health service and that's chaired by public health, and we bring together GDAS, GSSMS, ED primary care. We bring in people like Pobl and other third sector charities, homelessness charities, women's refuges; all these different things, all these different interactions and links we need to have, are sort of brought into that sort of brainwork… We try to link up quite nicely, so the reason why I think you're right, I think services should be targeting needs of the patient. But the reason we've done it this way is that we recognised there was a huge problem; the mental health services don't come in often enough to the wards because they haven't got the resource to be able to do that, and also, when people have got health-related problems they say "oh well, the health problems need to be sorted out first." We can sort out the health problems whilst dealing with the addiction issues concurrently.' (CO2)

'The GDPR rules you know, I mean when we work in a consortium we have GDPR agreements, but then there's so much… I would say at the moment, especially with sharing information, and I'm talking every organisation, Statutory and Third Sector, you're almost worried about what you can share… GDPR is a very complex system; it's a very complex document, and if you read it, you've got to have a degree in GDPR to understand it.' (CO3)

'The integration thing, I have some reservations about because within our own service we take individuals with a substance misuse problem who have an additional health complexity, and I would say we are 50:50 physical health and mental health. So, a lot of the people that come to us come to us because they've got COPD and they haven't got a mental health problem. So, to integrate us in with mental health services then doesn't fit with that side of things. So, I don't think it's a full integration thing. I think what we do that makes it quite difficult is, we put barriers in terms of appointments that they have to go to and where those appointments are and the fact that they have to start from scratch each time giving their history. And that lack of acknowledgement that actually if your life is very chaotic because of your emotional distress and your attempt to control that with substances, and if you are somebody that gets scared if you don't have the drugs there because you wonder what your mind's going to do to you, then you know you will be obsessed every day with finding the money to buy the drugs, getting the drugs, using the drugs, recovering from the drugs. And then some idiot tells you that you've got two attempts at attending a CMHT outpatient appointment at the back end of Newport where the bus route isn't very regular, and if you miss those two we're discharging you. And we wonder why that's difficult for people.' (CO13)

Workforce Development

What can you tell me about the skills, attitudes and confidence of the current workforce across Gwent in relation to working with those with Co-Occurring Conditions (both specialist AND non-specialist staff)?

Do specialist AND non-specialist staff have sufficient understanding and responses to those with Co-Occurring Conditions?

'What's been happening here is we've had approaches from Torfaen Council, to send some of their staff down to experience what it's like to work with a mental health charity. So, it gives people a real understanding; it's not just talking about, it's there for them…And the other thing of course for me is, because we have a strange system in Wales about how training providers work, because it's all done through the Welsh Assembly and through European funding etcetera, you know sometimes, when I look at some organisations who've been assigned to say deliver a course in mental health, they're not a mental health organisation.' (CO3)

'I think it's the under-recognition, which seems to be the main issue, so under-recognition and then because it's under-recognised therefore our staff don't know a lot about it when we do see patients. We feel quite unskilled I think sometimes in helping these patients because we don't recognise it – because we don't see it.' (CO7)

'Raising awareness, training I think. Yeah, raising awareness both in public but also in the widerhealth community. I think specific training for our staff, so that they feel more comfortable in being able to work with these patients… And actually yes, drug services and maybe, they may feel that the bulk of the population they work with are younger people aren't they? So maybe increasing their confidence and knowledge and skills of working with older people.' (CO7)

'A lot of people go straight from qualifying straight into substance misuse, and to be honest they don't know what they don't know. You need 6 to 12 months of... you know that old adage of you need to work in an acute mental health ward to understand, it's probably still prevalent. You do need it. So, the conversations were based around rotation, and we're still really keen to do that.' (CO10)

'Our inpatient units are... again, it's well documented nationally, our inpatient units have the least experienced staff looking after the most unwell patients... ...and we've got three rehab wards where substance use is a significant perpetuating factor to people's distress, and I would say that the staff have not got the skills or expertise or equipped for that. We've used some saved budget... wherever we've got spare budget the APP are very keen that we spend it. So, I'm quite creative in terms of getting... I'm not one to say, "We've got to save the bottom line." It's a case of, "What can we do?" And we did put some money invested into APT to deliver some training for some of our rehab wards.' (CO10)

'I think it's a number of things, because it isn't just about the practitioners from the substance misuse, coming in once a week to deliver, it's a cultural thing on the wards. It's that level of understanding, reinforcing the work that's being done. So, that's a gap that we've got with our workforce, our inpatient staff... it's down to providing training and I think the other problem we've got in Aneurin Bevan is we don't actually have a detox inpatient...And I know the consultant has been trying for a number of years to move that forward. I have mentioned as part of the specialist inpatient programme, what are we going to do about our patients who keep coming back in to hospital because they revert back to using substances, or alcohol and they get on to the acute wards, and then they're referred to rehab. They don't actually need rehab; it's just a form of containment for a period of time, to make sure we thoroughly detox them. Because that mix is not good in terms of trying to deliver a rehab programme, recovery model, with patients who've... yes, they've got mental health issues, but primarily the main issue is their substance misuse.' (CO11)

'GDAS is brilliant, probably one of the best third sectors I've ever come across, but we still have to acknowledge that the majority of people having the face-to-face involvement with the clients don't have any healthcare qualifications. They're support workers. So, they don't know the difference between schizophrenia and somebody who fucks up their brain chemicals every so often and then goes and slits their wrists and stuff. And to them it looks all the same, and then what you don't have is CMHTs sitting down and explaining to them what the difference is. You'd get CMHTs going, "Not appropriate," and the workers are saying, "Well, why? Fucking hell, that's not normal."' (JULIA LEWIS?)

'Police receive mental health training, however not as much as they should. There is a new scheme where existing officers are to receive a full day of mental health training, however, I am not aware of any substance use training. There is no dual diagnosis training that I am aware of.' (CO21)

'I've been in this Health Board since 2008, and I'm kind of nearly the only one who is interested in the co-occurring side very, very much. Very, very much. And I'm more than happy to, for

example, take the whole responsibility of a patient if needed in terms of the care coordinating and the substance misuse side, but obviously it's always about step this step and you can't just make that change immediately.' (CO24)

'So, I think before having this conversation about prevention, as you said, I think we need to ensure first, if you're talking with clinicians and with the leaders clinicians, first of all I think, as you say, improving their confidence in managing related to substance misuse and co-occurring, but also having an understanding about it in order to open this conversation. Because if I'm having... you know, a consultant said, "This patient has a pseudo affective schizophrenia," and when it goes back to the local consultant, "Well, I don't believe that. I think it's still drug induced psychosis," well there's a conflict. So, how can we have this opinion if we don't actually kind of provide the training or increasing the confidence? And they had this training in the past, but obviously they haven't utilised it.' (CO24)

'Nobody wants to do something that might be someone else's business and some of it is because… I don't think it's a lack of confidence, I think it's that you might be treading on someone else's toes.' (CO27)

[Do we need to improve our information on this population group?] *'Yeah, absolutely. People are working hard to try and understand it but I mean, like I say, more anecdotally I suppose but the numbers of individuals who were referred through into secondary services who have got a mental health problem, who have a co-occurring substance or alcohol use problem, the numbers are increasing greatly and again, even at a lower level where maybe a lesser mental health problem or a less debilitating mental health problem, I don't think we're even capturing it. I don't think we've really got… I might be wrong but I don't think that we've got a total handle on what we think the real problem is because even on a Primary Care level, generally the reasons that people go and see their GP is not because there's substance misuse, it's because of something else and I don't think that we're identifying it. Then I think the level of understanding within Primary Care, and some secondary care as to what is on offer and what could be provided and what is a problem is that for some, it just feels like there's so much more. Like I say, the harder end and where we've got the trauma and the serious incidents that are occurring feel to me like they're more often. If they're more often at that level then you can...' (CO27)*

What are the best ways to increase skills, improve attitudes and boost confidence of the workforce?

'Something I'd be really keen to develop going forward, rotational posts. Like I said to you the other day, when you first qualify as a nurse, you don't know what you don't know, and you're expected to know these things. I went straight into substance misuse and my experience in mental health was…From my perspective, I think HR would support it, and from a directorate point of view we'd support it. It just needs the commitment from the senior nurses, and I can see an area now where we could look to develop it. But it fell by the wayside partly because there was significant staffing challenges in two of our wards, and they were acute challenges. If people had seen that from a longer term, they could have rode it out, but when people are lowest off… So, I think we could do it. It kind of still is on our agenda… What we would like Andy... well the plan would be... you know, we've got... and so post-qualifying nurses, your offer is, "You'll be working

six months here, six months there, and then after two years you would have a good understanding."' (CO10)

'I actually think, and I've suggested this for the specialist inpatient service, is actually having more nurse consultants. So, rather than just sending people away on courses, is that you have those nurse consultant, or expert nurse, whatever you want to call it, the go to person on each ward… It's also about making people accountable. I think it's difficult because nurses are stretched so much, and pulled in so many directions, and I've always advocated that they should have protected time for delivering, whether it's one-to-one or doing a group with patients. It is difficult. I don't think we always get the best out of our staff, because we'll send them off on a course. We don't actually follow it up a lot of the time. What did you gain from it? What are you going to do with it? That kind of thing. A commitment from them, so that "okay, I'm going to go and do this course, and I understand when I come back, you're going to want x, y and z, from me". So, I'm hoping that we can start to change that.' (CO11)

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.

'It's not great at all, and there's misconceptions of what they can do, and what each other can do. I think because a lot of practitioners, especially in statutory services, have come through mental health training, you've got psychiatrists and what have you, so it's kind of like, "Well, they have done the same training as us. They should be kind of managing these patients the same way that we would." But you've got people that have chosen a career path with substance misuse, so they're not going to be as up to date with dealing with somebody with, say, a psychosis or a depression, and if they're needing secondary services they need to be care coordinated. So, it wouldn't be substance misuse services care coordinating them, and what makes it different in Gwent, and in Wales, is the fact that, you know, the legal framework with the mental health measure and having a care coordinator, which you haven't got in England. So, it would have to come through a community mental health team.' (CO1)

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.

'Raising awareness, training I think. Yeah, raising awareness both in public but also in the wider health community. I think specific training for our staff, so that they feel more comfortable in being able to work with these patients… And actually yes, drug services and maybe, they may feel that the bulk of the population they work with are younger people aren't they? So maybe increasing their confidence and knowledge and skills of working with older people.' (CO7)

Data availability/usage and information sharing/communication

How would you describe the quality of communication between services e.g. do services share information readily and talk to each other? What are the current barriers to information sharing and how should these be overcome? What improvements can/need to be made to communication between services?

> *'I think the thing is, what is good to see is, because of the way that substance misuse services are commissioned, there's always really good communication between statutory and third sector. That seems apparent wherever you go, but it's the difference then between the mental health services and the substance misuse services, is where it goes a little bit...' (CO1)*

> *'I'm just thinking of a couple of examples really. I guess that they find themselves, for whatever reason, maybe they've broken up with a partner or there's not any employment so they can't secure any housing, but that leads to maybe a relapse or initiating that substance use. They fall into kind of the wrong crowds, and that then obviously worsens their mental health results. But other issues as well. There's the stigma. It's massive. Even once they're in services for substance misuse, like just even going to pharmacies and picking up doses, it's just the amount of stigma that they experience.' (CO5)*

> *'For the individual patients, I can certainly think of patients that we've worked with individually that we have worked together with, yeah, fairly well… There may be reluctance on the part of GPs sometimes to necessarily refer an older person to a substance misuse service… the referral came into us in older adult mental health services because the GP said "Oh I don't think it would be appropriate for this 80-year old lady to be sat in a substance misuse clinic in the centre of Newport on Dock Street". Whereas actually, her needs would have been better met by attending that service but there was a bit of a bias maybe.' (CO7)*

> *'The model [mental health triage in Police control room] we have is good as we can share information in real time and as we are control room based, we can be dealing with 30 cases in one day. We aim to be much more responsive and offer advice and guidance from the word go. We are directly employed by Gwent Police, whereas other areas are employed by both the police and the health board. This gives us more freedom. We have 6 members of staff.' (CO21)*

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 absolutely shocked that we were still on kind of paper notes. I think that's a huge barrier. Yeah, so we're not digitalised at the moment. So we've put all our contacts on to the database but we write all of our detailed notes in paper folders. I was just shocked when I started. I think that there are definitely plans to go ahead with digitalising it all, but there have been barriers in the way. So, there's a new kind of digital service called Wikis, I think it is.*

That's in the process. We're still using the Apex which is just for the contacts. Whenever you go on there you can just see whether someone at another service has seen that person, but there's no outcome or any details of that appointment. It's really poor, yeah. I would say that.' (CO5)

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.

Prevention and early intervention

Is sufficient focus and resource given towards prevention and early intervention? What more needs to be done?

'I don't think [shifting more towards prevention] *it's very high on the agenda. I think people will... well, saying that, there's a lot of work going on for ACEs… Yes. I think it fits in with the ACEs agenda, and I think, what I said Wednesday, societal changes over the last 15, 20 years, and I don't want to criticise things but I think we're leaving a bunch of communities behind with substance use, with trauma and it's just perpetuating the problem. But it's a difficult one Andy because it's a societal issue, and if you go back to... it's two things, isn't it? If a young person is experiencing difficulty and is using substances to hide that difficulty there's possibly a high, high level of intervention needed probably for, initially, a very low, like you said, success rate because I guess people will go and revolve around that until... because, I know there's a lot of evidence coming out now about the brain, and especially for the males not really... and going from my experience from my oldest child, it's not really developing until a certain age where that sort of cognition of understanding is not developed until the late twenties. Yes, it's too clever for me to think about, but yes. I think there's a bit of joint up work in terms of how that all fits in.' (CO10)*

[So, strategically does this need to be higher on the radar on the agenda in Gwent in terms of intervention?] *'I think so. I think it's very easy to assess someone, and like I said we make formulations when referrals come in. Very easy to say, "They're using drugs. That's the cause of it."' (CO10)*

'I think it is… in my view, it's much the latter actually Andy. It's one we need to do more thinking and planning around. I think everybody understands the general dynamic as you just articulated it. I think we equally understand that even if you could come up with a good business case that's invest to save, you're unlikely to be able to do that well enough - although there is some evidence that this is changing in ABHBU. There is a but more evidence that if you came up with a general business case that is perhaps further downstream than primary care even, and it's a more community-based intervention, then you may get some funding for that, but it's still pittance by

comparison, as you quite rightly say to the treatment end of things. And I'm not sure how you unlock that. ' (CO12)

[Is prevention and early intervention on the agenda]*' I think it is, indirectly. We work with transition cases from CAMHS. So, I think we try to identify those individuals who possibly, if we'd got more involved at an earlier stage, might not have gone down the paths that they had. That's one of the reasons I guess that we open up the rehab service to the acute wards as well. In terms of the community teams, we do take on people who aren't necessarily forensic but they're complex, quite difficult…' (CO11)*

'I don't think it has been had so much in terms of the co-occurring and substance misuse. As far as I'm aware of in senior consultants meeting, I would say no. Obviously, it needs to be, and these conversations need to happen, but also with all clinicians and the leaders within the Health Board, they need to be first having the understanding and the education about it.' (CO24)

'So I think from a national strategic direction prevention and sort of early intervention is really up there. So I think from a national perspective that's great. And therefore there are some relatively small funding streams that has enabled us to, I guess, do some things locally. But what we've not done locally or what I don't think I've seen as examples is actually people moving around core budgets.' (CO25)

[What more could be done to shift to a more preventative approach?] *'I think we miss a gap with schools, with… and things are improving and I'm well aware of that, in terms of how we're addressing mental health as a society, but it's still hugely fearful by a lot of the population, and I know we have people who do go in to schools, but I just think we're not doing it right. Whether we use that through the medium of drama… there are theatre companies out there who would be more than happy to put on a play for 15, 16 year old kids who think "Oh God, this is really boring", but just be more creative. Get hold of people… we've got peer mentoring which is happening now and we have just put forward the name of one of our service users. He's done the peer mentoring; hopefully, he'll get a full-time job out of it. So, utilising them more.' (CO11)*

'I think we have a lot to do from a preventative point of view. We need to be looking more at the children. I know from a primary health and GDAS point of view, we have to try to prevent and educate the youngsters so we can break the habit. There is lots of work that we can do.' (CO17)

[Is prevention high on the radar in discussions in Gwent or is it we just spend all our money on treatment, actually prevention it's very hard to shift resourcing to prevention?] *'I would say that's absolutely definitely true. That's always been an ongoing issue. It's like, where do you start? It's good to create a service that gets upstream that's for sure. That's what we've tried to do but you can't go all the way upstream, you have to do it in stages, don't you?' (CO30)*

How can resources be redistributed over the longer-term away from the predominant treatment spend to increase proportions on prevention and early intervention (and recovery)?

'So within this role we do give some advice but try and encourage and support because out approach is quite a serious early intervention in nature and we try and build that relationship so that we can get them to engage with those services, so we would try and bring in the appropriate

service, however we're always faced with, especially in this service, we've got young people that have just experienced a first episode of psychosis, they've got lots going on in their lives, and substance issues seems to be further down their list. It's something that we assess and report on within our service and we do physical health monitoring within our service as part of our assessment, and we've just taken that on more formally so the physical health monitoring clinics that we run, we've just taken on more formally now, but we would definitely be linking in with our other specialist services like GSSMS or GDAS or whatever's appropriate for the area because we're covering Gwent, and like I mentioned before we started this interview also we've had the new service come over and speak to us this week, that's being piloted in Newport.' (CO6)

Resources and commissioning

Are more resources required to support the Co-Occurring provision across Gwent? If so, in what areas and what plans are in place (need to be in place) to increase investment? What opportunities exist for attracting further resourcing into this area?

'We don't have an inpatient unit in Gwent for additions. So, I have to admit all my patients to mental health wards. Now, obviously for the adults there's a ward that covers Newport, there's a ward that covers Caerphilly, there's a ward that covers Blaenau Gwent, there's a ward that covers Torfaen. So, I've got options there. For the older adults there's one ward for the whole of Gwent. So, that's kind of the restriction.' (CO13)

'Yes… needs to be a priority for all. We need to find a way to come together to ensure that there is enough funding to deliver the provision that is needed. The housing support grant has a fixed budget … no cuts this year, there is some hope that the homelessness budget is increased due to being a Welsh Government priority.' (CO16)

'I think the managing for co-occurring patients, there's two elements of it. It's the clinical need care. That's one side. And the other one is the care coordinator or the key worker. I think it's about having one care coordinator or key worker for this nature of patients. So, what it is, we're thinking about having specific staff or nurses to have this by experience, which is substance misuse and mental health, and this can be achieved, for example, if we kind of create a scheme of training within our Health Board. So, staff, they come in. So, "Are you interested to be working with co-occurring patients?" If the answer… let's say they have the motivation and that is something of their interest and that is of their wishes, then say, "Okay, we're going to do a scheme of training you. You are employed under ABHB, but first we're going to do a scheme. Possibly I would like you to have one year or a year and a half doing mental health purely, and then I want you to do a year and a half purely substance misuse. That takes you in a total three years. After three years you come out as becoming a co-occurring key worker or nurse." And they would be the best people that they will be able to care coordinate patients under the Mental Health Act law…' (CO24)

'So, if we start with resources, I think we have enough resources in Aneurin Bevan, but it's about how we break down those resources and use it. So, for drug and alcohol… so, there's like the

theory of having a drug and alcohol ward. So, we have to make a new business plan and bring in more money. In my personal opinion of what I'm seeing of the areas that I'm covering; I don't think that is the case that you need to open a full ward. So, currently how we are working is, for example if we are having a patient needing an alcohol detox, actually how it's doing... I know Gary was specifically in that role to do that liaison with the ward, but for North GSSMS it's not actually working yet.' (CO24)

'We seem to have, kind of, lost the resource. Where we've got to at the moment is we've got to the position now that there's 1.7 of us, whole-time equivalents. As opposed to previously, four. From my point of view, this is a conversation I've been trying to have with my division and my Adult Directorate for the last couple of years. I have to be honest with you, it's been really, really difficult to get any thinking or ongoing conversation with them. I managed to have a meeting in February with the division … to have a look at the situation that we find ourselves. That was helpful, but it was then batted to our Adult Clinical Directorate to pick up and work out what they wanted to do. It's only recently that we've had a couple of meetings to talk about that. We've had two meetings so far. I think the first one was in August and we had one a few weeks ago, and we've got one on Wednesday. So there's an ongoing discuss but I mean…' (CO30)

Monitoring and evaluation

What are the current arrangements for monitoring and evaluating current service provisions?

[pilot] *'So, in terms of successful outcomes, the Welsh government already provide eleven outcomes that we manage the service by, we measure the service on. So, for the people that are coming out with positive outcomes, and for us a positive outcome doesn't have to be everyone scores a ten…So, we will look at the outcomes and we will look at their sustainable accommodation. Are they advancing? Are they managing to keep that tenancy? Are they engaging? That will probably be a really good indicator, or if they're not engaging, is that because we've done such a marvellous job, they don't need us any longer.' (CO28)*

Care co-ordinating

Finally, one interviewee 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 kind of heard from going to a conference or meeting, or NICE guidelines and stuff is substance misuse services are actually care co-ordinating. And we don't. The Care Coordinator will be solely responsible for that person, but also co-ordinate the care with all the other services and be the first kind of contact to that service user. In the new NICE guidelines for co-incurring needs it's one of the quality statements that there needs to be a Care Coordinator involved. And I guess that just makes it easier for service users to access and navigate the different services as well.' (CO5)

Housing issues

What are the challenges surrounding housing options for those with Co-Occurring Conditions in Gwent? What support is available around Housing issues and what is good/could be better about this support?

> *'Housing… homeless hostel population, refuge and floating support provision, there is a big minority within that group that are vulnerable and chaotic… the biggest issue getting them into substance use services and making sure they get access to these services. It's challenging getting them into services and getting them to maintain links with services and maintaining their tenancy, one of the requirements of tenancy.' (CO16)*
>
> *'The main crux of services is in Newport … a range of services in other Local Authorities, complex needs, domestic abuse. There is a range of mental health services commissioned in each authority. Substance use is more difficult due to the legalities, and that is an area of work we need to think about. Such as wet houses or dry houses, or consumption rooms and we need to consider this going forward.' (CO16)*
>
> *'Outreach provision into hostels would be a good improvement, perhaps strengthened links with outreach specific provision at the hostels.' (CO16)*
>
> [on Equity of provision] *'Newport has the most specific provision. But each Local Authority has its own provision but depends it on the need. Newport is the biggest area of substance use, homelessness and mental health issues. Housing First … a funding bid was successful for only Newport but there is expectation that the project will be widened across went.' (CO16)*
>
> *'We get quite a lot of referrals for people with housing needs, we help them with their referrals. There is not adequate support. We can make a referral to tenancy support, but this can take a long time, and I don't want to just leave the person. Sometimes a few months after the tenancy support starts the are still not supporting the guys or do the things that I was doing, the tenancy support guys do not phone them or visit them as much, sometimes you have to phone people a few times. I have been disappointed at times with the referrals I have sent to tenancy support and then they close the case when the person still has issues around their housing. I'd be happier if they gave more help. Sometimes I am chasing up the tenancy support worker.' (CO18)*
>
> *'We've got a lot of sofa surfers in Newport, and obviously they don't come up on our radar as homeless, because they're not registered. So these guys then have trouble with their sofa surfers, and whether they are then going to become homeless. And because I work alongside the information centre, The Wallich, Salvation Army, all these sort of outreach teams, I'm sort of the glue between that. So if they say "so and so is looking like he's going to be made homeless. What do we need to do; we don't want to see him on the street; his mental health is going to decline." I know that process on how to stop them, to get them into housing, where they would then need to be assessed, and when to go. And then by having these links with Newport City Homes you know, and these new sleeping pods, it's like I know a pod is coming up, this guy is going to be street homeless, so let's work together to make this transition smooth. Let's keep his quality of*

life to where it is, and not decline any further. That's how it's worked. The team here are fantastic, and very accepting. Again I had someone this morning say to me "Darren, I'm not quite sure what you do; I've been off." So I'm going to hold a meeting, and then go from there and try and explain.' (CO23)

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.

'So, we see people now who are homeless who would never have been homeless before. They would always have the capability to cling to a bedsit, but they are now homeless.' (CO8)

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

'I think it's a lot of things really; the first one's stability. It's also feeling comfortable in your own surroundings, but I think one of the most important things is that wellbeing aspect. When we speak to people, or we go and visit somebody who's interested in our sort of services, and you go into some of their properties and they're absolutely dire. So, what will happen is, when they go back to the landlord for repairs, repairs aren't done. Some have got animals, and if they go into a hospital session the animals are just left there, so the smell is just… having a nice house I think should be everybody's right, because we want a warm, clean haven.' (CO3)

One interviewee expressed concern at the level of support received once a client has been referred onto a tenancy support service:

'We get quite a lot of referrals for people with housing needs, we help them with their referrals. There is not adequate support. We can make a referral to tenancy support, but this can take a long time, and I don't want to just leave the person. Sometimes a few months after the tenancy support starts the are still not supporting the guys or do the things that I was doing, the tenancy support guys do not phone them or visit them as much, sometimes you have to phone people a few times. I have been disappointed at times with the referrals I have sent to tenancy support and then they close the case when the person still has issues around their housing. I'd be happier if they gave more help. Sometimes I am chasing up the tenancy support worker.' (CO18)

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, whereas it was noted that chaotic individuals using substances are not always easily housed.

'The Biggest issue is getting them into substance use services and making sure they get access to these services. Challenge: getting them into services and getting them to maintain links with services and maintaining their tenancy, one of the requirements of tenancy.' (CO16)

'From a Housing Support perspective, we need to think how we deal with people with co-occurring conditions whilst they are able to access both the mental health and substance use services they need. How do we work with those people? Practically, we would need to be clear who we are working with and why we are working with them, perhaps be clearer that we are working with active drug users with mental health issues, be very clear. It's not clear enough.' (CO16)

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 misuse services had multi-disciplinary meetings there could potentially be better plans for housing individuals.

> *'What's happened really is that the Welsh Assembly have made a very, very strange move when it comes to housing, and they put the tenant as now responsible for paying their own rent. So what happens is, the tenant will get their money, and it's up to them to pay that rent to the landlord… Before that changed, what it was was people who are living in housing association houses, that rent would be paid immediately, directly to the housing association… So what we're seeing now is a massive increase in people being evicted, because they're not paying their rent… And that of course leads to homelessness, and of course then leads to your alcohol and drug addiction, because of the situation they find themselves in. So, if you like, one decision I think has had a massive impact on housing.' (CO3)*

> *'The other thing which I think's important is that I don't think that the Welsh Assembly have been strong enough in making sure that the new register of social landlords, they all have social clauses in their applications to become richer social landlords, and I think I'd like to see a bit more investment there in community, which it's supposed to be for.' (CO3)*

> *'Yes, and I think people are not going to have their housing needs met quite easily, and that's a significant challenge. God forbid, Andy, me and you were made homeless tomorrow, we'd be in some hostel where if we had substance misuse issues it'd be perpetuated.' (CO10)*

The team did hear an example of a veteran with co-occurring conditions being assisted to obtain social housing by veterans' mental health charity, Combat Stress.

> *'Combat Stress wrote a letter to assist me in getting social housing and helped me with my PIP claim.' (CO19)*

Housing First was also….

> *'I think, from a mental health point of view, if you've got somebody that's using substances, you've got someone that's male, you've got somebody that's probably got no family contact, they're all demographic risk factors. But then, I think this is the good thing about Housing First and getting those into that, because previously they wouldn't be top of the priority list for housing.' (CO1)*

Provision for specific populations

As highlighted in the focus 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 one interviewee, 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 staff.

> *'I think it's the under-recognition, which seems to be the main issue, so under-recognition and then because it's under-recognised therefore our staff don't know a lot about it when we do see patients. We feel quite unskilled I think sometimes in helping these patients because we don't recognise it – because we don't see it.' (CO7)*

> *'So, looking at older adults, most of the clients, as you said, could be alcohol-related and related to cognitive impairment, and obviously the prescribed dependency, as you mentioned. And with the alcohol-related older adults, some of them either historically that's been their habit in terms of the drinking, and it got kind of gradually... because it's long term, the problem surfaces only when they're in the older adults where possibly their cognitive problem goes down, or they start having more physical health problems, it surfaces only when it's older adults. And within the prescribed, which is mostly the opiate related and sometimes pregabalin, also benzos and stuff, for example. So, I think for the older adults, if we're looking at the long term, as we always start is the prevention, I think there needs to be a lot of... I mean, the stage when it will be the prevention approach. So, when you look at the prevention it's about the prevention on those group before they become older adults. So, within the prescribing it doesn't actually... I don't put the fault on the patient. I think it's more about there needs to be more with the clinicians. They are non-addiction clinicians. So, it will be the GP practitioners, it could be general specialists. So, there needs to be a focus. So, we need to identify for medication, what prescribed medication can cause an addition? Obviously we know it's the opiate-based painkillers, we know it's the pregabalin, we know it's the diazepam. So, the clinicians when they initially initiate those prescriptions, they have to understand what is the consequence of you prescribing it.' (CO24)*

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 younger people with substance misuse problems in Gwent. Not that I'm aware of. It's typical. You've got to be… They have got to be really seriously mentally unwell before CAMHS look at them. The madness is, you have got this ability to be able to refer into a Families First space MDT, so they will then discuss where substance misuse sits in all that. The other thing is, is alcohol a serious mental ill health? I did have a look through your 50 different questions. What do you mean by co-occurring? Dual diagnosis sometimes, for a while, as it was known, that used to be drugs and alcohol. There is quite a lot of alcohol-induced mental ill health as well. Mental ill health associated with alcohol.' (CO4)*

Key principles

A recent Public Health England (PHE) guide to better care for people with co-occurring conditions aims to encourage different agencies to work together to improve care for people with co-occurring conditions. Two principles which underpins this ambition are (1) 'It's everyone's job/responsibility'; and (2) 'There is no wrong door'. To what extent is the 'It's everyone's Job/responsibility' principle embedded and embraced across Gwent? To what extent is the 'There is no wrong door' principle embedded across Gwent?

> *'It isn't. Amongst people who deal with substance misuse, it very much is, but I don't think it's cascaded across all agencies by any stretch of the imagination… Even if you don't want to deal with it yourself, you should have a pathway to be able to refer the person to. I think that's the other thing. You only know what you know and you don't know what you don't know. There's a lot of people that see someone and think, "He's not very well," but they just don't know where is best placed for them to go to.' (CO4)*

> *'I think as a future objective, that's something very much that we would want to aspire to. I don't think we're there yet, and I guess… before I joined Aneurin Bevan, I worked at Llanarth Court, which was medium-secure and LSU, and before that, Cardiff. I trained in Cardiff at Whitchurch. So, I think yes, you… the danger is, when you develop these specialities, you do work in silos and you become very protective of your service and there's ample evidence of that.' (CO11)*

> *'It's very process-led, isn't it? It's all process-led really, because we're separate divisions within he health board, aren't we? So, we'll look… say for example, if someone turns up at GSSMS and said "I feel suicidal" they would be pointed in the way to say, "I think you need to see this person". So, they wouldn't necessarily say "alright come in and we'll…", so there's something around that… So, there is something… and I think GSSMS team are fabulous, I really do. But there is that… "that's not our job" but at the same time, they get that from us as well. So, if somebody goes to the ward and it's just drugs, you become unwell and that's the pattern of behaviour, so "this is where you need to go", rather than say, "well I tell you what, let's work on that", but I don't necessarily have those skills. But what we have been able to do is use Darren to link that all in together, kind of like the glue that brings everybody in. Again, he's still learning his role and he was only seconded for 12 months. So, I'm not sure what the plan is after that, but I definitely think there's something around that role that needs expanding and developing.' (CO29)*

COVID-19

How has Covid-19 changed the landscape for those with Co-Occurring Conditions in Gwent – and what should the priorities be now for this population?

> *'Because the support workers who have been appointment, they were not able to go to these individual people's houses, it was only on the telephone. And even at the best of times, I suppose individuals struggle to talk to somebody over the phone, and actually when you've not met them*

it poses a further challenge. I don't think we still really understand the prevalence, but what's surprising is that we were thinking that the number of patients that we would be referred to GDAS would be quite high, but that has not been the case.' (CO9)

'COVID has definitely not helped matters, because obviously at present none of us are able to see the same number of patients that we would for a face to face consultation. And I think that is not necessarily a good thing because I think there is a certain group of individuals who really need that constant face to face meeting because in order to enquire, reassure, also convince them that, "Look, we are here. It's not just a lip service," but at the end of the day they also have to do their bit. And I think if COVID continues or if we were to have another second wave, that would mean that the problem would further become much worse. And also I think the fear now is that if people were to lose their jobs and thereby impact on their life, families, relationships, we know that a lot of... it's a human kind of tendency, you then resort to other means that allow you to kind of be in a different plain in life, because that's helpful. So, I think my worry is that if this whole... it'll be interesting. Everybody's saying that the number of referrals to the mental health services is going to go up significantly. Now, obviously we'll come to know only with time, because at present it's just an assumption, but my worry is it's not just mental health. My worry is that then we'll see a lot more people maybe using a lot more alcohol, using more substances. Again, this is just...' (CO9)

'I guess what was initially interesting, because when it started, we introduced a traffic light system. So, those patients in the community that we had to see, whether they were on Clozapine, regular bloods, or risky to others or self, so they were in the red group. We continued to see them and support them. Those service users who weren't in the red group who you thought, they'll probably start to unravel a bit, they didn't. So, it actually raised the question of have we been deluding ourselves that they need us as much as we think they do. We kept telephone contact, but it did change for them. I think one of our anxieties was that we would be flooded with patients wanting to come back in to hospital, not being able to cope. But that didn't actually happen. Sure, we had a few who did become unwell, but generally speaking, they cope better than we thought they would, and likewise on our wards. They went in to complete lockdown, escorted in the grounds only, and I thought, this is going to be horrific. But no, they really coped admirably with it. Both wards, yes. So, I think quite often as professionals, sometimes we tend to predict...' (CO11)

'I do have to say in terms of COVID, there has been a sense of frustration with local authority. So, the social workers were... the unions I understand were like, "you've got to go and work from home", and we did have this, and it was a bit of a headache at the beginning for Aneurin Bevan, which was, "if you can work from home, that's what you should do". I had staff saying to me, "it's there, it's on the internet. I should be working from home". But with regards to the social workers, yes, that's caused a bit of a problem I think in terms of how we can move things forward, because fortunately, the three I've got... the one chap has been isolated at home because he's in the vulnerable group, doing a bit of work from home, but the other two, I negotiated with them. I said, "you're an integrated part of this team. There's only so much you can do from home". And they're very reasonable. They were very good about it. So, we continued with that. But other teams haven't been so fortunate, have struggled, and are still struggling and it's not going to go

away, is it … because at the moment, I know Newport for example, they are still… their staff, their social workers are continuing to work from home with periods when they do come in to the office and I know part of that is about social distancing, because a lot of our buildings, it's impossible. But yes, I do think that's a challenge for how we move forward with that.' (CO11)

'And then I suppose the COVID-19 stuff, don't know to be honest. I think that general stuff around COVID-19 for us, at the moment, try and engage with the APBs business is the main focus, and of course, really there is a cohort overlap between the homeless, which was the big push in terms of strategy for the homeless, and building on some of the work we were doing and the co-occurring dimension to that. Generally speaking, that's gone well and galvanised people and enabled them to put in place some new working arrangements. I haven't touched base with that since I don't really know. The other dynamic that we've already touched on Andy, around COVID-19, is that general one that I think people are starting to… we obviously had the dip in referrals that every support service saw. I guess they're starting to climb. So, there's something about both the flow and how quickly that comes back to us, and also something about the stock that will now have built up as a result of COVID-19. So, I'm expecting us to get very busy, very quickly. That's going to be challenging. We've now started to develop a waiting list for the first time in a long while.' (CO12)

'I think it's obviously brought lots of different challenges, but I think what it's also done is really brought a lot of barriers down in terms of… Particularly around that homeless cohort. There was such a big need, particularly in Newport again. Sorry to be banging on about Newport all the time, but housing every homeless person in Newport, and then obviously trying to bring in services to meet their needs, which are often multiple, I think that really… The developments, and we had the rough sleepers' initiative which led on and everybody that was around the table with that, police, housing, health, everybody that was there, just being able to have those conversations and work in a different way to try and meet their needs I think it's been really refreshing.' (CO13)

'I know GDAS and GSSMS, and particularly with the co-occurring and complex needs posts we've got with CMHT, they've been able to work in a really adaptive way around that, so I think there's massive positives. There's been some tensions between… From a GSSMS perspective, it's kind of… Because we're, I suppose, Health Board workers there's been a case of, "Well, business as usual." We've still got a job to do, and I'm not saying that hasn't been the case for anyone else, but then my understanding was GDAS weren't taking on any new referrals. I think there were some tensions arose around that and obviously patients becoming a bit more chaotic while they're waiting to be seen, and then knocking on GSSMS's door, so it's caused a few tensions, I think, there. Certainly from a mental health perspective, it's trying to support the people who need the support, see the people who need to be seen. We've still got to provide a service, but what we have noticed is that our crisis referrals have gone up by something like 65% for crisis teams in mental health. Of course, the staffing hasn't increased in response to that. We think part of that is because people are either delaying going to see their GP, or their GPs aren't doing the face to face. Some of those would be co-occurring patients as well. I guess it's that waiting now, waiting for the dust to settle a bit to see where the alcohol side of things are. There's a lot of anecdotal

evidence to suggest that people's alcohol intake has changed dramatically through COVID, whether they've been… I think the fallout from that will remain to be seen really.' (CO14)

'Yes. Yes, I definitely think so from a Health Board perspective anyway. I think at a local level, services themselves are obviously keeping it in mind, but I think at a higher level, there's various project leads within the Health Board that were very much involved in coordinating. We set up a COVID hub, and there was… It changed the way we worked for quite a significant amount of time really. They will definitely be spending some time looking at planning around… There's lots of planning going on around the new normal, but then there's also lots of planning going on in the background around, "Okay, so this is now, but we need to prepare for a second lockdown potentially."' (CO14)

'So when you normally ring in, people who need help would ring in, and then they'd allocate people off to have urgent assessments, and now we have screening processes, due to COVID, and we have somebody from sort of home treatment and crisis liaison background, who then provide our screening to see if they then need to be seen further by the team.Actually it's working really well within our CMH team, and to sort of have those gatekeepers, so that we are able to give the right help to the right people. Because sometimes people come in and they don't quite hit our CMHT criteria, and then we're able to signpost really fast on from that.' (CO23)

'My understanding from CMHT, these guys are here as well, although they are brilliant, they have their set criteria on how they work. I was lucky enough that Sarah, when I came in she was like "you've kind of caught us at a really awkward time that COVID has hit and everything like that," and again, I'm not used to work in the community, but I am very aware of the restrictions that that can come with. Sarah, I was very lucky because Sarah sort of gave me free rein, and then I thought "how I can make this work; how can I interlink these services; do I need to be that bridge?" And that's kind of what I've done. I had the capacity to go out and be very free flow in the way I work and think. So some days, this new Buvidal initiative is fantastic, and it's really gaining ground within our co-occurring community substance misuse and stuff, but whereas I said we would normally hold the clinic, give the appointments and they wouldn't turn up and it would fall down, now GDAS, GSSMS and myself, we hold clinics together, alongside sexual health clinics. And then say GDAS will assess somebody, I've come in and also assessed them for their mental health needs; it doesn't quite hit my criteria, however my role doesn't stop there; I still work alongside.' (CO23)

'I think it's sad that it took a global pandemic for us to evolve our practice, to evolve our services you know. And I'm lucky enough that… so what I did, I do a lot of networking; I'm always networking; you know how it is? As a nurse we always network; I always like good links, and I'm very lucky, so that when I first qualified I would always… being a PICU nurse you're always assessing another role, and always helping, so I'm constantly making these good links. And now, when I'm going to a lot of these services, I already know nurses there within the services, and I'm like "look guys, I've already got this report," and then I'm like "this is what I'm currently doing; we are working differently; can we work together, and how can we work together to make this successful?" … And it's worked really well, but it's took COVID I suppose for these… whereas

perhaps I would have been met with "no, we're not doing it that way because our way works," but because of COVID they are like "right, let's do what we need to do."' (CO23)

'And even I found out from some people that would… you would think actually, you don't really want to have that change because change is scary to some people when you've worked in one way, and you've got that one way thinking, or one track thinking. And because it's working, then people don't want that change, but what I've found is, because of COVID, it's forced people into change, even the ones that were kind of "okay, I don't like working this new way, but let's just go with this now, because COVID is going to be here for a while." So it's not like "okay, I can go back to the way I was working in a week, or two weeks' time." You know it's kind of forced people to have this longevity outlook of how can we improve the service; how do we evolve; how do we evolve our practice? It's making these connections between services, and I keep saying it, but at the forefront are the people we support. You know these barriers that we hit, it should be "okay, here's a barrier, and how can we work with that service to remove that barrier," you know?' (CO23)

'Even if you look at… this is just another thing, so within here you know we would all come to work, and we all go to an office to work. We have ex amount of space, ex amount of desks, and ex amount of computers. Well within our service we have social workers, CPMs, the bosses, healthcare support workers; we couldn't provide the service we do and all be in-house. That was another issue through COVID. Some days I will work from home, just to catch up on my paperwork; I couldn't do it permanently, because I need to access services here, but it's been a way of doing those things. We've slowed the traffic of people workers through the office, and again it's another way of working. And I suppose COVID again has highlighted that we can change if we want. Services are evolving, and I feel it's for the better; it is.' (CO23)

'So, interesting question. So, when I came in as an ST5 in the same place, this does not happen. When I started in February, that wasn't happening. COVID triggered that, putting in mind, and I have to say, as we were doing it every day for a month and a half, it means every day going to pick up, we are based in Abergavenny, the patient was in Abergavenny, it was very easy for us. There was some resistance from the staff here, okay. That is understandable. It is exhausting, because... And the patients have to go in twos. So, there's a lot of staff going out. So, if one staff goes on sick, one staff is off, if we don't have enough how is it going to be managed? So, there were other staff who were actually delivering for the patient who was not their patient. So, it was more teamwork. Some patients who, they know of him, but never seen, but they went out and delivered. So, it would have to be two patients. Unfortunately, when I moved into the post we didn't have a clinical room, we didn't have a drug storage cupboard. So, we were just going out. I mean, that's something we can talk about because it's a big area, but during the COVID we were able to create the clinical room and a cupboard. So, the staff, obviously, they have to go to the chemist, pick up the medication in twos, then go to the patient in twos, give it and come back. If the patient, for whatever reason, wasn't there they have to go in twos to return it to the chemist, and sometimes these are obstacles that happen. So, I can understand how it can be exhausting for the staff, but from my side and the team lead here, we stand together in saying, "That's what needs to happen," but I do get it that there sometimes could be resistance why we're doing that,

"If that patient is not engaging and isn't willing to engage, why do we need to go and deliver?" Obviously, the nature of the patient, he has been diagnosed with hebephrenic schizophrenia, even if the consultant hasn't, but there is something more than that. He's 25. He's more damaged. So, we need to do something more about it than just, you know... yes.' (CO24)

'And I can give an example. I was in Talygarn; we book normally the clinical room to do our clinic. We don't use a normal room. And one time, "Oh, sorry the clinical room is booked, but you can use the other room." So, I said, "Okay, no problem." I immediately pulled out the couch, put it in the room...and my clinic is running. If I don't have a couch there's no point of me doing a clinic, for example, because that is what we do. So, it's all about if you have a problem, you find the solutions and I know there were some obstacle about it, the number of bags, etc. and we're still thinking of how we solve it. From my side, I got a four wheeled... It got the trolley, four wheels, I bought it and then it's working and doing the job. So, you have to see what is the need for the clinic, you do it and then you can work around it to solve. And the mobile clinic, that's another one, but obviously that's a big business plan. I mean, we're having talks to go forward, but that's something also that could be in the pipeline.' (CO24)

'I mean, I have to say, when the COVID happened I came into post in February. In end of March the lockdown went on, then suddenly you can't see any patients. So, all April I just can't see patients. I know I'm communicating with them by the phone and potentially using the attend anywhere, but even me coming into post new, well I haven't seen the patient. I took an approach of taking a case review with the key workers to know all the patients in our system, but, for example, if the COVID happens we can still go locally because we don't need to see patients in crowded areas like in hospital where they need to come to an appointment where you put them at risk to them or other people. No, it's fully isolated between the patient and us and we are in control of that environment. We would take our PPE, the patients can have protection, etc. what they want, and it's our environment. We're in control of it. And I think patients will very much appreciate that, "I don't need to go to hospital. I don't need to go to the GP to see you. You're actually coming nearby to me." It also creates engagement for patients. Some patients for example, especially in our areas, they go and stay in tents, and we need to prescribe them. So, how are we going to outreach with them? There's no addresses there. All we have is a phone! And it's their friend's mobile. "Okay, I prescribe you whatever." But possibly if we know where they're sitting, where they put their tent, we pull the van nearby, come in, let's do everything, and then we get prescribed or we do harm reduction or we do certain interventions, etc. And going back to the co-occurring, patients with co-occurring, that is their situation.' (CO24)

'Yes. For example, the changes we're doing, we never had delivering medication. We never stored methadone, for example. This has happened. This has happened because of the COVID. It became a necessity, and we have to do it, but I'll then be able to use it more to the co-occurring. So, it's like the 25-year-old chap that I talked about, I used the advantage of COVID to go and deliver. He wasn't shielding, he wasn't isolating, but I was able to use the method of delivery because staff were already delivering to some other patients who are shielding. So, yes. The thing is about, I think, with COVID, what we want is, we don't want patients... I mean, out of COVID, we don't want now patients going out more into too much clinics. We want to reduce the appointments,

but we want to make the appointments more effective. So, when the patient is coming to having a face-to-face, not the phone or the attend anywhere, but if you're having a face-to-face, you need to do everything in that appointment. As we were saying, we're doing a one-hour appointment. So, we do everything for the patient, and so we need to reduce these numbers of appointments, and if we're going to also reduce… going back to what I said in the beginning, the patient is involved with too many staff. We need to reduce the number of staff involved with the patients. Too many patients, it's too much confusing for the patients. The issue is about we need to develop the expertise in the staff. So, if it's like one clinician can work with the patient, and they will have an understanding about everything, you're going to reduce the appointments. You're going to reduce the face-to-face. You're going to reduce the confusion, and less appointments, less contacts, the patient doesn't have too many contacts, people calling them, etc. But specifically for co-occurring and COVID, is it going to directly have an impact? I think individuals with co-occurring and COVID, when it comes into that they had to isolate… well, not isolate, they had sit at home because everything is locked down, there are people who have only purely mental health issues, they may have support around their family, they go and continue doing what they want to do, whether it's gardening or doing whatever indoors. But for the co-occurring if they have mental health, although it's like the other mental health that it's about how much they're coping, but they are going to be on a higher risk of using substances. So, post-COVID and co-occurring, they can be quite affected with the lockdown. So, it means they are more sitting on their own, they're…' (CO24)

'I guess we've been trying to do work around that space really from a mental health perspective I guess. And particularly in light of COVID actually. So it's given an opportunity to really push on a sense of we're all anticipating significant increases in demand for mental health support and I think the push that I've been trying to make to colleagues is… and therefore we need to make sure we're investing in the right tiers to support individuals because the last thing that we want is the wrong individuals being escalated into secondary care mental health services. There will be some people who absolutely will require timely access to secondary care, but actually what are we doing to support the mental wellbeing of our population and also what are we doing around trying to increase mental health support and capacity at primary care level? And now has been a good time to be having those conversations. So I guess two of the big initiatives that we're taking forward, so working with colleagues within primary care, we are developing a role called a… well definitely we call it sort of psychological wellbeing practitioner. So we've already got a primary care mental health service in place.' (CO25)

'One of the things that's really interesting isn't it, you've almost got, I guess, poles of opinion in relation to what is going to be the impact of COVID on the wellbeing of our population. So I hear a lot of colleagues talking about how communities have been incredibly resilient, have been really robust, have managed remarkably well, to other people talking about a tsunami of additional mental health need that there's going to be in our population. It's probably somewhere in the middle isn't it? So there's something for me there just about erring on the side of, I think there's going to be additional support required. So where do we need to put some capacity to do that? So I think that's one thing, is where do we enhance capacity? I think one of the other things that

I'm just mindful of is the sort of significant move to delivering a lot of our support and assessment and interventions digitally and I think we need to be really mindful around that that won't work for everybody and we don't want to be excluding some groups even more than they currently are from accessing support.' (CO25)

'Because our biggest barrier so far is going to be COVID-19 because we're not sure what's going to happen with that going forward, we'll see.' (CO26)

[COVID financial impact] *'I think absolutely it will. I think we're seeing that now and I think some of my anxieties around is that the withdrawal of services if you like or the refocus of services on providing, just from a physical care perspective is that in our safeguarding and concerns panel, we're reviewing things and that is a question we ask, "Did COVID have any impact on the decision-making that resulted in the person not receiving that service at that time?" And I think that it is having an impact and that certainly when people are going to their GP, people are not getting seen now. So, even in my own experiences with my physical health is that, whilst there's positives to it, is that you have some virtual consultations, they have opened the door to some things but I think that there's huge gaps now where people are not… like I say, people don't tend to go.' (CO27)*

'In Newport when the lockdown first started, the social workers in Newport were told to work from home, which was very difficult for both the team here, plus them, because what we said is, what we lost was that ability to have a conversation across the desk about something, because not everything can be done via Microsoft Teams. Not everything can be done in a phone call. Just being able to talk to somebody and get some supervision, informal, formal, whatever, but just being able to do that was so beneficial. So, having someone in the building that has got that knowledge, knows what support is out there… do you see what I mean? That's invaluable. He's been able to provide that in a short space of time. But if you had a couple of other people, or perhaps a GSSMS linked in with us here to have staff coming in and out in the building, working maybe one or two days from here, a couple of days down in their base there, but working… straddling across both teams, regardless of where your bases are but if they could do that, that's going to be more beneficial.' (CO29)

[The pandemic has] *'…brought people already to our service that I don't think we would have ever seen before. Really, acutely unwell individuals who are now left with serious mental health problems… The number of mental health access assessments we've done is phenomenal compared to what we've ever done before.' (CO31)*

Other considerations

What are your hopes and expectations for this Needs Assessment?

'I think we've got ideas. I definitely think a better understanding about trauma and the impact on our patients. I say patients, service users, but also our staff, because I think sometimes people

are drawn to the profession for a variety of reasons, and that was something that came out of the conference, was acknowledgement of staffs previous traumas and how that might impact on their working relationships with our service users. As well as staff wellbeing. We are changing to a more compassion-focused leadership style, and emphasis on wellbeing which is essential. If we can start there, there maybe the other components better understanding the substances. Maybe that will help us.' (CO11)

'I'm acutely aware from some of the work that actually we have got an aging cohort. By the time we reach the end of that ten-year period, actually, they're quite significant… proportionately significant but also in terms of service need. So, we've got to start to think about exactly the type of thing that you've just articulated. Older adult mental health support, I've got no evidence for this, but my sense of it would be, that might well be something we try and develop within… from the mental health teams, but within the drug and alcohol service, because I think direct control over that in terms of thresholds, in terms of case management, in terms of flow of service clients, is going to be absolutely key, because otherwise I think we're just going to chock things up quite quickly.' (CO12)

'Newport has… I don't know. It's funny. I suppose it's because it's got that sort of city feel, your referrers… It tends to be… It's quite a difficult area to work in I think. Your relationships with GPs can be a bit fraught; the patients can be very complex and very demanding. You get that everywhere, but we seem to get a lot of it in Newport.' (CO14)

'That it goes back to joint priorities there… that the Need Assessment picks up what those priorities are and those are able to be shared by other partners. A Needs Assessment is great, strategies are great, but it comes down to development, action and an implementation plan. And timescales to do it. Otherwise we will still be sitting here in years' time talking about the same issues.' (CO16)

[Do we really understand the level of drug use that's happening in that population?] *'I don't think we do. I think over the last decade or so we've become aware that obviously there is a graduating cohort of people that have been in our treatment services for donkey's years, and are now getting into that age group and requiring older adult services. But what's relatively new to me is starting to come across older adults whose first use is in old age. So, I get the starting to use cannabis because of the chronic pain stuff. I get that, but older adults who are being introduced to stimulants, for instance, and things like that and you're like, "Really?" or being introduced to smoking heroin for pain relief. And so there's that population coming through that I guess, even for us in substance misuse services, are a fairly new population. We expect the old timers to come through because we knew they'd eventually hit that age.' (CO13)*

'I think just the conversation this afternoon has made me, I guess, reinforce how potentially helpful it will be for us. So having a real sense around, so what are the needs of our local population in order to inform how we need to have further conversations to think about how we best meet that. And whether that's around how we commission differently, how we change our practice, those opportunities to learn from others. Yeah. And I think what would be amazing is

that we're not here in five years' time saying we haven't cracked the nut that hasn't been able to be cracked for 15 years. That would be amazing.' (CO25)

[How confident are you that this kind of way of working is going to continue?] *'I don't know, because of COVID, and funding is a massive thing. If we are going to hit any barrier, we know it's going to be funding. These services, the fact that they were stuck with one-way working, and they're now thinking out of the box, and all this joint working, we've got to be saving money. So like A&E, police attendance, you know community care, because sometimes if their wounds are not kept up to scratch, then they end up as amputees you know. We are sort of this wrap around service that is stopping them from going forward and deteriorating, and they aren't coming back on the street.' (CO25)*

'I would love staff to be identifying the gaps in their knowledge and experience. I love the idea about rotations but I'm mindful of that being a product of people saying, "I just don't know" actually. I worry we haven't got a system where people are allowed to say, "I don't know". So, that's what I'm cautious about. So, I'd love to see gaps in knowledge, gaps in experience identified. I'd love to put an ACEs lens on it. So, I'd like to see how much this is a trauma-based issue, because that could lead to us having narratives about… it was initially an adaptive response to stress, and now it's become reinforced by its own cycle. What can we do about that? What would we need to put in place if we're going to help somebody drop this behaviour? What needs to be in place? So, I'd love an ACEs lens on it.' (CO32)

Are there any other questions or considerations that you feel strongly about which we haven't covered?

'There's a couple of serious issues I think you've got. One is universal credit, the transfer from whatever benefit they're on to universal credit. We've had people not having any money at all for six weeks during that process… Well we've had to get together with the food banks to feed them. We've had to assist them and speak to housing officers and explain why they can't pay anything, look at how they budget with what little money they've got, if they've got any. That's a massive problem, and again, that's a national problem; it's not just in Wales… The other thing sometimes is that the crisis, when people go into crisis, like crisis teams are very thin on the ground and not always the quickest to respond. An example of that was a couple of months ago; we had somebody who was threatening to commit suicide in one of our projects. This was at two o'clock in the afternoon; no one came from the crisis team until seven o'clock at night.' (CO3)

'I'm just thinking of a couple of examples really. I guess that they find themselves, for whatever reason, maybe they've broken up with a partner or there's not any employment so they can't secure any housing, but that leads to maybe a relapse or initiating that substance use. They fall into kind of the wrong crowds, and that then obviously worsens their mental health results. But other issues as well. There's the stigma. It's massive. Even once they're in services for substance misuse, like just even going to pharmacies and picking up doses, it's just the amount of stigma that they experience.' (CO5)

'There's a stigma. You know, [A client] turned up and there's the kind of "Oh God, this is somebody that's…" And I can understand. We all work within priorities don't we? But there's

that door... "I'm trying to deal with [Name] schizophrenia that he's had since a child and he's trying to work with me, and then I've got to deal with you, and yours was induced by drugs and you keep doing it to yourself, or you keep drinking..." You know, sometimes there is a compassion fatigue around substance misusers because, you know, when you've got a caseload of lots of people and often, you know, they don't take advice. You know, they don't take the Doctor's advice, they don't take their tablets properly, they don't turn up for appointments, so in the end there is a kind of "Do you know what, you're going to have to just get on with it because whatever I tell you to do you don't do."' (CO8)

'I think the only issue that sometimes we feel, and I think a lot of patients who are under our service and are also then know to the criminal justice system and have been to prison, I think it is a challenge sometimes to work with these individuals, also because of the nature of threats that they constantly keep making to staff. And obviously then what happens is, if somebody is making threats to me, then the natural instinct is that you want to hand them over to somebody else, and I think it's the continuity of care, but obviously I've got to look out for myself as well because that's important. And it's not just one or two people. Of late we are seeing that that number is going up.' (CO9)

[on stigma] *'So, what I discussed with the team was, did we want to rebrand Thank you Skirrid, take away the forensic rehab label, and just make it a generic rehab service. So, that is what we're in the process of doing now, and so we'll still take 37 41's, if an open unit is what is warranted or other forensic patients, but we're taking away that label. Still coming under our umbrella here, so that's quite an exciting time for the team. Because I think people tended to think, "You're very specialist, you're forensic rehab", "no, it's rehab, you can call it what you like, but it's rehab". Sure, if somebody has got an index offence, then we are going to be working with them around that, and that might involve more complex assessments et cetera, but it's rehab.' (CO11)*

'So, a lot of our guys, fair proportion of them, will have been blacklisted by local authority, antisocial behaviour, debt and so on. A fair proportion that we discharge from our wards will go to supported placements for a period of time or longer, depends on need. But for those that don't necessarily need that level of support, finding them accommodation is extremely difficult. Obviously we link in with third sector. We've got good relationships with POBL, but sometimes we have, for whatever reasons, we have discharged patient fairly rapidly, maybe they've been using substances, dealing on the ward. That's a definite no, no. We will give them a couple of warnings, it continues, and then it's "right, you're going to be discharged". Then we've got to find them. And because of the risks that they present with, quite often housing will turn around, homeless will turn around and say "no, too risky".' (CO11)

Moving Forward

Have you got a sense of what you think would be better in future, what you would like to see?In what way are families and carers given a voice to influence developments in Gwent? Do they have

any specific needs that require attention in future e.g. respite care, more support for carers and families?

> *'I think there is a lot of support for family members and carers and Hafal has worked hard to improve this. We have set up carers café's and there is a growing awareness of the needs of carers. The carers are now part of discharge plans, unless there are confidentiality issues. This is something that is steadily growing. I've seen huge change over the years, so its trying to get the message across that you need to hear the voice of carers. Hafal, Carer's Trust have worked hard. Carer's Trust have set up a scheme where GP surgeries can get be accredited as 'carer friendly', so for carers there is a lot going on. Its better but there is a long way to go as most carers are not aware of their rights or their right to carer's allowance. Monmouthshire have care's needs as part of their strategy. They have three carers information staff who work alongside GP surgeries.' (CO22)*

> *'Well I think those two areas, drug service and psychological therapies. I think… because if you just canvas Newport… I've known it for a long time. So, if you canvas that area alone, there are your main two issues really. But how you then bolster that up, because what you've got then is caseloads of people who have had mental health services, they probably don't need… we're going slightly off here but I think that's where third sector services need to come in to help support those people, so we could perhaps turn our attention to the more trauma-based work, the more drug-induced-type work. I mean alcohol again is one we kind of accept, but is also something that is very damaging. But I think every now and again, we have emails about drugs, bad batches, stuff like that but we don't really talk about the stuff you can buy over–the-counter. It's difficult, because people use it as a coping mechanism, don't they?' (CO29)*

> *'We definitely need to be a service within a workable framework. There's no point fitting someone up for three months and then sticking them straight back into where they come from because you'll be back where you started within two…' (CO30)*

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.

Two 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 and COMPASS project in Birmingham – 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 elsewhere.

> *'I went and saw the model up in Trieste which is fantastic, because it's a completely normal clinic approach. Trieste in Italy. And they've got a very similar system in London, I can't remember the name of the place, I think it's Bow Bells, I think it is. Whereas what it is you'll have the Third Sector, the clinic clinicians, you have Statutory local authorities there, but they're all in one unit.And if you look at the Trieste model which is worth you looking at, it's reduced suicide by an amazing amount. They don't worry about ligature, tests; it's like going into a really nice, big front room.' (CO3)*

'I think it's more about collaborative teams, you know, and integrated teams, where it's joint-funded, you know, like the area planning board and different health directorates, and I don't think it just needs to be mental health directorates as well. I think, like, physical health, there might be some worth in buying into it, or local authority as well, and having multi-agency teams around that. More therapy-based ones. So, there's the Compass team that's in The West Midlands and Birmingham Trust. So, it's based in Birmingham. Okay. So, it's called the Compass project, the Compass team, so it's very much occupational therapy, social worker, psychologist, psychiatrist-led. They did a lot of work, and do a lot of research as well. …So, what they did, it was more therapy, CBT-based stuff for the client group, and it was kind of around not just working with the client. It was about trying to prevent that revolving door…So, you would basically see the client, quite intensively, with the care coordinator or whoever is the main care navigator to try and do the therapies that work with that person, but it's also training staff up to manage the relapses as well.' (CO1)

'I think it's either multi-agency or some sort of dedicated team that can access all kinds of services, but very multi-disciplinary. But I think that, you know, I can't say enough, I think that what works is probably joint funding from different areas. I always use the alcohol treatment centre in Cardiff, that was joint-funded by the emergency unit, by Welsh Ambulance Service, by South Wales Police, by third sector, and that is still standing. Now, obviously it's a very, very different service, which I appreciate, compared to doing something that's co-occurring. However, there's still a lot of buy-in for it. (CO1)

'There's only one detox bed in Gwent. So more in-patient provision for the more complex cases.' (CO4)

'From a GP point of view, I think what they need to be able to do is be able to refer on appropriately without this bounce. I think they need to be knowing if they put someone in place… Maybe what you need is more of a one stop shop, like there seems to a be a lot at the moment of one stop shops, so they go to an MDT and they discuss and they say, "This is definitely for GDAS. No, this is for GSSMS." Maybe that's something that could come out of it.' (CO4)

'I'm quite interested to see how this pilot's going to go. I think that might be quite a useful approach. It would be nice to have more – the thing is it's about cases and ability too isn't it with staff and things like that, it would be nice to do more joint work with our existing services. I think that would probably be the way forward and not sort of 'two strikes and they're out'. So something a bit more flexible where they can work with us for a bit longer, and maybe you know maybe linking with us with some of the things that we do. It might be nice. And I'm sure if we spoke to them they would consider that as an option, so maybe it's about organising that in some way.' (CO6)

'I'm not quite sure what model. I'm not sure about the model or the approach that would be, there's something about outreach which is quite effective, and I'm thinking that might be a more flexible approach that might have better outcomes but then you need to invest.' (CO6)

'I guess a big priority would be around education, public education. Recognition of… so that we recognise… a big priority is to try and… we know that there are these people out there, but we're not seeing them? And maybe we're seeing them too late.' (CO7)

'I think there's definitely something about the narrative. There's definitely something about how we all talk about, and we all talk about, treatment resistant clients, hard to reach people, difficult to engage… that's the narrative that follows people with co-occurring problems around, when in reality are we just offering them crap services that are not suitable for their needs? You know, we have to take some ownership, you know, like we're trying to do in drug and alcohol. Stop talking about treatment-resistant people because they're just resistant to the treatment we're offering, and they're not resistant to it, it just doesn't fit in with their needs. So I think there is definitely something about us taking… everyone taking ownership of… let's think about… is sending two letters and then discharging people, practical for the people we deal with? Is that a practical way to deal with people? Because I don't think it is. Is discharging people from our service when they go to prison, without a review or without meeting them in the prison, without getting an idea of where they are going to, when they're released from prison, are they going to take their medication? Without any of that, just a blanket "No, we discharge them once they go to prison". You know, they've got the sentence. Is that a practical thing to do to people, because we know those people will ultimately end up back up in our services?' (CO8)

'The only danger with the COG Panel, which is the danger in a lot of these things are set up; they have to be gateways to where people should be and not gatekeepers. And that's what sometimes will happen. When people have no capacity, so they have big numbers, what happens is that things like the COG Panel become gatekeepers to the next stage rather than gateways. And as long as the COG Panel remains a gateway to mental health and substance misuse services and not a gatekeeper for it, then it will work really well.' (CO8)

'So, at present because we are looking at this… so, that's why the COG was set up to kind of try and look at these people who fall in-between gaps in the two services, whether we can tap in to that population and see whether we can make a difference. And I think that's where… a lot of the times what happens is… in our service classically what happens is, if we get a referral we send an appointment letter and as you know most of these people are of no fixed abode, and they are not really good at opening their mail, they change their telephone numbers left, right and centre.' (CO9)

'So, I think what happens is, obviously as a service if I was supposed to see somebody today, they didn't come, I'll send one more appointment. If they didn't come, then I would be forced to then say, "Look, I have to discharge the patient back," because after all how many times am I going to keep sending a letter to this person? Yes, in the referral say if something does alarm me or worry me, then I might ask my team manager, "Can we send somebody out to knock on their door?" but if the person is NFA, and if we contact them over the phone, I think it's impossible. How do you locate somebody? And I think that that is the tricky bit, and I think that's where if we had additional resource in the form of more support workers, of somebody who could keep going. I think what you really need is to build a relationship and a rapport with these individuals, because

I think that is what the problem is. I think there's this element of fear, worry - "What am I going to be asked? I don't know this person. Am I going to be judged if I say something?" and we get all that, but I think the challenge is, I myself don't have that luxury of time and ability to go knocking on these people's doors, and at the same time, and I won't apologise for this, we also have to make sure that we are safe. You see, even if we are sending staff, we have to be very certain that we're not putting our staff at any harm. I think there's lots of things that come into play, and I think sometimes we would also appreciate more input and help from our colleagues within the criminal justice system. If somebody's on probation what we would really like is, if we know that there's a probation officer involved, we'd also try and see if we can contact the probation officer to see if they can come in for the appointment, if they can sit in, or if they can let the patient know about this appointment. It's rather disappointing that that's not really forthcoming. I can't even recall when the last time I saw somebody with their probation officer was. Having said that though, their reasoning might be that they don't have resource, they are inundated, and I get that. I get that, but I think if every one of us started saying the same thing, then I really don't think that we're going to make any progress.' (CO9)

'So, we don't have an assertive outreach team that caters for individuals with issues of this nature. So, at present we are going through a massive reconfiguration and changes in our service, although I know that it's still going to take a couple of years before it all really takes shape. But I know that colleagues of mine have been visiting different parts of the UK to try and see, not just for the substance misuse service, but also within the adult population, what is out there and what has worked and what has not worked. And I know that one of the things that staff were discussing at one point was where they had a small team who would after a certain time in the evening go out, especially individuals who are homeless or on the streets, or within the police control, what kind of calls they were getting.' (CO9)

'I think moving forward what we are aiming to have is... at present within Gwent we have so many different telephone numbers, so I think it's really difficult for anybody to know what number do you ring? How do you access help? Because there are so many inpatient units. Moving forward what we're aiming really to have is one number and then if in that hub we can have individuals from health, from social services, from housing, who can be sitting in this hub, who might be able to then redirect this person... or even from benefits.' (CO9)

*'Well, one of the things we were looking at in Newport is, we've got a number of buildings that are dilapidated, out of date and we've got a bit of an estate strategy going. We're looking at this kind of new build, and this is pre*COVID. They're thinking it'll have to change a little bit now, but what we were thinking was a kind of massive open plan office with substance misuse, older adult and adult all sat, not quite like a call centre, but broke bread together, had a coffee and met each other. So, any teething issues, you could have conversations with people. That was kind of thinking what we'd like to do for Newport, and then have your rooms downstairs for your group work, if there were joint assessments needed. So, you didn't have to phone someone, you didn't have to phone a duty desk, you just had a conversation.' (CO10)*

'I think we miss a gap with schools, with… and things are improving and I'm well aware of that, in terms of how we're addressing mental health as a society, but it's still hugely fearful by a lot of the population, and I know we have people who do go in to schools, but I just think we're not doing it right. Whether we use that through the medium of drama… there are theatre companies out there who would be more than happy to put on a play for 15, 16 year old kids who think "Oh God, this is really boring", but just be more creative. Get hold of people… we've got peer mentoring which is happening now and we have just put forward the name of one of our service users. He's done the peer mentoring; hopefully, he'll get a full-time job out of it. So, utilising them more … And actually getting in to the wards when those service users who it might be their first time admission… we've got a young lad now, he's 18. He's been in CAMHS, and he's so damaged, it's really sad, and he'll be with us about 12 months, I think. You look back through the history and you can see opportunities that were missed.' (CO11)

[On service user involvement] *'I don't think we're that good at it. I look at some of the SUI's that have gone on and a lot of time and energy is spent on the reports and the investigations and so on, but then it's how we share that information and how we agree things need to be changed and how we go about changing it. I don't think we do that very well.' (CO11)*

'I think we do. Yes, I think we do need more assertive outreach. The ability to do home visits, or at least visit to locations that people are more comfortable with. What have you got in every little God-awful village up the Valleys? You've got a pub and you've got a church. Why are we not using them? You've got readymade resources where people already feel comfortable coming through the door. There are things you can do there. You've got to acknowledge that you need different solutions for different geographical locations. So, you talked about Powys. I mean, the issue they get is with supervised consumption in pharmacies, because not every village has got a pharmacy.' (CO13)

'I think we very, very, very seriously need to look at the needs of that group that are those emotionally poorly regulated, multiple traumas and substances increase impulsive behaviour because they just can't manage what's going on in their head, rather than constantly saying, "You don't fit with us. You don't fit with them." Something's got to be done, because at the end of the day those individuals are suffering.' (CO13)

'I think some areas are definitely thinking in a different way and are further ahead of the game in terms of Gwent. Caerphilly, and Newport, and Monmouthshire, they seem to be… Particularly around the Housing Two stuff, and understanding the work that had been done around homelessness and complex needs. I think they've definitely prioritised within at least the next six months, they're looking at scoping out and putting new posts in place and I think that will definitely inform the co-occurring agenda. It'll be interesting to see how coordinated it is and how it looks. I think areas where there seems to be less engagement, on a borough basis at least, you've got Torfaen and Blaenau Gwent which are a little bit out on a limb. I don't get an understanding… Torfaen's always a bit like that anyway. The kinds of… I don't know what it is or why, or maybe it's because it's not… I don't think it's an integrated… Like Newport is an integrated… The CMHT is integrated and I think through that they've got very good links with

local authority and other partners. Maybe it's because it's not integrated in Blaenau Gwent. I think it's really trying to get on paper and evaluate all these different projects that are going on, particularly… Newport may be where they've started, but I think it's looking at, "How do we apply this elsewhere?"' (CO14)

'I think it's a point of access really, that hub, one stop shop, whatever you want to call it, that place where somebody, they don't need to be referred, they've got a problem, they need to talk to somebody about it, and having people available of all different backgrounds and professions on site to be able to go… They might not be the person sat down doing an assessment or having the conversation, but they're in the next room so you can go and ask. You've got the benefit of their expertise.' (CO14)

'What is needed is palliative care provision for very vulnerable service users. It's not currently available. Key area that needs to get onto everyone's agenda.. we have an aging population of homeless people. It's a huge priority… end of life late 40's early 50's for those who are homeless and have substance use issues. It's unlikely they could access hospice provision across Gwent given the chaotic nature of substance use.' (CO16)

'More delivery of more specific accommodation would be helpful. From a housing support perspective, we need to think how we deal with people with co-occurring conditions whilst they are able to access both mental health and substance services they need. How do we work with those people? Practically, we would need to be clear about who we are working with and why we are working with them, perhaps be clearer that we are working with active drug users with mental health issues, be very clear. It's not clear enough.' (CO16)

'It would be good to have services integrated with the mental health teams, that might mean someone could get help with both [substance use and mental health] at the same times rather than getting help for one and then the other later. Get workers within the mental health teams that specialise in drug and alcohol misuse.' (CO18)

'Genuinely, I mean all services since COVID have had to find a new way of working. That's fact, so their way of thinking has altered, which is fantastic, so then you haven't got that battle "hang on guys; that kind of way isn't working," or "it does work, but not as good as this way." The services that I've met so far are all really pushing forward. One service I am having a problem with is a lot of GPs, and how they work… There's a missing bridge between our GP service and us, and GSSMS, and GDAS, and this psychology support. Moving forward, I mean if we can build this bridge between our GP services, it would be fantastic. It would make this transition smoother, faster, and if we're picking up something here, why couldn't they pick up something there? You know we share provisions at the end of day, and ultimately our patient, these are the people that we are letting down by not having these things in place.' (CO23)

'That's what I do, but we're bringing them in, and then they get seen by the doctor, and we provide these links between the services. And I would just love to see psychology attached to GSSMS and GDAS, because without that we are just going to keep seeing this cycle, and we need to break the cycle. And that's what's needed. I mean services as a provision, I mean we are evolving, and that's just the way it is. But we are missing services; we are missing the psychology service,

because these guys are not going to stop taking substances. But we did have a bit of a breakthrough, you know initially if they use substances then they won't provide a level of psychology, which I get. However, we've managed to get it down to if their use is not extremely high, and they don't use on that day, they will provide some psychology.However, we need psychologists for substance misuse and trauma to be bolted to these other services, to substance misuse services so they will work with them. Keep this outreach going, we could even assist them to attend their appointments, and then with a wraparound service from Pobl and Houses First, this new initiative, you know that's the way forward. That's the way forward, because eventually if we improve quality of lives and help these people gain skills, then we will see this cycle change. It won't be this loop, you know in, out; in treatment, fall out of treatment, and it's just this continuous… and that's what we've got to break.' (CO23)

One interview recognised the need to think 'outside the box' and be more innovate in terms of future service provision to help those with co-occurring conditions.

'We need to be more innovative; how do we deliver projects to those with co-occurring conditions and housing needs. How do we acknowledge that people are taking drugs and deliver the projects that people need. We need to look at innovative projects such as wet houses, dry houses and safe consumption facilities. We have the regional governance established and great links with all services, so why can't we be more innovate with the support of the Welsh Government, so we give the people the support that they need. Have we got enough rehab beds? Recovery housing? Going forward let's be more innovative.' (CO16)

'So minimum unit pricing is definitely an important plank, in terms of a strategy to try and help minimise alcohol-related harm; there's no doubt about that. It's a population level intervention rather than a hospital level intervention, but the evidence shows where it has been introduced, and including recently from Scotland that it does lead to a reduction in population consumption, and particularly leads to the biggest reduction in cheap high strength cider, which is a big target population for people with co-existing conditions. So we see a lot of people who have… because we know in people with mental health issues and alcohol-related issues, proportionally those most severely affected are in lower income groups.' (CO2)

'We've still got an issue with drug death; that needs to be looked at and supported. But if I wanted to see a change, what I'd like to see is a greater attention within health board's finances for mental health services. I think, because one of the things that we have an issue with is people come in, sometimes they have brain disease-related to alcohol, and we don't have a good service for those people…And they're often young, they have like a dementia-like process, often in their thirties or forties… There are no nursing homes, or facilities to be able to take people, to help provide them with the right support, and they often struggle and stay in a hospital bed, which is the worst place for them.' (CO2)

'That's a hard one. I think the Third Sector needs to join up more, but I think that needs to be core facilitated; I don't think that the stack of organisations who fund the Third Sector to deliver these services actually work together. I mean the Head of local authority should be holding meetings with the Third Sector to say what they expect, to say what they want to see; to say "can

you please evidence for that; how you are core sharing services?" … That would be a massive difference for me, because in the Third Sector right across Wales really, all we do is compete with each other. … You know Third Sector will have a tendency to hang on to participants rather than pass them onto another organisation… But a lot of that comes from the pressures put on them by the funding bodies to say "hold on, we don't want that; we're paying you to do that." So I think there needs to be a far different approach to how things are funded, but also it should be evidence based. And if you've got organisations who are working in isolation, then I think you need to say "is that the best way to utilise our money, or do I need to invest in another organisation willing to work across multiple agencies?"' (CO3)

'I'm impatient by nature, so I had to really learn about patients working in these big systems. So, I think we're doing really well, aren't we? Scotland and Wales are doing really well at having ACEs networks. That's incredible and the research that is coming out of it. So, what happens then is that is fed back to a system that then… it's just about, can you just have a conversation about trauma, and then what people… they have the conversation and it's so… I think about myself, day to day, listening to detailed graphic… treat trauma, which is different to just hearing about it, isn't it? I listen to detailed, graphic accounts of trauma, and I come home to my children, and I've still got to let them walk out in the street, or with my daughter wearing next to nothing. So, how do we give this information about trauma, and hold optimism. So, if you've watched the ACEs in Wales video, it's so depressing. It's so depressing. Everything about it. o, how do we hold optimism? How do we be mindful that we might be delivering those messages to people that have multiple ACEs? How do we treat our staff, in recognition that many of them will have those same experiences and help them reduce the dissonance that they feel? Then how do we help people… to give trauma the weight that it needs, but to be really optimistic about post-traumatic growth and healing? So, that's one thing, is about how we manage the message about trauma and then I guess the other thing for me is just whole systems approaches. So, I feel so inspired by what, certainly in Aneurin Bevan, they're doing with Children's Mental Health. CAMHS will do whatever CAMHS does, but certainly people like Liz Gregory and her cohort I guess, her department, are embedding themselves in services where children will be, in schools, in colleges. In families, in the local authority with looked after children. Having all those things that you're talking about in Dundee, modelling kindness, talking about compassion, understanding that a child is not being… my daughter is in year ten. She'll come home and say, that person is smoking weed, or that person is on Snapchat sniffing a line of coke, and I think, in year ten? There's no point giving those kids a drugs lecture. Their teachers need to be acting with kindness and compassion at all times, and if that changed, those kids would probably feel that they had someone they could go and talk to and trust. So, it's really… psychoeducation on a Public Health level, does next to nothing. Too much dissonance, isn't there? So, I have real optimism around these whole systems approaches. I think Child Services have got a real window of opportunity. I think with adults, we need to try and learn from it and look at what are our whole systems, like A and E and… did you ever see Critical? The ICT in the Gwent, they were filmed for the BBC. I was struck that they had better psychological formulation skills than our psych liaison team. So, they had multiple people that have significant problems with drugs and alcohol, unconscious, in

resus. I was so struck by their compassion and their ability to understand that this was socially-driven, because it's not… treating this person with methadone or Subutex or whatever was not going to be the thing. So, whole systems and really understanding the message about trauma and stuff. (CO32)

APPENDIX V: SURVEY RESULTS (STAFF)

Introduction

A series of three surveys were developed for distribution amongst:

1. Staff working in Substance Use services (GSSMS and GDAS) - 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

Substance Use Staff Survey

There were fifty-three total responses to the Substance Use Staff Survey. Nineteen of these were deleted by the team as they contained demographic details only. The overall total of responses used for analysis was therefore **34**, broken down as follows:

- **26** (76%) responses were deemed 'fully complete', as 100% of questions were answered by respondents.
- **8** (24%) responses were deemed 'partially complete', less than 100% of questions were answered by respondents.

The majority of respondents were female (85%, n=**29**), with males (12%; n=**4**) and non-binary (3%; n=**1**).

Just under two-thirds (n=**21**) of respondents were aged between 36-65 years. The full breakdown is as follows:

- **2** (6%) aged 21-25
- **5** (15%) aged 26-35
- **9** (26%) aged 36-45
- **12** (35%) aged 46-55
- **5** (15%) aged 56-65
- **1** (3%) ages 66+

Job role

Staff who responded came from a variety of job roles within alcohol and drug services, however 41% (n=14) are in a Keyworker / Case Holder position. The full breakdown is shown in the table below.

Table AV.1: Respondents' Job Role

Job Role	Frequency of Response	As a % of Total Responses (n=34)
Keyworker/ case holder	**14**	**41%**
Team Manager	3	9%
Service Manager	3	9%
Nurse	3	9%

Other job roles include:

'Data Administrator.'

'Recovery Worker.'

'Outreach Worker.'

50% (n=**17**) of respondents have been in their job role for over 5 years. Just over a third (n=**11**) have been in their job role for between 1 to 5 years, whereas 18% (n=**6**) were new to the role (less than 12 months.

Service

The majority of staff who responded work for Gwent Drug and Alcohol Service (79%; n=**27**). Other services include Gwent Specialist Substance Misuse Service (GSSMS); Gwent VAWDASV; Barod; and Independent Supported Living.

Language / terminology

Given the variety of terms used to describe individuals with co-occurring conditions (e.g. dual diagnosis, co-occurring, complex needs, co-existing, comorbid etc.), respondents were asked to comment on the issues /challenges around the language/terminology. A key theme to emerge in terms of how to refer to this issue 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.

'I believe it is simpler for the service user's needs to be referred to as dual diagnosis.'

'I believe that it should be dual diagnosis this is clear definition that any person can understand whether professional or client.'

'I usually come across the terms dual diagnosis, co-occurring and complex needs. I understand these terms, but I feel universally something like dual needs would make sense.'

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

'I prefer the term co-occurring to dual diagnosis (often there isn't a diagnosis). I think medical services need a term that they feel offers an understanding of the threshold that they treat people at. It is less for substance misuse services but more important for medical services. Complex needs is too broad.'

Respondents did have mixed views in terms of the issues and/or challenges with using the terminology and there was recognition that the terminology used by professionals may not be understood by those being diagnosed.

'Some Clients would struggle to understand certain terms used as very often allocated workers will need to spend time explaining this. I would consider a self-screening tool that prompts staff to ask the correct questions which then continues to ask further questions relevant to client disclosure.'

'The terminology is overly complex. When events around this are on, I have to explain to them what the terminology means as they initially don't think it includes them. I feel going back to basics would be better so for instance 'anyone with a mental health concerns as well as alcohol or drug use' - so make the terminology more straight forward and service user friendly.'

Sources of learning, training and development about co-occurring conditions

Respondents were asked to state their main sources of learning, training and development about co-occurring conditions. 85% (n=**29**) of respondents stated that their main sources of learning were through 'In-service education', which was followed by 'Multi-agency training day' (47%; n=**16**). Respondents were able to choose more than one option. A full breakdown of responses can be seen in the table below.

Table AV.2: Respondents' Main Sources of Learning, Training and Development

Main sources of learning, training and development	Frequency of Response	As a % of Total Responses (n=34)
In-service education	**29**	**85%**
Multi-agency training day	16	47%
Own reading of research (e.g. journals etc.)	21	62%
Attending conferences / seminars	11	32%
Academic course	5	15%

A number of respondents provided additional details on the types of academic courses and other training which has aided their professional development, as seen below.

'I have attended substance misuse training and have signed up to participate in further substance misuse training this month as it appears to be becoming more common in my everyday work. I read various journals and articles in relation to substance misuse in order to try and keep on top of the topic and any new information that comes to light. I have also attended training in relation to mental health which includes topics such as substance misuse, Dementia and risk assessments.'

'I have a BSc Psychology undergraduate degree, so have learned about mental health and substance misuse through studying and reading articles through the course. I have also learned about mental health and substance use conditions through training provided through my current job.'

'Psychology degree, counselling diploma, Inservice training, day to day experience and learning.'

Primary source of learning, training and development about co-occurring conditions

Respondents were asked to state their *PRIMARY* source of learning, training and development about co-occurring conditions. Just under two-thirds (62%; n=**21**) of respondents stated that their primary source of learning was through 'In-service education', which was followed by 'Own reading of research (18%; n=**6**). A full breakdown of responses can be seen in the table below.

Table AV.3: Respondents' Primary Source of Learning, Training and Development

Primary source of learning, training and development	Frequency of Response	As a % of Total Responses (n=34)
In-service education	**21**	**62%**
Own reading of research (e.g. journals etc.)	6	18%
Multi-agency training day	4	12%
Academic course	2	6%
Attending conferences / seminars	1	3%

Additional comments on respondents' primary source of learning include.

> *'Having worked in this field in a number of different locations geographically over quite a long time, I have realised that mental health services and substance use services operate very differently across the UK and have found I need to learn how the services work together whenever I change employment I feel it would be better is services had a standardised approach but understand that services also have to reflect the local services user's needs.'*
>
> *'There is no doubt that once in service, you encounter difficult situations and learn from colleagues, seniors, managers and exterior agencies about the nature of different mental health conditions and how to work with people with these conditions. Although I arrived, knowing much theory about different mental health conditions, how to work with them was something I had to learn while on the job as it were.'*

Learning, training and development opportunities

Respondents were asked whether the learning, training and development opportunities they had received, had been sufficient to enable them to work effectively with individuals with co-occurring conditions. 62% (n=**21**) of respondents indicated that it **has** been, whereas for 35% (n=**12**) it **has not** been. The 12 respondents were given the option to explain the reason for their answer. Below is a flavour of comments provided.

'I did not feel it was sufficient to receive a few hours of training to be able to address the needs of complex clients.'

'I feel the training I have attended to date has been very good at providing information relating to both mental health and substance misuse in general but I do not feel it has provided much information with regard to the best way to work with people experiencing co-occurring conditions and how to work with these clients appropriately.'

'Insufficient training. I learn from supporting individuals.'

'I feel that I am aware of many mental health conditions and have knowledge around substance misuse. However, I do not feel that I am not as confident when working with individuals with co-occurring mental health and substance use conditions and feel that it would be beneficial to have more training around co-occurring conditions/dual diagnosis.'

Future learning, training and development needs

Respondents were asked to identify their future learning, training and development needs to work effectively with individuals with co-occurring conditions. Twenty-eight responses were received. 'Training' arose as a key theme, with eleven (40%) respondents alluding to this in their responses as seen below.

Joint working/ training

'Training from the MH team would be useful specific to the area that the service is based.'

'In order for me to carry out my role effectively I believe the need for training is with external agencies making referrals for people with complex needs.'

Additional training

'More training in understanding and triage of mental health issues associated with substance abuse "

'Consistent training package delivered through WG so that everyone is at the same level and understanding going forward.'

'More intensive, in-depth training. Regular updates and multi-agency forums to discuss the changing requirements of our clients.'

Co-occurring conditions specific training

'Dual diagnosis training.'

'I feel that I would like to attend more training courses in order to work effectively with individuals with co-occurring mental health and substance use conditions.'

Other notable comments received centred around partnership working.

'Continued research and multi-agency working.'

I would like to see more emphasis on partnership working between health and social care.'

Defined criteria for assessing co-occurring mental health and substance use conditions in Gwent

Respondents were asked if they were aware of a 'defined criteria' for assessing co-occurring conditions in Gwent. Just over two-thirds (69%; n=**19**) of respondents were not aware of any defined criteria, compared with 31% (n=**8**) who were.

What is the criteria for assessing co-occurring mental health and substance use conditions in your service?

In terms of the criteria for assessing co-occurring conditions in respondents' service, of the 21 responses, 71% (n=**15**) noted an awareness for a defined criterion, with this occurring during the assessment process.

> *'The person can request an integrated assessment. We would carry out an integrated assessment , speak to both the person and their family, as well as any other professionals involved in their care, in order to gain a holistic picture of their situation and use this information to devise an appropriate care and support plan with the person concerned.'*
>
> *'During initial assessments, keyworkers will ask a range of questions about an individual's mental and physical health. Often, clients will have mental health issues such as anxiety and depression. It is important that keyworkers establish whether clients are getting the appropriate support that they need for their mental health issues. GDAS employ dual diagnosis workers that specifically work with individuals with complex mental health and substance use conditions.'*
>
> *'We ask about current and past mental health service involvement as part of our assessment.'*

However, the other 29% (n= **6**) were not aware of specific details or unsure of any set criteria:

> *'I am not aware of specifics.'*
>
> *'Am aware of the criteria but don't know the details of this.'*
>
> *'Unsure.'*

Joint working between mental health and substance use services

Respondents were asked how well mental health and substance use services work together for people with co-occurring conditions. In the main, respondents had consensus on this issue, with the current situation needing improving as few examples of effective joint working were noted. From the comments provided, there appears to be a reluctance of mental health services to work with people who are using substances.

> *'Many of my service users do not get the support that they need i.e. therapies because they are using drugs/alcohol and told by MH services they need to be abstinent. The problem with this is that many have endured trauma in their life and self-medicating with substances. My service users receive therapy If they request rehabilitation placement. Unfortunately some service users*

do not complete their rehab placements and I feel that if they received some therapy in the community prior to going in (if applicable) they would have a better understanding of what is required and maybe outcomes would be different.'

'From my experience working for the Wallich, Mental health services are reluctant to work with substance misuse conditions.'

'Poorly - the services continue to work against each other. Mental health services are be resistant to working with active drug users.'

There were some respondents who provided examples of collaborations, with particular praise coming in for an under 18 service, and links between Gwent Drug and Alcohol Service and Gwent Specialist Substance Misuse Service.

'Excellent for under 18 services as we have an integrated service model. All substance misuse referrals in Gwent are discussed at a joint allocation meeting and allocated to either the complex CAMHS substance misuse workers or generic substance misuse workers depending on level of need. Once allocated the two strands of the service work together to ensure the appropriate support is offered - this can mean joint working on cases, transitioning young people from one strand to the other and/or supporting each other with consultancy support and advice. For young people requiring more generic mental health support (that does not require the support of the N-gage substance misuse team), referrals are made into the SPACE and well-being panels within Gwent for access to PMHT/CAMHS teams. N-gage are actively involved in these panels which ensures referrals can be discussed to ensure the appropriate service can be offered. Ongoing support that is offered by these teams can be monitored via the substance misuse CAMHS team as they have access to the NHS databases.'

'There are pockets of very good practice. GDAS works well with GSSMS when we have patients who need dual support. We have good lines of communication and set pathways.'

'Very. We have a dual diagnosis nurse whom we can access very quickly.'

Primary responsibility for treating those with co-occurring conditions

Respondents were asked to identify which service should take primary responsibility for differing (combined) severity of mental health and substance use presentations. The results are shown in the table below.

Table AV.4: Primary Responsibility for Treating those with Co-occurring Conditions

Presentation	Substance use service	Mental health service	Both	Other
High level substance use and high mental health problems	3% (1)	11% (3)	**86% (24)**	0% (0)
Low level substance use and high mental health problems	3% (1)	**60% (16)**	37% (10)	0% (0)
High level substance use and low mental health problems	**52% (14)**	0% (0)	48% (13)	0% (0)
Low level substance use and low mental health problems	22% (6)	0% (0)	**78% (21)**	0% (0)

The table above shows that, when the presentations include equal levels of both substance use and mental health problems respondents are overwhelmingly of the view that both services should take primary responsibility. For example, 86% (n=**24**) of respondents were of this view in terms of presentations for high-level substance use and high mental health problems, whereas 78% (n=**21**) were of this view for low level substance use and low mental health problems. Mixed views are observed when it comes to primary responsibility for high-level substance use and low mental health problems, with 52% (n=**14**) of respondents thinking substance use services should take primary responsibility and 48% (n=**13**) thinking this should be the role of both services. Just under two-thirds of respondents believe that the primary responsibility for those with Low level substance use and high mental health problems, should be mental health services (60%; n=**16**).

Challenges facing those with co-occurring conditions

Respondents were asked, based on their experience, what challenges do those with co-occurring conditions in Gwent face. Key themes to emerge centre around 'Access to mental health services', 'Housing / homelessness' and 'Accessibility.'

Access to mental health services

From the comments below it appears that lack of access to mental health support is a pressing challenge for those actively using substances.

> *'Not getting the support from mental health due to on-going substance use.'*
>
> *'Mental Health services will not assess when a service user is under the influence.'*
>
> *'When you try to support clients to access support substance use services are advised that the mental health issues cannot be assessed until drug/alcohol use is managed.'*

Housing / homelessness

There was also acknowledgement that access to housing and or homelessness is challenging, with one respondent of the view that difficulty in maintaining a tenancy results in homelessness.

> *'Housing: those with co-existing conditions often find it hard to maintain tenancies leading to homelessness.'*
>
> *'Homelessness.'*

Accessibility to services

Related to accessibility to mental health support above, a lack of, and poor accessibility to, wider support for clients was stated by some, with more flexibility suggested going forward.

> *'To access the support they require, not putting other barriers in the way of accessing the support they require and deserve.'*
>
> *'Services need to ensure that they work in a flexible, needs-led way to maximise accessibility for service users. We need to learn from our service users about how we can make ourselves more suitable for those that don't fit the 'norm' and are unable to engage in the office/clinic-based appointments that so many people struggle with. Working in more community-based settings, co-locating with services, offering support to attend appointments etc.'*

<u>Gaps in Current Service Provision</u>

Respondents were asked whether they thought there are any gaps in service provision/ support for those with co-occurring conditions in Gwent. **28** people answered this question, and 93% (n=**26**) thought that there were gaps. Respondents talked about mental health support as a priority area and there was recognition that those with co-occurring conditions are not receiving adequate support: A flavour of responses are presented below.

> *'As described earlier service users don't always receive the correct support due to being dependent on drugs and alcohol and being transferred back to substance misuse service. Mental health support is usually provided in crisis situations i.e. suicidal and admitted to hospital. Service users don't always receive support for their mental health. Often referred to voluntary sector such as Platform or MIND. Very few referrals to primary mental health or community mental health team.'*
>
> *'More investment in mental health support to liaise with both drug and mental health services to prevent people falling through services as what we have is good but there needs to be more of them. Educating staff in mental health and substance use what services are available and who can make referrals. More community mental health support such as what MIND currently offer.'*
>
> *'I feel there should be a team who are willing and able to work with people who experience co-occurring substance use and mental health conditions who fall into gaps within the present services. For example, a person with co-occurring conditions who is not compliant with*

substance use services and is not eligible for mental health service support as these people are materializing more frequently and there is no appropriate support that can be provided to them. If there was a team who could visit these people regularly and build a rapport with them, they may be able to help people become compliant with the appropriate services while monitoring their situation and ensuring their safety. At present these clients are being left at risk in the community with no appropriate support.'

Areas of Duplication and Overprovision

Respondents were then asked whether they thought there were any areas of duplication or overprovision in Gwent for those with co-occurring conditions.

Twenty-eight people answered this question. 82% (n=**23**) did not think there were any areas of duplication or overprovision. Comments made by those who feel there are areas of duplication include.

'Some service users are being supported by Substance Misuse Social Workers, GDAS and CMHT/GSSMS rather than 1 substance misuse service being involved with the service user and 1 mental health service.'

'At present there are two separate services which do not work well as a joint entity, resulting in duplicate assessments and many different faces asking similar questions which is frustrating and confusing for the people experiencing co-occurring conditions.'

Other assets, resources, groups, individuals, and/or opportunities

Respondents were asked to provide examples of other assets, resources, groups, individual, and/or opportunities available across Gwent to support mainstream services in meeting the needs of those with co-occurring conditions. Eighteen people responded. Six respondents were 'unsure' or answered 'none.' The main assets, resources, groups, individuals and other opportunities identified/referenced are:

- Mind (n=**6**)
- New Pathways (n=**4**)

Other comments include.

'Police, especially the forensic psychiatric team. I have managed to get several clients into ST Cadocs for an assessment that way, sometimes after several assessments by CMHT. People need to be in total crisis before anyone listens to them. Clients are aware of safeguarding guidelines and will threaten to kill themselves or others or disclose they are carrying weapons.'

'Recovery activities, drop-in centres, self-help groups.'

Groups who have a co-occurring conditions who are NOT well- catered for

Respondents were asked to identify any groups which were NOT well catered for in Gwent. **20** respondents provided commentary, with people affected by homelessness a key theme to emerge.

> *'Homeless individuals are difficult to engage into services. It would be great if there were strategies in place to help this group of individuals to seek help and support for their co-occurring conditions.'*
>
> *'Those that are NFA.'* [no fixed address]
>
> *'The Homeless.'*

For two respondents, all groups are not well catered for.

> *'All groups.'*
>
> *'All groups are not well catered for.'*

Co-occurring principles

A recent Public Health England (PHE) guide to better care for people with co-occurring conditions aims to encourage different agencies to work together to improve care for people with co-occurring conditions. Two principles which underpins this ambition are:

- **'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).
- **'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).

Respondents were asked to what extent are the 'It's everyone's Job' and 'No wrong door' principles embedded and embraced across Gwent. The table below has a full breakdown of responses.

Table AV.5: Co-occurring principles ratings

Principle	Not at all	A little	Partially	Fully	Don't know
To what extent is the 'It's everyone's Job' principle embedded and embraced across Gwent?	25% (7)	**29% (8)**	**29% (8)**	11% (3)	7% (2)
To what extent is the 'No wrong door' principle embedded and embraced across Gwent?	**29% (8)**	**29% (8)**	21% (6)	11% (3)	11% (3)

From the table above, it can be seen that for both principles, more than half of respondents believe that the two principles, 'It's everyone's Job' and 'No wrong door' are 'Not at all' or 'A little' embedded across Gwent, with (54%; n=**15**) and (58%; n=**16**) respectively.

Areas of support that are particularly good in mental health services for those with co-occurring conditions

Respondents were asked what they felt their services did particularly well in supporting those with co-occurring conditions.

Dual diagnosis support

A consistent message to emerge from the analysis of respondents' comments centres around 'Dual diagnosis support' with a number of respondents of the view that dual diagnosis specific staff and the links into dual diagnosis services were working well. A selection of comments to illustrate this include.

> *'Referring to the in-house dual diagnosis nurse.'*
>
> *'We have an in-house dual diagnosis team who are fantastic and supportive with any queries and with supporting clients that wish to engage. The team needs to be much bigger as they are overstretched with picking up the slack from the MH services.'*
>
> *'I believe that it is beneficial that GDAS has employed dual diagnosis workers to work alongside those with co-occurring conditions to ensure that these individuals engage with services and do not slip through the net. Our keyworkers have had a variety of mental health training so are able to give out general advice and support around mental health support. Keyworkers are also able to signpost individuals to appropriate support groups to help with specific issues.'*
>
> *'Good assessment and access to dual diagnosis services.'*
>
> *'The Hub is often quoted as a good support for clients with mental health issues as they can drop in when they feel the need for support. Our new dual diagnosis team works well to advocate for clients with mental health providers.'*

'Appointments' was another message to emerge from the data, with supporting clients to appointments an area of particular praise, as seen below.

> *'Supporting clients to attend medical appointments.'*
>
> *'Ensuring they attend appointments with services and encouragement throughout.'*
>
> *'Whilst trying our best to address the substance misuse issue we also support clients with CMHT appointments. This may be to arrange joint appointments etc. We also keep the CMHT consultant informed with what we are doing / prescribing.'*

Service improvements

Respondents were asked how they think their service can be improved for those with co-occurring conditions. Two messages to emerge can be grouped into the themes of 'Mental health' and 'Training.'

Mental health

Mental health was generally seen as an improvement area. There seemed to be a view that better links with mental health services are required to fully support people with co-occurring conditions:

> *'Networking with mental health support services to ensure individuals receive the support they require.*
>
> *'More access to specialist services more outreach provision More prescribing spaces less silo working/better links with mental health services*
>
> *'Understand more about mental health.'*
>
> *'Having their expert opinions listened to by mental health services. A lot of work goes into supporting the client with their mental health long before they then refer the client to mental health services.'*

Training

Training was also seen as an improvement area.

> *'Better training - in-depth, relevant, frequently reviewed and updated.'*
>
> *'A national diploma for all drug and alcohol workers (conducted on the job if possible), to allow them to have consistently good and appropriate training. This would also give some credence to what is a fairly new professional body, similar to the way in which social workers started to educate themselves in the 60s. I believe that such a diploma is already in operation in some countries such as Australia.'*
>
> *'Need more staff to work with dual diagnosis clients. Training on ACES and PIE.'*

Other comments

Respondents were asked to provide any further comments. From the comments below, client engagement and accessibility appear to be putting individuals with co-occurring conditions at a disadvantage.

> *'It can be very difficult for us to engage with NHS mental health services in a meaningful way. Substance misuse is a smaller issue for them than mental health is for us.'*
>
> *'I have found this an in depth survey ,but would like to add that in my experience if people with dual diagnosis problems were given correct mental health support and shown more empathy from statuary services their need to use substances to self-medicate would greatly be reduced.'*

'When I stated the lead agency in the earlier question I would like to add that this needs to be needs led - whilst someone with a high substance use and low mental health need would primarily be led by the substance misuse worker, there may be additional factors that may affect these. I think the key is ensuring that this is agreed and communicated effectively by everyone from the onset.'

'Addressing the waiting times for clients to access treatment. Waiting over a year to be assessed and treated for poor mental health is not conducive to client's well-being.'

Mental Health Staff Survey

There were 136 total responses to the Mental health staff survey. 33 of these were deleted by the team as they contained demographic details only. The overall total of responses used for analysis was therefore **103**, broken down as follows:

- **74** (72%) responses were deemed 'fully complete', as 100% of questions were answered by respondents.
- **29** (28%) responses were deemed 'partially complete', as less than 100% of questions were answered by respondents.

Demographics

The majority of respondents were female (75%, n=**77**), with males making up 25% (n=**25**). Most respondents were in the 46-55 age range (n=**38**; 37%). The full breakdown is as follows:

3 (3%) aged 21-25

21 (21%) aged 26-35

23 (23%) aged 36-45

38 (37%) aged 46-55

17 (17%) aged 56-65

Job role

Staff came from a variety of job roles within mental health services, with just under one-fifth (18.5%; n=**19**) in a clinical psychologist role. A breakdown of respondents' job roles is shown in the table below:

Table AV.6: Respondents' Job Role

Job Role	Frequency of Response	As a % of Total Responses (n=103)
Clinical Psychologist	**19**	**18.5%**
Community Psychiatric Nurse	16	15.5%
Support/Recovery Workers	11	10.6%
Service Manager	7	6.8%
Team Manager	7	6.8%
Counsellor	6	5.8%
Psychiatrist	6	5.8%
Occupational Therapist	4	3.8%
Social worker	2	1.9%

Other job roles include:

'RNLD practitioner.'

'Housing Solution Service.'

'Mental Health Liaison Officer.'

Over half of respondents (57%; n=**59**) have been in their job role for over 5 years. Just under a third (30%; n=**31**) have been in their job role for between 1 to 5 years, whereas 13% (n=**13**) are new to the role (less than 12 months.

Service

Staff came from a variety of mental health services across Gwent, with several services frequently mentioned, which is reflective of a good level of engagement from mental health services across Gwent. For example, 18% (n=**19**) respondents work within 'Older adult mental health' services, whereas, 13% (n=**13**) respondents report working within a 'Community mental health team.' 11% (n=**11**) work within the 'Gwent Primary Care Mental Health Support Service', and 6% (n=**6**) work for a 'Housing support service'. Other services mentioned include:

'Pobl, Caerphilly Move on.'

'Adoption Service.'

'Child and Family Psychology and Therapies Service.'

'Dementia floating support.'

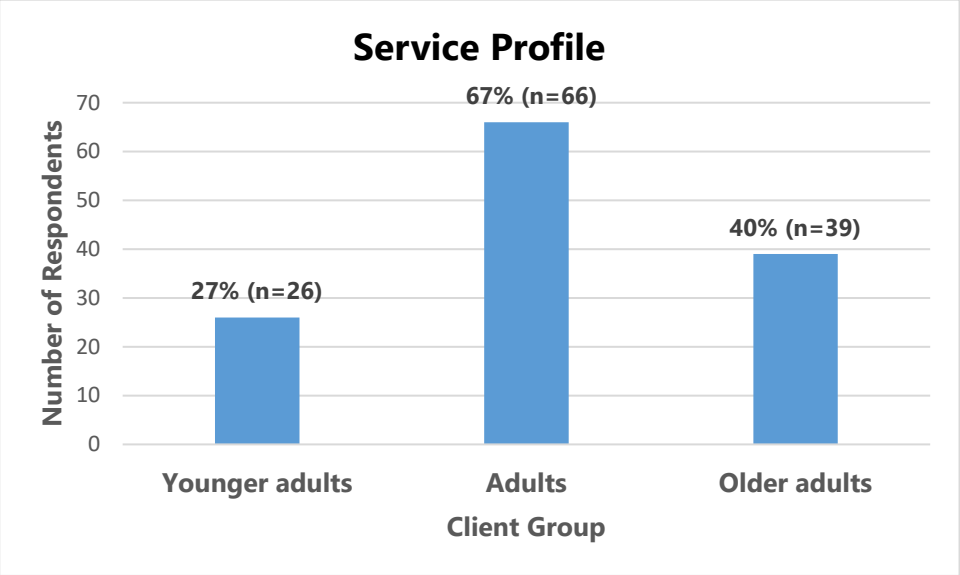
'Eating disorder.'

'Crisis Team.'

Service profile

Respondents were asked if their service works with 'Younger adults', 'Adults', or 'Older adults. Respondents were able to tick more than one answer and a full breakdown of responses is presented in the figure below. It can be observed that for over two-thirds of **98** respondents, their service works with 'Adults' (57%; n=**66**).

Figure AV.7: Service Profile



Language / terminology

Given the variety of terms used to describe individuals with co-occurring conditions (e.g. dual diagnosis, co-occurring, complex needs, co-existing, comorbid etc.), respondents were asked to comment on the issues /challenges around the language/terminology. Mixed views were expressed in the **80** responses in terms of the challenges around using the terminology. As seen below, there was recognition that terms used can be vague and present difficulties in terms of clinicians diagnosing a condition:

> *'Certain patients do not understand different terminology - should refrain from doing so and explain diagnosis in a easier language style for said patients,'*
>
> *'Different phrases mean different things to a clinician. These phrases are vague and do not clearly identify any actual diagnosis or presenting need.'*
>
> *'Can be confusion over terminology used, subjective to each individual.'*
>
> *'It doesn't really matter as long as there is one term chosen. That said it would be very unhelpful to pick a term that is widely understood to mean something else. My personal preference would be dual diagnosis and I consider co-occurring in particular to be an ugly word that is both inelegant in itself and has an association with various comedic catchphrases in the popular consciousness which would be an unhelpful association to bring to this subject matter.'*

'Challenges can include the difficulties in knowing whether certain presentations are as a result of the individuals mental health conditions or from substance misuse.'

Another issue for some respondents is that terms being to describe individuals accessing support can have a stigmatising effect:

'Issues with labelling and stigma. Essentially this client group comprises people with complex needs (and no doubt complex histories) who are unwell.'

'Terminology can be difficult for client group to understand and stigma attached.'

'One generic term that would encompass all and remove some stigma of certain language.'

'Most of those words has a stigma attached to them. People can be judged against these labels. If we are working towards a patient-centred, recovery focused models, those terms should not matter at all. Our service should be catered to individual patient's needs. What's most important is not to create more teams with fancy names but to develop a working culture and environment where every clinician in mental health services (including substance misuse service) work towards that goal without passing the ball to others or blaming others. Effective communication and co-working among clinician from different teams is more efficient and cost effective.'

In terms of preferred terminology, again, as with the comment above, varies views were expressed. A selection of comments is presented below:

'Not sure about this, I tend to think of them as people and patients who are struggling with mental health issue.'

'Co- occurring is preferable.'

'I prefer terms that don't involve a diagnosis. So, perhaps 'co-existing' and then specify the issues.'

'Dual diagnosis.'

'Co-occurring seems an appropriate term to use.'

Sources of learning, training and development about co-occurring conditions

Respondents were asked to state their main sources of learning, training and development about co-occurring conditions. Nearly two-thirds of the **102** respondents stated that their main sources of learning about co-occurring conditions were through 'Own reading of research' (65.5%; n=**67**), which was followed closely by 'In=service education' (60.5%; n=**62**). Respondents were able to choose more than one option. A full breakdown of responses can be seen in the table below:

Table AV.8: Respondents' Main Sources of Learning, Training and Development

Main sources of learning, training and development	Frequency of Response	As a % of Total Responses (n=102)
Own reading of research (e.g. journals etc.)	67	65.5%
In-service education	62	60.5%
Attending conferences / seminars	32	31%
Multi-agency training day	26	25.5%
Academic course	22	21.5%
None	8	8%

Respondents were able to provide additional comments to this question and of those who did, a flavour of these are presented below:

> *'In my previous roles I have worked with adult CMHT and closely with a drug and alcohol team, and prior to that I have worked in a drug and alcohol service. I have gained knowledge and information from other professionals primarily and through my own research. I spent time with OT's also who are based in drug and alcohol services to gain further knowledge. In my current role I have had limited input with people with substance misuse so far.'*
>
> *'Joint working with GSSMS but this is rare.'*
>
> *'We have received a training session via the Specialist Substance Misuse Service. I also experienced a placement with this service whilst a nursing student. I have also nursed patients with various substance misuse problems.'*
>
> *'Training provided during post graduate nursing course. In house training - substance misuse awareness. External training providers.'*
>
> *'Learning from patients themselves.'*

Primary source of learning, training and development about co-occurring conditions

Respondents were asked to state their *PRIMARY* source of learning, training and development about co-occurring mental health and substance use conditions. It can be seen in the table below that just under half of the **101** respondents (42%; n=**42**) stated that their primary source of learning was through 'In-service education', which was followed by 'Own reading of research (24%; n=**24**). A full breakdown of responses can be seen in the table below:

Table AV.9: Respondents' Primary Source of Learning, Training and Development

Primary source of learning, training and development	Frequency of Response	As a % of Total Responses (n=101)
In-service education	**42**	**42%**
Own reading of research (e.g. journals etc.)	24	24%
Academic course	9	9%
Attending conferences / seminars	8	8%
None	8	8%
Multi-agency training day	6	6%

Some respondents made the following additional comments:

'Own experience.'

'Workplace experience.'

'Joint working with GSSMS. MDT - SHARING INFORMATION.'

'I had a small amount of teaching on substance misuse during my Clinical Psychology training (1996-1999) but mostly I've learned on the job - and through discussions with colleagues in the multi-disciplinary team.'

Learning, training and development opportunities

Respondents were asked whether the learning, training and development opportunities they had received, has been sufficient to enable them to work effectively with individuals with co-occurring mental health and substance use conditions. Over half of the **102** respondents who answered this question, 55% (n=**55**) indicated that it **has** been sufficient. For 42% (n=**45**) of respondents it **has not** been sufficient and a selection of comments displaying the views of these respondents are presented below:

'Haven't recieved any formal training.'

'Would like ACES training to be widely available to all front line staff.'

'More information about multi-disciplinary working between teams would be useful.'

'Was some time ago. Used to work in a forensic setting and I was more up to date on recent developments. If I was seeing more people coming to therapy for this as an issue I think that I would have to do some CPD looking at any recent optimum therapeutic developments or issues.'

Future learning, training and development needs

Respondents were asked to identify their future learning, training and development needs to work effectively with individuals with co-occurring mental health and substance use conditions, with **76** responses received. 41% (n= **31**) responses provided commentary to the theme of 'Training', with a focus on substance use and additional and up-to-date training at the forefront of respondents' views:

Training

> *'For myself and my team, training needs to be ongoing rather than a one off, as things are changing all the time, and our funders don't include training costs or time to train in their allowance for activities, unless it is housing and tenancy focused.*
>
> *'Ongoing up to date training. Motivational Training - ongoing refreshers DBT/CBT ongoing training to work effectively with this client group.'*
>
> *'I would benefit from training around co-occurring mental health and substance use as this is still relevant to older adult services however I feel that training is mostly aimed at other areas.'*

A number of respondents emphasised the need for training to be focused on substance (mis)use. A selection of comments to illustrate these views include:

> *'Spending time with the Substance Misuse Team. Having more training via the Substance Misuse Team. Further reading.'*
>
> *'Better understanding of the physiology of substance misuse and mental illness (when it co-occurs) better understanding of how the needs of individuals with both substance misuse and mental illness can be met, rather than them 'falling through the gap' and being denied services.'*
>
> *'I would like to improve my knowledge of substances and their effects on mental state and would also like to know more about the addictive properties of each of the substances.'*
>
> *'How to work effectively with this client group, particularly those who resist intervention and/or who are known to pose risk should mental health deteriorate, which is likely when misusing substances.'*

Other notable, albeit fewer, comments received centered around the theme of 'Updates':

> *'Regular updates. Joint training for OAMH and Substance Misuse health professionals, leading to more joint working.'*
>
> *'Remain updated in relation to developments in substance misuse services.'*
>
> *'Attending a course and annual updates, spending some hours within the drug and alcohol team.'*

Defined criteria for assessing co-occurring mental health and substance use conditions in Gwent

Respondents were asked if they were aware of a 'defined criteria' for assessing co-occurring mental health and substance use conditions in Gwent. Overwhelmingly, (96%; n=**72**) respondents were not aware of any defined criteria, compared with 4% (n=**3**) who were.

What is the criteria for assessing co-occurring mental health and substance use conditions in your service?

In terms of the criteria for assessing co-occurring mental health and substance use conditions in Gwent, respondents' service, of the **44** responses, 39% (n=**17**) were unsure of any defined criteria. A selection of comments to illustrate these views include:

> *'I am unsure of what specific criteria has to be met to decide on if they should be assessed by the CMHT, other than there being an indication of a mental illness as well as substance misuse. A relevant staff member from GSSMS or GDAS will often attend new assessments of people with these co-existing difficulties to determine the best way forward/role of each service.'*
>
> *'Don't know.'*
>
> *'Unsure. Rely on clinical interview and Joint Assessment/Warrn information gathered from patient/ family member.'*

No clear themes emerged from the other **27** responses, however, comments received include:

> *'Asking the service user. Asking the referring person. Asking any specialist agencies involved.'*
>
> *'Those with any current substance abuse issues are usually directed back to substance abusee.'*
>
> *'Services prior to any mental health assessment.'*
>
> *'If the substance use is the primary concern, we ask GSSMS to assess. If not, we assess and may ask GSSMS for advice.'*
>
> *'Much of this is down to professional relationships.'*

Joint working between mental health and substance use services

Respondents were asked how well mental health services and substance use services work together for people with co-occurring conditions. Just under half of the **60** respondents who answered this question (47%; n=**28**) were of the view that joint working between mental health service and substance use services is currently limited or poor:

> *'Poorly - services are often stretched so our inpatient mental health service users have limited access substance misuse services. Further, interventions are rarely adapted to meet the needs of the client population i.e. those who have been in inpatient settings for years and who pose a risk to others.'*
>
> *'There is no direct, dove tailed pathway for clients and we do not meet to discuss a clients journey though we can refer to services on paper. We encourage clients to self refer but no longer work with them or the agency they are referred to once this has happened. I prefer to do a handover by phone with the client present or if possible, a face to face handover(with the consent of the client) as this I believe, helps the client to feel safe and is more seamless for them. Mostly, there is NO TIME to work closely and communicate due to the targets to meet in Primary Care which is a brief intervention service.'*

'Once signposted to specialist services there is no pathway for feedback or outcome re client health/wellness/recovery.'

That said, a number of respondets (18%; n=**11**) were of the view that joint working between the services is working well:

'Reasonably well depending on the severity of the case. '

'I know I can email over to the psychological therapist and we sometimes do joint appointments. This is a very helpful approach.'

'We have a substance misuse team who have CPNs in it. If the substance misuse is a primary problem, they tend to deal with it or we work together.'

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 as demonstrated below:

'We are able to refer to GSSMS and CDT - the problem is that mental health services often won't see somebody if they have a drug problem - it needs to be sorted out first.

'Its patchy, could be improved. we do not know the team well enough to call a specific person. No shared documentation - planned new data system should resolve this we don't understand the role of GDAS / GSSMS fully.'

'We often refer clients who report substance use to GDAS or GSSMS.'

Primary responsibility for treating those with co-occurring conditions

Respondents were asked to identify which service should take primary responsibility for differing (combined) severity of mental health and substance use presentations. The results are shown in the table below:

Table AV.10: Primary Responsibility for Treating those with Co-occurring Conditions

Presentation	Substance use service	Mental health service	Both	Other
High level substance use and high mental health problems	12% (9)	11% (8)	**78% (59)**	0% (0)
Low level substance use and high mental health problems	1% (1)	**70% (53)**	28% (21)	1% (1)
High level substance use and low mental health problems	**76% (58)**	0% (0)	22% (17)	1% (1)
Low level substance use and low mental health problems	12% (9)	13% (10)	35% (26)	**40% (30)**

The table above shows that, when presentations include high levels of co-occurring conditions, the majority of respondents (78%; n=**59**) agree that both services should take primary responsibility. There was, however, far less agreement over which service should take primary responsibility when there are low levels of co-existing problems with 35% (n=**26**) selecting 'Both' and 40% (n=**30**) selecting 'Other.' Over two-thirds of respondents (70%; n=**53**) 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 (76%; n=**58**) of the view that substance use services should take primary responsibility in the opposite situation.

Challenges facing those with co-occurring conditions

Respondents were asked, based on their experience, what challenges do those with co-occurring conditions face in Gwent. Key themes to emerge from the **63** responses centre around 'Access to services 'Mental health', and 'Social needs.'

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, but for some individuals, this presents a double barrier due to lack of transport:

> *'Lack of support, Access to substances readily, poor opportunity for development, taking drugs/drinking too much as part of their social groups.'*
>
> *'The location of the support services for mental health as a lot of my clients cannot access due to travel costs and also travelling far alone with anxiety issues is difficult. needs to be more services available in all areas.'*
>
> *'Access to support for addiction, long waiting times to be seen, not enough psychological therapies for addiction, rehabilitation opportunities for people who are in work, i.e. they can not afford to go to rehab but cant get funding because they work.'*
>
> *'Lack of suitable support services, transport, stigma.'*

Mental health provision

There was also acknowledgement that access to mental health provision for people actively using substances is challenging, and at times non-existent. For example, there was a view that this client group has to cease illicit substance use before mental health support is available:

> *'Lack of support from mental health services if not engaging with specialised services.'*
>
> *'Not receiving the mental health support, they need due to ongoing substance misuse.'*
>
> *'Accessing mental health provisions as often seen as needing to come off substances before MH support provided.'*
>
> *'Mental health staff working in older adult services lacking familiarity particularly with substances other than alcohol.'*

Social needs

Related to accessibility to mental health support above, a lack of, and poor accessibility to, wider support for clients was stated by some, with the issue of transport noted again:

> *'Social isolation, lack of suitable services.'*
>
> *'General challenges I have identified clients experience are lack of transport to allow them to attend social activities and lack of befriending services. There are long waiting lists for the few that are available.'*
>
> *'Lack of basic skills, difficulties in establishing social bonds etc.'*

Housing needs were also identified as a challenge for those with co-occurring conditions:

> *'Appropriate housing insufficient.'*
>
> *'Physical health social - such as housing.'*

Gaps in Current Service Provision

Respondents were asked whether they thought there are any gaps in service provision/ support for those with co-occurring conditions in Gwent. Of the **73** respondents, 71% (n=**52**) are of the view that gaps exist in current service provision. 'Access to mental health support' and 'Joined-up working' are the two key themes to emerge from the data.

Access to mental health support

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:

> *'For people who have low level issues in each area. These people wouldn't meet the criteria for Secondary Care services but would be beyond what Primary Care services can work with. There also doesn't appear to be enough staff with the appropriate skill base to offer adequate psychological interventions in Substance Misuse Service or trained support staff to encourage adherence to the interventions.'*
>
> *'There feels to be a gap where people need to deal with their substance misuse first before being properly assessed for their mental health and vice versa.'*
>
> *'People having to wait up to 6 months to a year to speak to a counsellor, even though this is needed alongside their mental health and substance misuse treatment*
>
> *'Limited access to clinical psychology in GSSMS.'*

Joined-up working

A variety of observations were made about gaps in joined-up working across Gwent, including:

> *'Services do not work in partnership.'*
>
> *'Again, Not working together is the main problem.'*

'I believe there are many "gaps" in the service. Substance misuse and MH services do not appear to work closely together and from our experience the support we have received as a team has been very limited. There is also a lack of "taking responsibility" and we have been told numerous times that substance misuse services do not "care co-ordinate CTP's", which I do not feel is appropriate, particularly if they know the individual well.'

'Joint working between services.'

Areas of Duplication and Overprovision

Respondents were then asked whether they thought there were any areas of duplication or overprovision in Gwent for those with co-occurring conditions. 76% (n=**55**) do not think there are any areas of duplication or overprovision. Comments made by the 15% (n=**11**) of respondents who feel there are areas of duplication include:

'I would imagine that people go through various assessment processes of a slightly different nature which duplicates and frustrates people trying to access services.'

'GSSMS and CMHT - it because the joint working can be 'messy' with no shared documentation and not effectively communicating.'

'There is CDAT, GSSMS, GDAS - there must be some overlap here and it's confusing as to referral pathways and criteria.'

Other assets, resources, groups, individuals, and/or opportunities

Respondents were asked to provide examples of other assets, resources, groups, individual, and/or opportunities available across Gwent to support mainstream services in meeting the needs of those with co-occurring conditions. Of the **49** respondents, 37% (n=**18**) of these said they 'did not know or were 'unsure' of any. The main assets, resources, groups, individuals and other opportunities identified/referenced were:

- Mind (n=**6**)
- Gwent Drug and Alcohol Services (n=**5**)
- 12-step fellowships (e.g. Alcoholics Anonymous) (n=**4**)

Other comments include:

'Gwent mental health consortium Social clubs.'

'Voluntary and 3rd sector organisations, within probation.'

Groups who have co-occurring conditions who are NOT well-catered for

Respondents were asked to identify any groups which were NOT well catered for in Gwent. **49** respondents provided commentary, with 'Older people' 'Mental health' and 'People experiencing homelessness' themes to emerge.

Older people

There was recognition by some that older people are not well-catered for, with one respondent emphasising the difficulties in attempting to treat an older adult's mental health issue:

> *'Older Adults with alcohol related issues. Their alcohol intake can be linked to their social activity and routine. This can be difficult whilst attempting to treat their mental health issues.'*
>
> *'Older people. There should be more screening for alcohol and other substances of misuse when people are screened for memory problems.'*

Mental health

Individuals with mental health issues were also noted, with particular concerns expressed for those experiencing risk-taking behaviors, suicide attempts and additional behavioural issues:

> *'Those diagnosed with Personality Disorder and substance dependence.'*
>
> *'Yes - those patients who have high level substance misuse issues and engage in regular risk taking behaviours including suicide attempts.'*
>
> *'People with chronic substance misuse histories and associated severe mental health difficulties whose behaviour leaves them subject to eviction notices and other consequences of their behavior.'*

People experiencing homelessness

It was recognised by some that people experiencing homelessness are a group not well-catered for in Gwent:

> *'People released from prison and the homeless.'*
>
> *'Homeless.'*

Co-occurring principles

A recent Public Health England (PHE) guide to better care for people with co-occurring conditions aims to encourage different agencies to work together to improve care for people with co-occurring conditions. Two principles which underpins this ambition are:

- **'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).

- **'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).

Respondents were asked to what extent are the 'It's everyone's Job' and 'No wrong door' principles embedded and embraced across Gwent. The table below has a full breakdown of responses.

Table AV.11: Co-occurring Principles Ratings

Principle	Not at all	A little	Partially	Fully	Don't know
To what extent is the 'It's everyone's Job' principle embedded and embraced across Gwent?	8% (6)	26% (19)	**38% (28)**	7% (5)	21% (15)
To what extent is the 'No wrong door' principle embedded and embraced across Gwent?	16% (12)	22% (16)	**34% (25)**	5% (4)	22% (16)

From the table above, it can be observed that a greater number of **73** respondents felt that the two principles, 'It's everyone's Job' and 'No wrong door' 'Partially' embedded and embraced across Gwent, compared with the other options (38%; n=**28**) and (34%; n=**25**) respectively.

Areas of support that are particularly good in mental health services for those with co-occurring conditions

Respondents were asked what they felt their service did particularly well in supporting those with a co-occurring condition. Two consistent messages emerged from the **60** comments, which centre on 'Supporting clients' and 'Signposting.'

Supporting clients

There was a view that the support available to clients accessing mental health provision is an area of particular praise, with a number of initiatives put forward:

> *'Our service offers weekly support, which includes visits, phone support, supporting to any mental health appointments and ensuring the client is safe, and maintaining their mental health/tenancy.'*

> *'We offer support to substance use groups in order to get them the mental health help they require. we offer weekly support at home / in the community/ or over the phone.'*

Signposting

Signposting was another area of praise, as seen below:

> *'Signposting people to get help with mental health with the right agency.'*

'Signposting to available resource (GSSMS, GDAS).'

'As a Housing Solution's Officer / Mental Health Liaison Officer we support applicants regarding any homelessness duty. We would signpost our applicants to support workers so that they can access further support. If applicants needed additional support outside of the specific homelessness arena, we would signpost to medical (GP) in order to address any health concerns. We would also phone GDAS or Kalaediscope on the applicant's behalf to try and obtain an appointment for them about their substance misuse issues / concerns.'

Service improvements

Respondents were asked how they think their service can be improved for those with co-occurring conditions. Recurring themes to emerge from the **55** respondents focused on two main areas of improvement, 'Training' and 'Joint Working.'

Training

Training was viewed as an improvement area, with substance use training much sought after:

'Further training and meeting with the drug and alcohol services to discuss roles and what the services provide to increase the teams understanding.'

'It is not something we come across very often, more training would probably help.'

'Yes - more training and education about drugs.'

Joint working

Several respondents were of the view that joint working between the variety of services requires improving, which for one respondent, could potentially reduce duplication and improve access for those with co-occurring conditions:

'More built in liaison between substance misuse service and CMHTs.'

'Possibly by more joint working (with individuals and groups).'

'Better joint working with all agencies to reduce duplication and improve chances of services being accessed by the cliental group.'

Other comments

Respondents were asked to provide any further comments. From the **22** comments received no clear themes emerged from the data, however the comments provided by respondents were insightful and varied as demonstrated below:

'People are a whole organism with the brain as part of that - we know how trauma affects the body and the brain functioning and the behaviours that follow when trying to cope with this - we need to design services which understand this too.'

'Generally, more joined up working could achieve a lot for clients. I have also found that substance misuse services can be closed off. It is great that they have a strong sense of community, however if clients have additional needs, this is not always appropriate.'

'To further delve into these services and look into the "criteria" for such services as we are confused by this ourselves. I think this needs to be looked at not only in the younger adult mental health teams but in the older adult mental health teams as well. Older adult mental health teams seem to be more confident working with individuals with "dementia" as opposed to a "psychotic" diagnosis as well as substance misuse. I do feel that when health professionals reads "consumes alcohols and substances", professionals can often "write off" the referral and "blame" substances for psychosis (even though this may be the case, this is not further explored or signposted to other services).'

'All boroughs in Gwent need inpatient alcohol detox units. How are pour patients ever going to take their problems seriously if the NHS doesn't.'

Generic Staff Survey

There were 158 total responses to the Generic Staff Survey. 43 of these were deleted by the team as they contained demographic details only. The overall total of responses used for analysis was therefore **115**, broken down as follows:

- **61** (53%) responses were deemed 'fully complete', as 100% of questions were answered by respondents.
- **54** (47%) responses were deemed 'partially complete', less than 100% of questions were answered by respondents.

Demographics

The majority of respondents were female (81%, n=**91**), with males making up 19% (n=**22**). Over 80% (n=**94**) of respondents were aged between 26-65 years. The full breakdown is as follows:

- **2** (2%) aged 21-25
- **28** (25%) aged 26-35
- **31** (27%) aged 36-45
- **35** (31%) aged 46-55
- **15** (13%) aged 56-65
- **2** (2%) ages 66+

Job role

Staff came from a variety of job roles within wider, generic services, with just under one-third (32%; n=**37**) in a Project / Support Worker. A breakdown of respondents' job roles is shown in the table below:

Table AV.12: Respondents' Job Role

Job Role	Frequency of Response	As a % of Total Responses (n=115)
Project / Support Worker	**37**	**32%**
Team Manager / Leader	20	17%
Social Worker	9	85
Service Manager	7	6%
Admin/Reception/Finance / Support functions	7	6%
Advocate	2	1%

Other job roles include:

'Community Safety Officer.'

'Regional Partnership Co-ordinator.'

'Deputy Director.'

50% (n=**58**) of respondents have been in their job role for over 5 years. 44% (n=**50**) have been in their job role for between 1 to 5 years, whereas 5% (n=**6**) are new to the role (less than 12 months).

Service

There was a good level of engagement from across several sectors in Gwent. The most frequent response came from respondents within 'Housing services' (42%; n=**48**). This was followed by respondents who work for Pobl (8%; n=**9**), whereas 7% (n=**8**) of respondents' report working within 'Social services'. 5% (n=**6**) work for Gwent Police. Other services respondents stated include:

'Vulnerable Families.'

'Gwent IDVA Service (Domestic abuse).'

'Adults.'

'Women's aid.'

Language / terminology

Given the variety of terms used to describe individuals with co-occurring conditions (e.g. dual diagnosis, co-occurring, complex needs, co-existing, comorbid etc.), respondents were asked to comment on the issues /challenges around the language/terminology. There were mixed views from the **72** respondents in terms of the preferred terminology. For example, 17% (n=**12**) of respondents preferred the term 'Complex Needs', whereas 13% (n=**9**) favoured 'Dual Diagnosis.' The was followed by the term 'Co-occurring conditions', which was the preferred term for 10% (n=**7**) of respondents. A selection of comments to illustrate the mix of views include:

> *'Complex needs would fit the bill.'*
>
> *'In our organisation we use the term complex needs as I think it covers a variety of different areas.'*
>
> *'There is not enough understanding of all the terms. Dual diagnosis seems to be the easiest to understand.'*
>
> *'Dual diagnosis.'*
>
> *'Some are derogatory and scary for people - especially comorbid. Co-occurring feels the nicest and least negative.'*
>
> *'Co-occurring.'*

Although respondents provided comments on their preferred terminology, there was recognition of a number of challenges and/or issues associated with the terminology. For example, issues of clarity, signposting and referral pathways for clients accessing services were expressed:

> *'Co-occurring doesn't make it clear from a simple English point of view that we are talking about drug and alcohol issues. Complex substance misuse may be more informative.'*
>
> *'Unless the same terminology is used, there is no common understanding or pathway identified for individuals to receive the care and support they need. There is also confusion over who to signpost to.'*
>
> *'Service Users with duel diagnosis often have difficulty accessing health professionals. Either a Mental Health or Substance Misuse agency will often say that the "other" issue will need to be addressed first. This leads to the Service User being unable to access either service.'*
>
> *'It doesn't always give you the actual issues that go with a definition. Too broad as usually each language used the individuals have specific needs.'*
>
> *'In-consistent terminology dependant on area or services. The terms used are vague; it is not clear from a professional point of view how to approach the service user.'*

Sources of learning, training and development about co-occurring conditions

Respondents were asked if they have received any previous learning and/ or training about co-occurring mental health and substance use conditions, and if so, to state their main sources of

learning and/ or training. The main source of learning for respondents was through 'In-service education', (43%; n=**48**), which was followed closely by 'Multi-agency training day' (37%; n=**41**). A breakdown of responses can be seen in the table below:

Table AV.13: Respondents' Main Sources of Learning, Training and Development

Main sources of learning, training and development	Frequency of Response	As a % of Total Responses (n=112)
In-service education	48	43%
Multi-agency training day	41	37%
Own reading of research (e.g. journals etc.)	33	29%
None	30	27%
Attending conferences / seminars	23	21%
Academic course	11	10%

Other sources of learning/training/development noted by respondents include:

> *'Research in University.'*
>
> *'Mainly has come from my experience of years served within the work area. Our client have mostly always had "complex needs" and only more recent years has this been acknowledged as needing further support or workers needing to expand their knowledge base to support the client effectively. Cyfannol Women's aid have always been proactive in accessing training in relation to alcohol/substance misuse and mental health and are one of few refuge providers who offer housing to women with "Complex Needs."'*
>
> *'Direct work experience.'*
>
> *'Mental health first aid trauma training working with young people and substances.'*

<u>Learning, training and development opportunities</u>

Respondents were asked whether the learning, training and development opportunities they had received, has been sufficient to enable them to work effectively with individuals with co-occurring conditions. Over half of respondents (55%; n=**58**) indicated that it **has** been sufficient. For 43% (n=**45**) of respondents it **has not** been sufficient and a selection of comments displaying the views of these respondents are presented below:

> *'I haven't had any opportunities to undertake any formal training.'*
>
> *'We don't really receive any training to equip us to deal with mental health and substance use conditions. I have had to draw on personal knowledge / experience of the conditions (gathered through life and watching family and friends) and interpersonal skills.'*

'Only information gleaned from attending conferences.'

'This area is so complex. As a housing professional I do not feel equipped to tackle it without specialist support.'

Joint working between mental health and substance use services

Respondents were asked how well mental health and substance use services work together for people with co-occurring conditions. Of the 55 respondents, 51% (n=**28**) 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. For example:

'This is an area which is lacking from a housing perspective. we see many cases of tenants with serious mental health issues but also with substance misuse issues around drugs or alcohol. however, it is almost impossible to obtain help from the mental health perspective where there is substance misuse as the general rule applied is that they cannot be assessed for potential mental health issues until the substance abuse is addressed. Often the two are inextricably interlinked leaving the tenant with little or no support and housing professionals unsure of who to go to for help and support for the tenant. Some such cases are picked up in my organisation by crisis support who can offer short term support but very often this means multiple calls to mental health services to raise our concerns. Sometimes these individuals are picked up to late and have already hit crisis pint with their mental health.'

'We are often told that mental health services will not work with a tenant whilst they are using drugs because the drugs are likely to be the cause of the mental health issue. However, it is often chicken and egg. A tenant may have been more susceptible to drug addiction because of underlying mental health issues.'

Further examples of joint working between mental health and substance use services not working well are presented below:

'Not very well from what I have seen. Whilst our organisation is able to make referrals, there appears to be limited resources and putting together a care package, even a first visit, can take far too long.'

'They dont. They also dont consider Violence Against Women Domestic Abuse and Sexual Violence (VAWDASV) as a potential underlying cause from both a perpetrator and victim perspective.'

'Lack of communication from outside agencies can be an problem. You make a referral but are not be kept in the loop even though you're still visiting the resident. I have a resident who is struggling to remain independent and I have made a referral to an outside agency but because of her condition she can't remember if anyone has been in contact or if someone has visited her, she doesn't remember who they are or what agency they're from. When this happens I have

to ring around the relevant agencies until I find who is dealing with the issues even though my contact details are always on the referral form.'

Examples of effective joint working between mental health and substance use services were provided by one-fifth (22%; n=**12**) of respondents, however, as seen below, issues exist with some relating to communication:

'I have seen really good practice where both agencies work together in the best interest of the person and I have seen the lack of working together where someone can't access mental health services due to their substance misuse. As a whole I feel this could be addressed through appropriate planning of support, both issues are co-occurring and both agencies have specialist knowledge in their fields and could share this to promote effective support for individuals. This also needs to be cascaded to other providers as the impact this is having on the person's wider issues may include their relationships, housing, finances etc. where the person finds themselves increasingly isolated, threat of, or homeless and possible debt. without timely interventions from all relevant agencies the issues escalate.'

'I believe that in Newport the do work quite well together as we have GDAS, GSSMS and various mental health teams including those provided by the NHS. I feel that the substance misuse services work better together and engage a little better than the mental health teams, however mental health teams do seem to be improving. Lack of communication seems to be the main issue.'

'With experience, and once a support worker realises the type of help available, that they can flag out to the service user, then, in my experience, substance use and mental health services are easy to work with and provide support also.'

Challenges facing those with co-occurring conditions

Respondents were asked, based on their experience, what challenges do those with co-occurring conditions face in Gwent. Several key themes emerged from the **54** responses; 'Social isolation', 'Housing support/ homelessness' and 'Access to services' and 'Access to mental health services.'

Social isolation

For several respondents, social isolation is one challenge which individuals with co-occurring conditions face, as seen below:

'Social isolation lack support time scale the services are provided.'

'Social isolation and stigma.'

Housing support/ homelessness

Another challenge facing those with co-occurring conditions relates to individuals who require general housing and support and / or homeless, and from the comments below it appears there is not adequate resources currently to support these individuals:

'Lack of suitable services & housing with continued support.'

'All of the above - in particular, within my service, I see clients who then have issues with homelessness as a result of not getting access to support with MH and substance misuse issues - the issues they have cause them to cope poorly with practical areas of life, which then become a crisis in themselves.'

'Inability to manage a tenancy and therefore housing is put at risk.'

Notably, two respondents expressed concern of 'Cuckooing', where criminal gangs, by way of violence and abuse, target the houses of vulnerable individuals and use them as bases for their drug dealing activities:

'In my role, cuckooing if one of the main concerns. Through social isolation, residents accept any act of 'friendship' that is shown to them. They are then taken advantage of financially and often have no control over their own property. They then feel too threatened to ask or look for support. If support is offered, they are often too scared to accept it.'

'Breakdown in family support, alternative treatments, lack of safe injecting facilities/drug consumption rooms, employment, gang culture, cuckooing, unsafe hospital discharge, flexible support workers e.g. 24 hr, weekend support, social isolation/older age.'

Access to services

Lack of access to wider support services was also noted:

'Lack of access to support services.'

'Individuals and professional workers knowing what services exist, how to access them and what connections to make.'

'There is sometimes too long a waiting time for services, or the services are overwhelmed.'

'All of the above - in particular, within my service, I see clients who then have issues with homelessness as a result of not getting access to support with MH and substance misuse issues - the issues they have cause them to cope poorly with practical areas of life, which then become a crisis in themselves.'

Access to mental health services

As seen below, it appears that accessing mental health services is a challenge for individuals with co-occurring conditions:

'There is always an issue when trying to access mental health services. Constant waiting lists and a notion by the service user that they feel let down by the service/or won't receive the right treatment which would help them.'

'Accessing good quality mental health support without being labelled as making 'lifestyle choices' etc.'

Gaps in Current Service Provision

Respondents were asked whether they thought there are any gaps in service provision/ support for those with co-occurring conditions in Gwent. Overwhelmingly, 86% (n=**51**) of the 59 respondents believe that gaps do exist in current service provision. No clear themes were identified from the additional 13 responses provided, however as selection of these is presented below:

> *'Probably, but I don't know, as there is no clear publicly available information or directory of services available within Gwent.'*
>
> *'Often, a service user will be asked to complete the same tasks or be given the same information from a number of sources. They can then start to think, what is the point, I'm just doing the same thing again and again (this is not a guess, this is feedback from service users).'*
>
> *'Assessments can be repetitive.'*
>
> *'People have the right to choose which services they attend even though agencies may provide the same or over-lapping services. Some prefer non-statutory provision that complement statutory services.'*

Areas of Duplication and Overprovision

Respondents were then asked whether they thought there were any areas of duplication or overprovision in Gwent for those with co-occurring conditions. 86% (n=**51**) do not think there are any areas of duplication or overprovision, whereas 10% (n=**6**) believe there are areas of duplication or overprovision. A selection of comments provided by respondents is presented below:

> *'Assessments can be repetitive.'*
>
> *'Often, a service user will be asked to complete the same tasks, or be given the same information from a number of sources. They can then start to think, what is the point, I'm just doing the same thing again and again (this is not a guess, this is feedback from service users).'*
>
> *'Probably, but I don't know, as there is no clear publicly available information or directory of services available within Gwent.'*

Other assets, resources, groups, individuals, and/or opportunities

Respondents were asked to provide examples of other assets, resources, groups, individual, and/or opportunities available across Gwent to support mainstream services in meeting the needs of those with co-occurring conditions. Of the 39 respondents, 28% (n=**11**) stated they 'did not know or were 'unsure' of any. The main assets, resources, groups, individuals and other opportunities identified/referenced were:

- Gwent Drug and Alcohol Services (n=**8**)
- Housing support services (n=**7**)
- Mind (n=**3**)

Other comments of known assets, resources, groups, individual, and/or opportunities available across Gwent include:

> *'There are groups such as craft /walking groups Mindfulness, reading groups / healthy eating.'*
>
> *'Caerphilly Council gives information and advice signposting you to relevant services, there is The Assertive Outreach Service who work intensively with people with severe and complex problems.'*
>
> *'Horizon sexual violence services provided group-based support, 1-2-1 specialised support and counselling and information and advice. Wallich reflections counselling GDAS support groups and drop-in sessions as well as on-going support.'*

Other notable comments include:

> *'In my experience the provision for co-occurring conditions are not available at all. there are support services for alcohol and substance misuse, but this does not consider the mental health issues and vice versa.'*
>
> *'I think that not many people are aware of all the support services that are available to them.'*

<u>Groups who have co-occurring conditions who are NOT well-catered for</u>

Respondents were asked to identify any groups which were NOT well catered for in Gwent. **45** respondents provided commentary, and the themes to emerge, 'People experiencing / affected by domestic violence', 'Young people' and 'People experiencing homelessness', are presented below:

People experiencing / affected by domestic violence

There was recognition by some that people who are, or who have, experienced domestic violence are not well-catered for:

> *'People fleeing domestic violence.'*
>
> *'Victims and perpetrators of domestic abuse.'*

Young people

Young people were another group who respondents' believe are not well-catered for, as seen below:

> *'I believe the younger people who are in our client group can be afraid to admit if they are using substances or are mentally unwell due to them feeling "silly" or it having an effect on their support.'*
>
> *'Young persons 16-24.'*

People experiencing homelessness

People experiencing homelessness were another group identified as not well-catered for:

> *'Homeless individuals and the EUPD/PD patients who we frequently have contact with.'*
>
> *'Homeless individuals Those leaving custody.'*

Other notable comments include:

> *'I feel that all of the age groups are in need of more services.'*
>
> *'Those who have not had a medical diagnoses and refuse to engage.'*
>
> *'Mother's whose children have been removed. There is no provision to support them emotionally and even if they have managed their mental health and substance misuse, they are likely to return to it at this time.'*

Co-occurring principles

A recent Public Health England (PHE) guide to better care for people with co-occurring conditions aims to encourage different agencies to work together to improve care for people with co-occurring conditions. Two principles which underpins this ambition are:

- **'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).
- **'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).

Respondents were asked to what extent are the 'It's everyone's Job' and 'No wrong door' principles embedded and embraced across Gwent. The table below has a full breakdown of responses.

Table AV.14: Respondents' Co-occurring Principles Ratings

Principle	Not at all	A little	Partially	Fully	Don't know
To what extent is the 'It's everyone's Job' principle embedded and embraced across Gwent?	7% (4)	22% (13)	**35% (21)**	15% (9)	22% (13)
To what extent is the 'No wrong door' principle embedded and embraced across Gwent?	17% (10)	17% (10)	**32% (19)**	5% (3)	29% (17)

From the table above, it can be seen that for both principles, a greater number of respondents believe these are 'Partially' embedded and embraced across Gwent (35%; n=**21**) and (32%; n=19) respectively, when compared with other options. However, the 'No wrong door' principle appears to be more embedded and embraced across Gwent, with 50% of respondents (n=**30**) selection 'Partially' or 'Fully', when compared with the 'It's everyone's job' principle, with 37% of respondents (n=**22**) selecting 'Partially' or 'Fully.'

Other comments

Respondents were asked to provide any further comments, with **16** people choosing to add additional commentary. From the data analysis, no clear themes appeared, however presented below are a selection of notable comments:

> *'No wrong door feels like "all wrong door" mental health - missed appointment are dealt with harshly; they are not understanding as to why these individuals have missed their appointment. The strike them off a waiting list for one missed appointment but if their anxiety takes over on that particular day, they just can't go. They are then punished for this- inflicting another poor experience of services and a further reluctance of getting future help. What work can be done pre-appointment to ensure they are ready to prepared to get to their appointment.'*
>
> *'Seems to be a lack of acknowledgement around toxic trio - mental health / drugs / domestic abuse and so a lack of service provision within both mental health services and substance misuse services. This is a well researched and evidenced area, but appears not to be on anyone's radar, except VAWDASV services.'*
>
> *'I feel that some people get lots of support, those who are linked to children, however there 'are those who are missed may be single people who do not make a fuss.'*
>
> *'I'm glad this is being looked at because substance users are treated quite poorly in my experience, by the MH services.'*

APPENDIX VI: FOCUS GROUPS (SERVICE USERS)

Introduction

In order to capture the views and opinions of adults with co-occurring mental health and alcohol/drug problems (dual diagnosis), staff at Figure 8 facilitated a series of **eight** qualitative focus groups with **27** service users and volunteers of Gwent Drug and Alcohol Service (GDAS) and Gwent Specialist Substance Misuse Service (GSSMS).

The groups were conducted across Gwent during February 2020, with each group lasting between 45-60 minutes. GDAS and GSSMS are organisations that provide support to individuals experiencing substance use and mental health issues in Gwent. Participants were adults aged 18 and over residing in Gwent.

A decision was made to hold focus groups across a wide area, with the team conducting groups in Caerphilly, Ebbw Vale, Pontypool and Newport. Having the focus groups spread across this area was beneficial as it provided a platform for a range of service users living in both urban and rural areas to add their voice to the project. Moreover, this was advantageous, given the diverse spread of individuals accessing services across the region.

Convenience sampling was used to recruit participants, which was aided by the assistance of staff members from GDAS and GSSMS who attended working groups the team held across Gwent prior to the focus groups. The Figure 8 research team initially contacted team managers within both services, with participant recruitment facilitated through email and poster invitations distributed through service networks. Once this initial contact commenced, the team managers at GDAS and GSSMS kindly agreed to co-ordinate the groups and help with recruitment, with the research team at Figure 8 keeping regular contact with them by way of follow-up emails and telephone calls.

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. 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 set up in Ebbw Vale at very short notice.

A semi-structured interview schedule was created in order to look at relevant issues. The focus groups were semi-structured in nature, primarily focusing on the following topics:

- Current service provision;
- 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;
- What support should look like in the future for those with Co-occurring Conditions.

All groups took place at times and locations convenient to the attendees, with all provided with a ten-pound shopping gift card. All comments have been anonymised. It is important to note that the focus group participants were all engaged with GDAS and GSSMS at the time of the fieldwork (who by their nature may have favourable views toward the service they receive support from), therefore findings must be interpreted within this context.

For ease of reading, participants' quotes have been coded by area and show below as FG1 or FG2, for example. The full coding is as follows:

- Pontypool GDAS group is coded as FG1
- Caerphilly GDAS group (1) is coded as FG2
- Caerphilly GDAS group (2) is coded as FG3
- Newport GDAS group (1) is coded as FG4
- Newport GDAS group (2) is coded as FG5
- Ebbw Vale GDAS group (1) is coded as FG6
- Ebbw Vale GDAS group (2) is coded as FG7

Ebbw Vale GSSMS group is coded as FG8.These discussions have been combined with data from the service user's survey and are summarised in SWOT analysis form in **Chapter 4** of the Main Report.

What is working well across Gwent

Respondents were asked what currently works well, especially in terms of the local services or supports. Across all Gwent Drug and Alcohol Service (GDAS) focus groups, many of the study participants described being pleased with the support on offer for their substance use issues, with respondents of the view that the package of support on offer from GDAS is suitable for their current needs. From the comments received, there was a sense that respondents' felt that it was more than 'just a service' as demonstrated below.

> *'I love this place I cannot say enough about this service. It feels like people here are my family.' (FG2)*
>
> *'We don't get chucked out of here if you relapse, they help you through it.' (FG3)*
>
> *'I feel like this is a safe place, my adopted family where you are felt welcome and not judged. It keeps me on the straight and narrow.' (FG 4)*
>
> *'My life is better since coming here, I am learning about my life and wellbeing. I stopped drinking in October. I have found that coming here has really helped, just by talking; talking to someone who has been in the same boat as you. I have a better outlook on life, I suppose.' (FG 6)*

A common theme to emerge relates to social isolation, and there was a sense across a number of groups that attending the services and supports available at GDAS is helping to reduce isolation and loneliness for some.

> *'I had a good keyworker, but in many ways, she helped me to engage. And I am sad that so many people ask me why the drop in has gone. GDAS were the first people who took me on board… and then go to art [class] which helped me to get out the house.' (FG3)*

> *'SMART recovery, conservation group, breakfast drop-in, creative therapy, and this helps me get out of the house as I don't have many family members here, it helps me with social integration, this is helping me to socialise again and GDAS is helping with that.' (FG7)*

Positive sentiments were also echoed across a number of groups for the support received by staff members at GDAS and GSSMS. In the GSSMS focus group, staff member John came in for particular praise.

> *'The case workers here fabulous you can just drop in and the staff will speak to you.' (FG 2)*

> *'The support from John here was marvellous, I was going on an all-inclusive [holiday] and I asked him if he could stick with me to see how I could cope and he kept me on his books, the support was fabulous. He said stay in touch, fair play.'* (FG 8)

> *'Fair play to John, he is good as gold, very supportive.'* (FG 8)

Understanding and responding to those with co-occurring conditions

Respondents were asked if staff have sufficient understanding to respond to those with a co-occurring condition. 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. Respondents often reported negative factors associated with attending services, as seen in the comments below.

> *'There is a lack of understanding and people do not know.' (FG 2)*

> *'Sometimes you go to services and they tell you just stop the drugs and your mental health will be ok.' (FG4)*

> *'Personally, I don't think the jobcentre gives a shit, they don't care what your problems are, if you're fit to work you're fit to work. To be honest you've got to go in there with a plaster and crutches.' (FG 6)*

Alongside an overall sense of services not understanding and responding to those with co-occurring conditions, there was also a view that GPs do not have sufficient understanding to effectively respond to those with co-occurring conditions, which was conveyed by a number of respondents. For example, respondents did not feel that their concerns were understood when they presented to their GP for support with an issue.

> *'I don't think many people understand my position, you see so many different doctors all the time and you have to tell your story all over again. I have to tell the doctors that I am not here*

for sleeping tablets because that is what they think. The attitude is very much like, 'just stop drinking.' (FG 2)

'I think GPs and nurses should have training in SU to understand the cycle of it a lot more. They know about the drugs and the harm but there is more to it than that. I think if this happened services would be better.' (FG 4)

'I think that counselling is a big thing. It should also be like a number one thing. One of the first things that GP's should be doing is putting you forward for counselling or mental health checks. There should be more understanding about addiction in general, it's still very looked down on.' (FG7)

Communication and information sharing between 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. It seems, however, that this depends on which services an individual presents to, as seen below.

'Shelter do if you ask them, you have to be forceful with them and say to them can you do this for me.' (FG 1)

'GDAS have shared information with social services which has helped me. They ask my consent.' (FG 2)

'I am lucky, I have St Cadocs, GSSMS, and probation, and they are all communicating between themselves, they do share with each other, but they have only just started that. It has taken years.' (FG5)

Although positive experiences were voiced, 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.

'It's very difficult to see if there is communication. I had one case worker who could not look at my housing issues as the other services would think she is stepping on their toes.' (FG 1)

'No, they don't. it all comes under data protection. I've been waiting for over a year now and not one service has contacted me yet.' (FG 4)

'Communication between services is really poor.' (FG7)

Housing provision across Gwent

With housing one of the most crucial support services for individuals with co-occurring conditions, respondents were asked about the potential challenges surrounding housing options in Gwent, and also what support is available. 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 an individual at the required time.

> *'At the end of the day we need a lot more services in Newport, not just drugs but housing. I am homeless now and living in a tent.' (FG4)*

> *'I didn't get help from housing as everything was in my partners name, it took ages to get things done, there was domestic violence involved. I didn't feel like I was supported by them.' (FG4)*

> *'It's difficult to find housing, and the whole mental health form. People with mental health problems are not a priority and they cannot get housing, I am only young, I cannot find somewhere to private rent. I'm 25 and only entitled to a small amount each week. I have to live between my nan and my aunties. There is no room for me to move forward, I am stuck. I have applied to the housing but who knows how long that will take?' (FG7)*

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.

> *'I'm homeless and sofa surfing between places. I was evicted on 30th January and everything went into 8 bags, because universal credit.' (FG1)*

> *'I am sofa surfing I am.' (FG5)*

> *'I'm in the bail hostel.' (FG 6)*

Certain problems associated with living in hostels and supported accommodation were put forward, with one respondent expressing vulnerability at living in a hostel where drugs are prominent.

> *'I don't want to go into a hostel as they are full of drugs. People turn down Albert street hostel due to the drugs and the prostitution down there.' (FG5)*

Meanwhile, one respondent was scathing when describing the support he received from staff at a bail hostel.

> *'Staff in the bail hostel … we are getting looked at in a different way … like numbers I feel like I have stars on my arms or we are just like numbers like Jews, the staff in the bloody bail hostel don't give a shit about us. They help to sort your dole out, but I do not feel comfortable and it effects my mental health.' (FG5)*

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

> *'Housing is a big cause of mental health problems.' (FG5)*

Whereas, for one respondent who did receive housing support, further barriers were put in place preventing this important occasion from being a smooth process.

> *'I was offered a place but until I get money, I cannot furnish it. The housing gave me an ultimatum, the day before I got kicked out of temporary accommodation, I would have to accept a flat, but they wouldn't give me an address, so I had to sign for the place but they could not*

tell me the address. They also would not take into account the money I would spend on bus fares so I had to half my electric and half my gas to buy food for my cat, they said I could manage now. I can't manage it as I am using £30 a week for my travel and £10 instead of £5 for my cat. I also visit my mum, so I need a ticket for that. They said unless I signed for the house I would be refusing.' (FG1)

Although negative experiences were often voiced, the team did hear examples of positive housing experiences, albeit in the minority.

'Shelter is the only place I could go to, they are marvellous, they tell you how to go about going to the council' (FG1)

'GDAS have just allocated me someone from housing support. That was through Dawn and Lynn here].' (FG2)

Equity and accessibility to services

All participants were asked to comment on the current provision of co-occurring services across Gwent. Unsurprisingly, a number of barriers were put forward by respondents which appear to cause difficulty in accessing service provision. A number of factors that functioned as barriers to support provision were in contrast to those which facilitate progress in an individual's treatment / recovery journey.

Barriers to mental health services

The generally expressed view across all groups was that 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.

'I was offered support but its too far away, I cannot go to my local shops some days due to being crippled with depression, there is not a lot in terms in mental health. I've had no support whatsoever.' (FG 2)

Moreover, there was recognition of this limited support in urban areas such as Newport, but also in rural areas such as Ebbw Vale. Some said that substance use provision is more accessible, but respondents were of the view that individuals are at a loss when it comes to accessing mental health support.

'I was lucky I got support, but others do not get that. I was put in a mental health institution. I was shipped to London in a private hospital and had the best support, I feel I was very lucky. A lot of people go in and out, but I had a lot of support from psychologists and psychiatrists, but they did not have enough spaces in Wales for me so I was in London. A lot of people here are not getting the mental health support.' (FG 4)

'I'm sure there are others, there is mental health help out there, but I could not tell you where it is. (FG 6)

The research team also heard several accounts of long waiting lists for mental health support, with respondents on more than one occasion frustrated due to the length of time they had to wait to access this support.

> *'I was on a waiting list for psychotherapy and I was waiting for a year.'* (FG 2)
>
> *'On the mental health side of things, the waiting lists are shocking.'* (FG 4)
>
> *'I've heard that women have had to wait 6 months after they were sexually assaulted, 6 months to wait for a counsellor.' (FG5)*

For one individual who was fortunate enough to be offered mental health support, lack of transportation at the required time prevented this. This was further compounded given the individual's financial constraints at the time.

> *'I was trying to access mental health support but the trouble was counselling was offered, but I would have to make my way to Abertillery, but the appointment was at 9-9:30 am and it was impossible to get there … I do not know anyone with a car. The public transport here is non-existent and I could not afford a taxi.'* (FG 8)

There was also a sense across a number of groups that mental health support is not available until an individual reached a crisis point, which was expressed in the following.

> *'I've dealt with mental health services since I was a young child, and they just dismiss you until something serious happens and they can't refuse you any longer. I was 14 when I first started going to see about mental health issues and they just pass you from one place to another.' (FG3)*
>
> *'I have to ring the mental health in Caerphilly, but it depends on how they class the emergency. I will be seen depending on the situation.' (FG2)*
>
> *'I went back and forward to doctors several times before I got help and was eventually signposted. It took me overdosing for them to offer me this group …why did you not offer me that group before?' (FG4)*
>
> *'When I had a mental breakdown the emergency team came out right away to my house and gave me medication. It was the crisis team that came out.' (FG5)*
>
> *'Why does it have to become a crisis for someone to sit up and listen? The system is wrong.' (FG5)*

Lack of information

A common theme heard was that 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 to knowing what 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.

> *'I didn't even know about this place, I'd never even heard of it but I was speaking with someone who was attending groups here, but I didn't know about it until my friend mentioned it.'* (FG 4)

'If you come to GDAS they can put you onto to different groups, but if you don't come here you will not know about the supports in different villages.' (FG 6)

'Before I came here, I didn't know about any other services.' (FG 6)

Consistent with these views was a sense that individuals experiencing co-occurring conditions are not aware of what services are available to them.

'You don't know unless you ask, or you are going off your head or you have the police involved. If you are like me, you have nowhere to go.' (FG 1)

'Are there any services that actually provide for both? That's part of the problem, we don't even know.' (FG3)

'There is GDAS, GSSMS, and Mind, but people don't know about the services.' (FG5)

Service opening times

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 services out of hours support available at night and at weekends.

'I don't think there are services, there is nothing at night. Maybe a church. They were looking for me to sleep in a church instead of a tent.' (FG 1)

'We can ring a helpline, there's not that much at the weekend. There's a substance abuse line and AA.' (FG 2)

'There's nothing at the weekend. There is a helpline. But you need to have a phone, the phone boxes now are few and far between. And when you do get a call you spend the first eight minutes going through the criteria.' (FG 4)

'The most vulnerable times for people is the evenings and weekends and there is nothing there.' (FG 4)

One individual's account clearly signals the need to have services open over the festive period.

'I was speaking with a friend recently and he had a bad time over Christmas, he said to me, "funny that, imagine a substance use service not being open over Christmas." To have that service not available at that time of year… now he has relapsed and there was no one to help him. He's a part of this group, he is a part of GDAS and now he is off the rails again. After 3 years. If he had access to this service when he started to slip he could have come down here and spoke to people and prevented him from going there.' (FG 3)

Transportation

Echoing access issues to mental health support which was noted above, lack of transportation /transport costs appears to be creating barriers for people accessing drug and alcohol support in rural areas:

'We are lucky in Caerphilly that we have GDAS some people have to get two buses here, and they don't always turn up on time. We need more in different areas as Caerphilly is massive … or even if something is attached to the GP surgery.' (FG 2)

'I live 3 and a half miles away. Luckily, I have family and friends, but if you've not got the money. I've been lucky with lifts, family and friends.' (FG 6)

'There is enough support for me, but it's getting here for other people, travel wise, if they are 4-5 miles away.' (FG6)

'The public transport here is non-existent.' (FG8)

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.

'When we have no money because we are on universal credit, universal credit has been abominable for people and ourselves, its left us in poverty, I'm 53 years and homeless, and living on fresh air basically. Last month I had 56 pounds to last a month. It's not just poverty sweetheart, when you've been suffering what we have been though, which is mental health plus addictions trying to get this money to get from A to B, I don't drive, how do you get to the services?' (FG1)

'If I have to travel 5-6 mile, and I am on universal credit, so travelling expenses is a big thing.' (FG6)

Funding

Across a number of groups, the team heard that the withdrawal or reduction in funding has resulted in reduced levels of support offered across a number of domains such as wellbeing groups, housing support and access to Opioid Substitution Therapy.

'There seems to be lots of services; some services work better than other, I was accessing Mind, but they lost the funding so now I've gone to platform. Platform came to my home then I didn't hear back from them. When I was getting support from Mind they were very good. My platform worker was meant to get back to me, but he hasn't. I've fallen behind on my rent and I see the citizens advice, but they also have funding issues so I could not access them for a while.' (FG 1)

'Mind is a massive for mental health in Wales, but they say the funding has gone up in the air, a lot of people have lost their jobs. They had wellbeing courses and I had support over the years.' (FG 2)

'Wellbeing group in the library, but the funding is now gone. Someone else will take it over but it won't be for a while.' (FG 2)

'There is a long waiting list for counselling. OST treatment- the waiting list is absolutely horrendous, I've saw someone waiting for 3 months, it's way too long. It's to do with the fact that there is limited funding and limited spaces in the service.' (FG7)

Waiting lists

A number of individuals across several focus groups were clear in their views that long waiting lists are preventing individuals from accessing necessary substance use support. Consistent with the views above relating to the waiting lists for mental health support, examples of long waiting lists for substance use services were reported, to the detriment of those trying to address their issues.

> *'I was quoted a 14 month wait to get into an inpatient detox in Gwent, but I could not wait that long my family ended up paying 6 grand to get me in for treatment. In 14 months, I would have been dead anyway.' (FG 3)*

For one Ebbw Vale group member, the length of the waiting list for a bed at a local in-patient detox resulted in him having to travel to Newport for this support.

> *'The waiting list for Cym Coch – my last detox I had to go to Newport.' (FG 6)*

In one group, the view of some respondents was that involvement with the criminal justice system could potentially speed up the process of accessing opioid substitution therapy.

> *'If you get arrested and you tell them you have a drug problem, you have access to a script.' (FG5)*

> *'The waiting lists are ridiculous. For methadone, people are going to prison as you get put on a script quicker in prison. Sometimes you have to wait five months, but in prison you get put on a script in a matter of days.' (FG5)*

> *'My female friend has been waiting months and she's been told to go shoplifting. Go shoplifting and get arrested. That way she will get a script quicker. She is desperate to get on it [Methadone].' (FG5)*

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.

> *'I've been coming to services for a number of years my situation was getting worse. Even though GDAS is marvellous, the waiting list for treatment here is disgraceful, I am sorry. For me to get treatment for Subutex, it was a wait. I couldn't wait for four months. To see Dr.* [Redacted] *a session was 590 pounds, but I was so desperate and my family helped. And I had to pay for the prescriptions 18 pounds per day. I had to pay for my prescriptions. I was a private patient. I did that for four months before I was transferred to GDAS's care. I am so grateful to GDAS for the care here, the 1:2:1 support but actually trying to get help when you are doing morphine of cocaine or whatever… there needs to be services available.' (FG3)*

Stigma

The theme to emerged from several respondents across two focus groups relates to stigma. A stigma can be described as a long-lasting mark of social disgrace which effects the relations between the stigmatised and the un-stigmatised. A key negative consequence of being an individual experiencing co-occurring conditions was the apparent stigma attached. This was articulated in several ways.

Firstly, was the sense of a perceived stigma acting as a barrier to those with co-occurring conditions accessing services and supports.

> *'There is still a massive stigma, which is a barrier. I know people who are in well paid jobs because they cannot come here or go to AA.' (FG4)*
>
> *'Stigma has prevented me from doing a lot of things. But its not all drugs; its I am not eating properly and its my mental health. I've been in temporary accommodation for five years.' (FG5)*
>
> *'There is a lot of stigma, there are people who are afraid to go and see social services, especially if they have kids.' (FG5)*

Secondly was the sense that stigma prevents an understanding of what those with co-occurring conditions experience in their day to day lives.

> *'I think there is a stigma of being an alcohol or a user, it's not seen as an illness, I just don't think that… I think people think that I'm just an alcoholic and I can't hold down a job. If I am filling in a form I think that they will throw it to the bottom of the pile.' (FG7)*
>
> *Over here, the stigma with mental health is not good, it's not seen as an actual problem. A lot of stuff isn't available to me. It's overlooked but it affects me in my life. Counselling is needed as having someone who is trained is very good.' (FG7)*

An antidote to stigma, for one respondent, is the support offered by individuals who have lived experience of co-occurring conditions.

> *'Lived experience is important also as you know they understand so you can open up more. It breaks the stigma. Volunteers who have been through it also is very important.' (FG7)*

Provision going forward

Respondents were asked what they think support should look like in the future for those with co-occurring conditions. There was general agreement that there has not been enough information or support available to date and increasing this in the future would be welcoming.

> *'Make it easier for us guys, ensure that we get the right help at the right time, giving us information, yes, but making sure that the information is carried out.' (FG 1)*
>
> *'Something like GDAS so can go in when you are ready, as sometimes it is now or never. Or if they had a mental health worker in this building.' (FG2)*
>
> *'The drop-in centre – more emphasis on mental health awareness.' (FG3)*
>
> *'More places like this [GDAS], what we have in Newport, a drop-in centre where you can be around volunteers and progress.'* (FG 4)
>
> *'A wider range of activities and courses that you could do.' (FG6)*

Looking to the future, improving provision in the evenings and at weekends was also suggested:

'We need more services over the weekend. On a Friday, Saturday and Sunday … I am really scared of going back into that hole that I was in.' (FG 4)

Improving accessibility to mental health support, also formed a crucial part of participants' hopes for the future, with several providing examples of how this could be achieved:

'I think every town in Caerphilly borough should have a centre like this [GDAS] with two people who have mental health experience so we can have easy access to get help because it seems like a big mountain to climb to get support.' (FG 2)

'You have mental health and drugs and counsellors, but you should have them all together they should all communicate as you have to speak to each person separately and go over things again.' (FG 4)

Other comments

Respondents were asked to provide any further comments. From those received no clear themes emerged from the data, as seen below.

'I think a holistic approach is the way to go as opposed to drugs. It needs to have that sort of hands-on loving approach rather than putting labels on.' (FG1)

'Even if I am a drug addict, I deserve more than they are doing for me now.' (FG5)

'The general feeling is to get more help from the higher people, it would be easier to get into detox if there was more beds available, you know? Things we cannot control.' (FG6)

'MH services need to be trained in addiction and addiction services need to be trained in mental health.' (FG 7)

APPENDIX VII: SURVEY RESULTS (SERVICE USERS AND FAMILIES/CARERS)

Introduction

The purpose of this element of the research was to seek the views from a broad audience of service users and carers on the current provision of services across Gwent. Specifically, service users and carers were asked to provide their views on the quality of services, key issues, gaps and areas for improvements.

Limitations

Despite extensive efforts to advertise and support the distribution of surveys across service user groups, completion numbers were limited, and care must therefore be taken with the findings presented below.

Service user survey - response rates

There were **12** total responses to the Service User Survey. Two of these were deleted by the team as they contained demographic details only. The overall total of responses used for analysis was therefore **10** as these responses were deemed 'fully complete', as 100% of questions were answered by respondents.

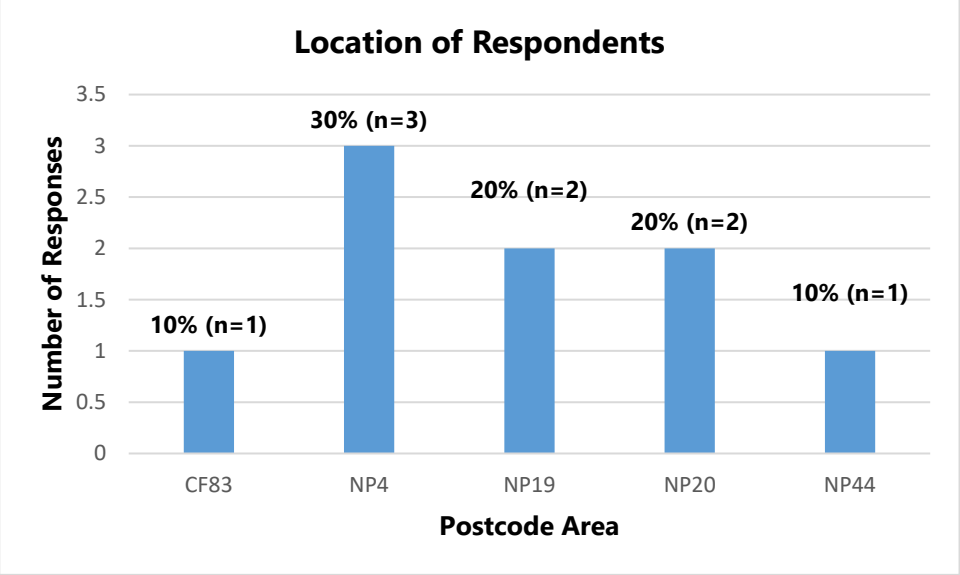
Survey respondents - demographics

There were slightly more male (55%; n=**5**) respondents compared to female respondents (45%; n=**4**). Just under half (n=**4**) of respondents were aged between 36-55. The full breakdown is as follows:

- **3** (33%) aged 16-25
- **4** (44%) aged 36-55
- **1** (11%) aged 56-65
- **1** (11%) ages 66+

Nearly one-third (30%; n=**3**) of respondents live within the NP4 postcode. The full breakdown is as follows.

Figure AVII.1: Location of Respondents



Respondents were asked what kind of mental health issue/condition they have. The majority of respondents reported 'depression' (70%; n=**7**) and this was followed closely by 'anxiety' (60%; n=**6**). The full breakdown of results is shown in the table below.

Table AVII.2: Respondents' Reported Mental Health Conditions

Mental health issue/condition	Frequency of Response	As a % of Total Responses (n=10)
Depression	7	70%
Anxiety	6	60%
Bi-polar Disorder	1	10%
Post-traumatic Stress Disorder	1	10%
Schizophrenia	1	10%
Obsessive Compulsive Disorder	1	10%

There was an even split between respondents who reported that they have received a formal diagnosis from a medical professional (e.g. GP, Community Psychiatric Nurse) in relation to their mental health condition (50%; n=**5**), and those who have not (50%; n=**5**)

Just under half of respondents (40%, n= **4**) consider themselves to have a current substance misuse problem, compared with 60% (n=**6**) who did not.

Two respondents (22%) reported having had a formal diagnosis from a medical professional for alcohol dependence.

Service and/or support provisions

Respondents were asked to name the service/support provision that they are accessing or have recently accessed, with Gwent Drug and Alcohol Service (GDAS) the most frequent response (50%; n=**5**). The breakdown of responses is provided in the table below.

Table AVII.3: Service / Support Provision

Service/support provision name	Frequency of Response	As a % of Total Responses (n=10)
Gwent Drug and Alcohol Service (GDAS)	5	90%
The Wallich	1	10%
Gwent Specialist Substance Misuse Service (GSSMS)	1	10%
Mind	1	10%
Community Mental Health Team	1	10%
Tenancy Support	1	10%
Counselling	1	10%
Citizens Advice	1	10%

Respondents were then asked to name the *main* service/support provision that they are currently using/accessing or have recently used/accessed, with Gwent Drug and Alcohol Service (GDAS) again the most frequent response (50%; n=**5**). The breakdown of responses is provided in the table below.

Table AVII.4: Main Service / Support Provision

Type of service/support received	Frequency of Response	As a % of Total Responses (n=9)
Gwent Drug and Alcohol Service (GDAS)	3	33%
Growing Spaces	1	11%
Gwent Specialist Substance Misuse Service (GSSMS)	1	11%
GP support	2	22%
Tenancy Support	1	11%
Leaving Care	1	11%

Respondents were asked to give details of the help they have received from this service. From the responses presented below it can be seen that respondents receive a wide variety of support in terms of their health and social care needs.

'Support with alcohol, support with the job centre.'

'Lots of support.'

'Help in getting myself on track.'

'GDAS Assisting with reduction Alcohol Phoenix helped with past and present issues.'

'Provided medication.'

'Referrals to appropriate services, support to attend appointments, encouragement generally.'

Respondents were asked if they have any needs in respect of their co-occurring mental health and substance use condition that are not met by these services. No clear themes emerged from the responses which are presented in full below.

'Counselling for my children'

'GP's usually do not recognise that drug use is used to relieve mental health symptoms and so are not always willing to put in place necessary referrals, etc.'

'Memory problems.'

Service Evaluation

Respondents were asked to evaluate the service/support they were reporting on against a variety of criteria. Their responses are shown in the table below:

Table AVII.5: Service Evaluation

Statement	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree
The information I was given about this service/ support provision helped me decide whether to come along.	**37.5% (n=3)**	25% (n=2)	25% (n=2)	0	12.5% (n=1)
My referral to the service/support provision was straightforward and dealt with quickly.	**37.5% (n=3)**	12.5% (n=1)	**37.5% (n=3)**	0	12.5% (n=1)
I find it easy and convenient to get to the service/support provision.	22.2% (n=2)	**44.4% (n=4)**	22.2% (n=2)	0	11.1% (n=1)
I feel safe and comfortable when I attend the service/support provision.	**33.3% (n=3)**	**33.3% (n=3)**	22.2% (n=2)	0	11.1% (n=1)
The service/support provision is available at the times I need it.	**33.3% (n=3)**	22.2% (n=2)	**33.3% (n=3)**	0	11.1% (n=1)

The assessment/ initial discussion I was given helped me to work out my needs; and how they can best be met.	22.2% (n=2)	11.1% (n=1)	**44.4% (n=4)**	11.1% (n=1)	11.1% (n=1)
I have been actively involved in putting my care plan together and I am in agreement with it.	22.2% (n=2)	0	**55.5% (n=5)**	11.1% (n=1)	11.1% (n=1)
Other services/support provisions have been involved in my assessment and care plan.	12.5% (n=1)	12.5% (n=1)	**62.5% (n=5)**	0	12.5% (n=1)
My family/partner/carer are allowed to contribute to my assessment and care plan.	11.1% (n=1)	**33.3% (n=3)**	**33.3% (n=3)**	11.1% (n=1)	11.1% (n=1)
The service/support provision I attend encourages and supports me to talk honestly about my mental health needs.	11.1% (n=1)	11.1% (n=1)	**55.5% (n=5)**	11.1% (n=1)	11.1% (n=1)
The service/support provision I attend encourages and supports me to talk honestly about my general wellbeing.	**22.2% (n=2)**	**22.2% (n=2)**	**22.2% (n=2)**	**22.2% (n=2)**	11.1% (n=1)
The service/support provision I attend encourages and supports me to seek help from other services.	12.5% (n=1)	**37.5% (n=3)**	25% (n=2)	12.5% (n=1)	12.5% (n=1)
The service/support provision I attend has assisted me to get involved with my community.	11.1% (n=1)	**33.3% (n=3)**	**33.3% (n=3)**	11.1% (n=1)	11.1% (n=1)
I have a direct say in how the service/support provision is run and developed.	11.1% (n=1)	11.1% (n=1)	**44.4% (n=4)**	22.2% (n=2)	11.1% (n=1)
The service/support provision is good at working together with other services that I need and use.	25% (n=2)	**37.5% (n=3)**	25% (n=2)	0	12.5% (n=1)
The service/support provision focuses on my recovery.	22.2% (n=2)	**33.3% (n=3)**	22.2% (n=2)	11.1% (n=1)	11.1% (n=1)
The service/support provision meets my needs and helps me achieve my desired outcomes.	11.1% (n=1)	**44.4% (n=4)**	22.2% (n=2)	11.1% (n=1)	11.1% (n=1)

Levels of agreement with the given statements above ranged from a minimum of 22.2% up to a maximum of 66.6% of respondents. At least 50% of respondents agreed with eight of the statements

above. However, for the statements where there was not agreement, it can be seen that a large percentage of respondents chose the answer 'Don't Know.'

Respondents were then asked what they particularly liked about the service/support they are receiving. Eight responses were received, with positive aspects noted across a number of domains such as meaningful activities, health needs and overall non-judgemental support.

> *'Gives you support when you need it and joining in with the activities like cooking, swimming, art and gym.'*
>
> *'People are friendly and supportive.'*
>
> *'Everything.*
>
> *'Talk not be judged about drinking (GDAS) Pheonix empathy understanding.'*
>
> *'Only seen GP and haven't accessed any other service. The GP provided me with medication.'*

Conversely, this was not the care for all respondents. For one respondent, there was not one thing that they liked about the service/ support received.

> *'I don't have one.'*

Respondents were then asked whether there was anything they disliked about the service/support they are receiving. Seven responses were obtained, with five respondents stating 'don't know, 'nothing' or 'N/A.

> *'Nothing.'*
>
> *'N/A.'*
>
> *'Nothing.'*

Other comments include.

> *'It touches on sore subjects.'*

Respondents were then asked what improvements they would like to see in service/support provision. Eight responses were received, with more group discussions proposed by one respondent.

> *'Would like some more group discussions to happen.'*

For another respondent increasing the opening times of the service and having the service open at the weekend is an improvement which could potentially reduce barriers.

> *'Longer opening hours, weekend opening.'*

Accessibility was highlighted as a barrier for one respondent, who was also of the view that more mental health provision is required.

> *'Services spread throughout BG difficult to get to, costs getting to services, more support mental health counselling.'*

Other comments include:

> *'Don't know.'*

'More care given to motivate service users at the moment have been told the centre is just for those to have training. someone there to talk through problems many people have told me they can't help with peoples problems I run a carers group so the service users talk to me.. have to ask when the meals are on in the centre.'

Respondents were then asked to rate their overall level of satisfaction with the level of help and service they have received. (Rating scale: 1=not happy at all and 10=very happy). The **10** responses received are presented in the table below. It can be seen that 50% (n=**5**) of respondents are very happy with the level of help and service they have received.

Figure AVII.6 Overall Level of Satisfaction

Other comments

Respondents were asked to provide any further comments, with **3** people choosing to add additional commentary. From the data analysis, no clear themes appeared. The comments provided are as follows.

'I would like some support with filling in forms and dyslexia.'

'Feel GP have no sympathy, just want to give you antidepressants, trying to get counselling via GP does not happen. Felt judged by GP way I have been spoken felt worse coming out than going in.'

'In my role of volunteer, I support a number of people who struggle on a daily basis with MH conditions and associated problems for some, this is exacerbated by substance use, prescribed or illicit. In some cases, the damage is historic with associated legacy conditions affecting and impacting upon physical and mental health. Not one of these 'clients' will have access to IT in order to complete a survey such as this. I am sure that those individuals who are on a journey with their substance use will say that there are many peaks and troughs - only today I spoke to

one young man who regularly contemplates taking his life or harming himself and this 'depression' seems to be linked with his deep frustration over lack of support-actually it is much deeper than this in that nobody seems to want to spend time with him and just listen to what he has to say. He is often asked 'What do you want?' this is a young man in crisis, living a chaotic lifestyle with many co-occurring illnesses and conditions-he has no medical or psychiatric training yet seems to be asked a really complex question by health care professionals who then dismiss him as 'he doesn't know what he wants'. Often people want just to be listened to, given support, some return to dignity and self-respect and perhaps then that journey can be given a destination. It does seem to be clear that, in this area of work, that caseloads seem to be heavy and many fall through the net....I end up supporting those that fall through that net. I feel that the gaps are getting bigger, more need support, more are feeling isolated, more are lonely, more are struggling with life. Surveys are great when you want to buy a car or book a holiday but when you are looking to complete a gap analysis, the work requires much more, certainly so in this complex arena. Yes, its time consuming but meeting people on a face to face basis, listening to their individual stories and some common themes will emerge.'

APPENDIX VIII: BETTER PRACTICE EXAMPLES

During the course of the needs assessment the research team put together a set of 'better practice' examples, mainly from around the UK, but where appropriate from abroad. These have been purposely labelled 'better practice' rather than 'best practice' as we do not have sufficient evidence to assess them as 'best' practice. Our aim is to highlight examples that we hope will inspire commissioners and practitioners across Gwent to think creatively about 'better' solutions to age-old problems.

Coronavirus (COVID-19): Guidance for Substance Misuse and Homelessness Services

Source	Coronavirus (COVID-19): Guidance for Substance Misuse and Homelessness Services
Author(s)	Welsh Government
Year	2020
Retrieved from	https://gov.wales/coronavirus-covid-19-guidance-for-substance-misuse-and-homelessness-services-html
Key findings	• This guidance is intended to assist Substance use and homelessness services, and those working with vulnerable populations, especially those with drug and/or alcohol use disorders, co-occurring mental health, and complex needs. • The guidance seeks to address some of the very specific issues that apply to the sector in responding to COVID-19 whilst continuing to support some of the most vulnerable people in Wales
Practice implications/gaps (i.e. relevance to Gwent services)	• This guidance is based on what is currently known about coronavirus disease 2019 (COVID-19) and provides direct advice to employers and staff in both homeless and substance use services. • The guidance acknowledges that individuals who are homeless, those with substance use or with co-occurring conditions are significantly more likely to have pre-existing medical health conditions, lack financial resilience and may have specific barriers to following general public health advice. • Recognises the importance of ensuring that stigma is not further raised towards groups who are already subject to high levels of discrimination. • Homeless and substance use services support people with some of the most complex needs who may face very significant challenges during the current emergency.

Development of a Standardised but Flexible Process for the Sustained Uptake of Integrated Care in Mental Health and Drug and Alcohol Services

Source	Development of a Standardised but Flexible Process for the Sustained Uptake of Integrated Care in Mental Health and Drug and Alcohol Services
Author(s)	Foley, C.
Year	2019
Retrieved from	
Key findings	• Suggests that at least two pre-conditions are required for the successful and sustained uptake of integrated care (IC) into the routine provision of clinical practice: 1) the availability of a service-delivery model of IC that is standardised based on best-evidence principles, but also able to be tailored to different circumstances and in different countries; and 2) the availability of a practical, evidence-based process to guide the uptake of IC through the complex transition process into routine clinical practice. • Introduces a framework for facilitating the sustained uptake of IC into a range of clinical settings which involves six steps: 1) form a partnership of key stakeholders; 2) establish the status quo (who is currently doing what); 3) build relationships and develop a shared vision; 4) codesign/tailor a pragmatic, best-evidence IC model; 5) develop clinical supports for its delivery; and 6) embed sustainability mechanisms.
Practice implications/gaps (i.e. relevance to Gwent services)	• Presents the co-design and co-implementation of a standardised but adaptable integrated care across separate mental health and addiction services in Australia. • A mixed-methods approach using Participatory Action Research was led by practitioners in existing clinical services. Partnership with a group of external researchers throughout the process enabled the experiences and expertise of clients and service-providers to be combined with the best available research evidence. • A model of care that is underpinned by evidence but also able to be tailored to different circumstances was co-produced, along with a framework for guiding services through uptake of that model.

Capability Framework: Working effectively with people with co-occurring mental health and alcohol/drug use conditions

Source	Capability Framework: Working Effectively with People with Co-Occurring Mental Health and Alcohol/Drug Use Conditions
Author(s)	Clink
Year	2019

Retrieved from	https://www.clinks.org/sites/default/files/2019-06/Capability%20Framework%20FINAL.PDF
Key findings	• The framework supports the implementation of Public Health England's (PHE) Better Care guide, setting out the values, knowledge and skills required for effective care of people with co-occurring mental health and substance use conditions.
Practice implications/gaps (i.e. relevance to Gwent services)	• The toolkit identifies 'no wrong door' as a crucial factor, so that 'wherever a person presents that service will assess their needs and strengths, support them to make contact with appropriate services, offer help in a crisis and offer a range of options from advice, to treatment and recovery'. It also identifies making every contact count (MECC) and the use of brief and motivational interventions to support a hollistic approach to service user's health and wellbeing, whilst also setting out key organisational issues to be addressed.

Staying Alive in Scotland: Strategies to Prevent Drug Deaths

Source	Staying Alive in Scotland: Strategies to Prevent Drug Deaths
Author(s)	Scottish Drugs Forum
Year	2019
Retrieved from	http://www.sdf.org.uk/toolkit-containing-strategies-to-prevent-drug-related-deaths-in-scotland-updated/
Key findings	• Identifies key areas that have been identified as of critical importance in adequately addressing Scotland's response to drug-related deaths. • The easy-to-use toolkit lays out the evidence-based measures that will help to reduce drug-related deaths. It will also be useful for commissioners, planners and managers in stakeholder organisations to self-audit current provision and practice, and to work jointly to improve these. • Details summaries of the key findings of the scoping work and consultation.
Practice implications/gaps (i.e. relevance to Gwent services)	• Accompanying each key finding is a list of associated Good Practice Indicators (GPI) to assist in self-assessment of current practice and to aid in the planning for future developments. • GPI-11 is 'Dual Diagnosis and Suicide'. • The GPIs have been developed into a good practice baseline tool for Alcohol and Drug Partnerships (ADP) (similar to Area Planning Boards) to measure their work against and help prioritise actions for implementation. It can also be used by individual services to assist with actions for development plans.

Glasgow Drug Crisis Centre

Source	Glasgow Drug Crisis Centre
Author(s)	Turning Point Scotland
Year	2019
Retrieved	https://www.turningpointscotland.com/what-we-do/substance-misuse/glasgow-drug-crisis-centre/
Key findings	• The Glasgow Drug Crisis Centre offers a safe, confidential service which supports and encourages people to find ways of making their substance use less problematic and to achieve a better quality of life. • Assessments are carried out on a 24-hour basis and an abscess and ulcer clinic is also provided by Glasgow's Physical Health Team. • The Naloxone Programme educates people on what to do in the event of an overdose. Training in basic first aid skills is provided along with training to administer naloxone, which reduces the risk of fatality in the event of an overdose. • The needle exchange is open 24 hours a day. Used injecting equipment can be brought in to be disposed of safely and exchanged for new equipment. Those who come to the needle exchange for the first time will also be given a brief initial screening. It is expected that those who use the service may want to access other services offered or be put in touch with relevant local agencies.
Practice implications/gaps (i.e. relevance to Gwent services)	• The crisis centre is a 'One Stop Service'. The One Stop service provides 24-hour advice, information and support on substance use and related issues. • There are no waiting lists or appointment times at the Glasgow Drug Crisis Centre. • The centre offers a range of support services 24 hours a day.

Support for Hepatitis C Treatment in Homelessness Charity

Source	Support for Hepatitis C Treatment in Homelessness Charity
Author(s)	HCV Action
Year	2019
Retrieved from	http://www.hcvaction.org.uk/resource/good-practice-case-study-treatment-support-people-experiencing-homelessness
Key findings	• Harbour Housing is a homelessness charity providing accommodation and support for up to 70 individuals across six properties in Cornwall. The organisation aims to provide tailored support to help individuals with

	varying levels of complex support needs such as co-occurring conditions to be able to eventually live independently. • People are able to move towards independent living at their own pace, with their six properties offering varying levels of independence, and some stay in accommodation for over two years. Harbour Housing provides advice and assistance for people's mental health, financial situation, employment, addiction, and physical health. • Individuals experiencing homelessness face significant barriers to accessing hepatitis C treatment and care, despite the virus being particularly prevalent in this group. • In partnership with NHS England and Addaction, Harbour Housing has developed an exclusive pathway to make hepatitis C treatment as easy and rapid as possible.
Practice implications/gaps (i.e. relevance to Gwent services)	• Care pathways are often complex and fragmented, making it difficult for anyone to navigate, but particularly individuals with less stable lifestyles, such as those with co-occurring conditions. Harbour Housing's hepatitis C project aimed to address these issues to support people who would otherwise have struggled to complete treatment. • Harbour Housing has supported seven people through to treatment in the past year, individuals who would not ordinarily have been able to access treatment. • Harbour Housing now assesses all new referrals into their system to see whether they would benefit from the pathway and holds monthly clinics. • The success of the hepatitis C pathway demonstrates the need for it, so Harbour Housing intends to continue to provide this service, as well as working with Addaction, the NHS, and funders to promote the strategy to other providers.

Dual Diagnosis assessment: A Case Study Implementing the Reasons for Use Package to Engage a Marginalised Service User

Source	Dual Diagnosis assessment: A Case Study Implementing the Reasons for Use Package to Engage a Marginalised Service User
Author(s)	Kroes, S., Myers, K., Officer, S., O'Connor, S., and Petrakis, M.
Year	2019
Retrieved from	https://www.tandfonline.com/doi/full/10.1080/2331205X.2019.1630097
Key findings	• The Reasons for Use Package (RFUP) is a dual diagnosis resource developed by a Melbourne metropolitan dual diagnosis service (Nexus), in consultation with service users, family members and staff.

	• The RFUP consists of the Reasons for Use Scale (Spencer et al., 2002), and a number of potential follow up strategies to explore with the service user. • The package includes a specific "spirit" guiding the desired approach which entails a collaborative and supportive process between staff and the service user using the RFUP as a doorway to conversation about dual diagnosis. • Staff receive training and, importantly, mentoring in how to use the RFUP which reinforces this "spirit." The service user is supported to actively explore their dual diagnosis issues.
Practice implications/gaps (i.e. relevance to Gwent services)	• This user-friendly purpose-built tool and associated workforce development approach could have a positive impact in reducing the economic and health burden of dual diagnosis • The service user and the staff member gain a shared understanding and, importantly, the service user is actively involved in negotiating their treatment plan. • The Reasons for Use Package can be a practical way to start conversation with service users about their substance use in relation to their mental health in a gentle, non-threatening and non-judgmental way.

Housing First Anglesey

Source	Housing First Anglesey, the Wallich
Author(s)	The Wallich
Year	2019
Retrieved from	https://thewallich.com/services/housing-first-anglesey/
Key findings	• Housing First Anglesey is available to both men and women who are homeless and aged 25 or above, who have no immediate access to settled accommodation and have support needs that can be met through housing related support. • All clients have an agreed support plan and receive person-centred support from staff and volunteers. • The Housing First approach focuses on getting homeless people straight into their own accommodation – rather than finding temporary solutions – such as a hostel place – before permanent accommodation is sought. • Once housed, support may involve help with accessing the right benefits, reducing levels of debt or rent arrears, understanding tenancy rights and obligations, or even accessing learning and employment opportunities.
Practice implications/gaps (i.e. relevance to Gwent drug services)	• Housing first Anglesey helps homeless people to find a permanent home quickly, providing ongoing support to help them settle in and maintain

	their new home, thus many individuals co-occurring conditions and other complex needs could benefit from a Housing First approach. • The project provides an intensive support package to actively address issues in a creative and innovative way. • The approach is trauma-informed and follows a therapeutic model of support. • Housing First Anglesey is a flexible and responsive service, open 24/7, in response to individual clients needs to help achieve positive outcomes.

The Delivery of Psychological Interventions in Substance Misuse Services in Scotland: A Guide for Commissioners, Managers, Trainers and Practitioners

Source	The Delivery of Psychological Interventions in Substance Misuse Services in Scotland: A Guide for Commissioners, Managers, Trainers and Practitioners
Author(s)	Scottish Government
Year	2018
Retrieved from	http://www.gov.scot/Publications/2018/06/1568
Key findings	• Psychosocial interventions are key components of effective substance use treatment. In some cases, where no pharmacological interventions are available, they offer the only evidence-based treatment. • Sets out a strategy for best practice, following an identified need outlining the delivery of psychological interventions for substance use Services in Scotland. • The report indicates that evidence based, psychologically informed support, delivered by a well-trained and supervised practitioner at any level of the treatment system, can be effective as part of an early intervention model. • It was written to correspond with recently published UK guidelines on clinical management of drug use and dependence and links directly to several a relevant action outlined in the Mental Health Strategy 2017–2027: 'Action 27-test and learn from better assessment and referral arrangements in a range of settings for dual diagnosis for people with problem substance use and mental health.'
Practice implications/gaps (i.e. relevance to Gwent services)	• The report contributes to the delivery of improving referral and treatment arrangements for people with co-occurring conditions. • This guide is designed primarily to support commissioners and providers in developing effective recovery-oriented systems of care, with psychological and psychosocial interventions at their heart.

Better Care for People with Co-Occurring Mental Health and Alcohol/Drug Use Conditions A Guide For Commissioners And Service Providers

Source	Better Care for People with Co-Occurring Mental Health and Alcohol/Drug Use Conditions A Guide For Commissioners and Service Providers
Author(s)	Public Health England
Year	2017
Retrieved from	https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services
Key findings	The guidance aims to encourage different agencies to work together to improve care for people with co-occurring conditions. Two principles underpin this ambition: • 'It's everyone's job.' Co-occurring conditions are the norm rather than the exception, and commissioners and providers of mental health and alcohol and drug use services have a joint responsibility to work collaboratively to meet the needs of people with co-occurring conditions • 'No wrong door.' Providers in alcohol/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.
Practice implications/gaps (i.e. relevance to Gwent services)	• Guidance on commissioning and providing better care for people with co-occurring mental health, and alcohol and drug use conditions. • It aims to support local areas to commission timely and effective responses for people with co-occurring conditions. It encourages commissioners and service providers to work together to improve access to services which can reduce harm, improve health and enhance recovery. • The guide points to a number of resources available to support development of a competent workforce with the requisite values, knowledge and skills, include those with sufficient expertise to provide clinical leadership and supervision. There are links to implementation prompts for commissioners and providers, and further sources of help and information are included at the end of the document.

SUFARI (Substance Use Frequency, Amount, Risk Identification) Substance Use in Mental Health screening tool

Source	SUFARI (Substance Use Frequency, Amount, Risk Identification) Substance Use in Mental Health screening tool
Author(s)	Public Health England
Year	2017

Retrieved from	https://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services
Key findings	The SUFARI screening tool is a three step process to help identify problem drug and alcohol use among people with co-occurring conditions. 1. It begins with **S**ubstance **U**se and asks: Do they drink alcohol, use drugs, smoke tobacco? 2. If so, the next step asks for **F**requency and **A**mount, followed by the individual's perception of any **R**isk. 3. Assessors then use this for **I**dentification of risks and intention to change, informing care plans.
Practice implications/gaps (i.e. relevance to Gwent services)	• Guidance on commissioning and providing better care for people with co-occurring mental health, and alcohol and drug use conditions. • This guidance is aimed at commissioners and providers of mental health and alcohol and drug treatment services, however it's also suitable for support services that have contact with people with co-occurring conditions. • The guide is envisioned to cover all ages, 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 which includes therapeutic alliance, optimism and workforce training needs.

The Edinburgh Access Practice

Name	The Edinburgh Access Practice
Author(s)	Kirolos, A., Glen, C., McCormick, D.
Year	2017
Retrieved	https://www.nhslothian.scot.nhs.uk/Services/A-Z/HarmReductionTeam/Pages/default.aspx
Key findings	• Edinburgh Access Practice (EAP) is a primary care facility designed to provide healthcare services to patients, including those with co-occurring conditions who are homeless, at risk of becoming homeless and/or have extreme difficulty engaging with mainstream services. • The Edinburgh Access practice provides Opioid Substitution Therapy (OST), however, unlike other General Practices, Edinburgh Access Practice routinely initiates prescribing with nursing non-medical prescribers (NMPs).
Practice implications/gaps (i.e. relevance to Gwent services)	• This pathway is the shortest and simplest route to OST requiring a minimum of two appointments with the nurse and with weekday dispensing supervised in pharmacies. It is available only for those who are homeless or not registered with another GP. • There is good access with a single assessment process and practitioner relationship in a single location Safe.

	• The service has very close linkage to general medical interventions in primary care.
Practice implications/gaps (i.e. relevance to Gwent services)	• There are opportunities to learn from, and adapt for other localities, good practice in Edinburgh such as Edinburgh Access Practice.

Drug Misuse and Dependence UK Guidelines on Clinical Management

Source	Drug Misuse and Dependence UK Guidelines on Clinical Management
Author(s)	Department of Health
Year	2017
Retrieved from	https://www.gov.uk/government/publications/drug-misuse-and-dependence-uk-guidelines-on-clinical-management
Key findings	• Common mental health problems are typical in drug use treatment populations. Interventions for these may need to be provided in drug use services. • Those with severe mental health problems should have high-quality, patient-focused care integrated with mental health services. • Complex and comorbid mental health and other problems need to be assessed and may need to be addressed alongside or ahead of the drug use problem.
Practice implications/gaps (i.e. relevance to Gwent services)	• Provides a framework for services so that commissioners and providers of health and social care within any local area are be able to meet the identified needs of those with co-existing substance use and mental health conditions. • Acknowledges the importance that individuals are not turned away from either drug and alcohol treatment services or mental health services due to their coexisting illness. • Recognises that services should aim to be perceived by service users and their carers as supportive with 'no wrong door' through which to enter services (whether based on levels of alcohol and/or drug dependence or on presence or absence of specific diagnoses of mental illness), even if subsequently this sometimes leads to referral for alternative pathways of care.

Coexisting Severe Mental Illness and Substance Misuse: Community Health and Social Care Services

Source	Coexisting Severe Mental Illness And Substance Misuse: Community Health And Social Care Services
Author(s)	National Institute for Health and Care Excellence (N.I.C.E)
Year	2016
Retrieved from	https://www.nice.org.uk/guidance/ng58
Key findings	• This guideline covers how to improve services for people aged 14 and above who have been diagnosed as having a co-occurring condition. • The aim is to provide a range of coordinated services that address people's wider health and social care needs, as well as other issues such as employment and housing.
Practice implications/gaps (i.e. relevance to Gwent services)	• The guideline includes recommendations for all staff who may be the first point of contact with young people and adults with co-occurring conditions which include recommendations on: first contact; referrals; care planning; partnership working between specialist services; improving service delivery; keeping contact between services and people with co-occurring conditions who use them. • Recognises that previously those with co-occurring conditions have been excluded from services and recommends, in terms of referrals to secondary care mental health services, that secondary care mental health services do not exclude people with severe mental illness because of their substance use, and do not exclude people from physical health, social care, housing or other support services because of their coexisting severe mental illness and substance use.

Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem

Source	Service Framework for the Treatment of People with a Co-occurring Mental Health and Substance Misuse Problem
Author(s)	Welsh Government
Year	2015
Retrieved from	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
Key findings	• The framework is designed to inform and influence the delivery of integrated and collaborative practice in the delivery of mental health and substance misuse services for adults, children and young people.

	• To fully realise the intent of this framework will require partnership arrangements across a broad range of services including housing and homelessness services and criminal justice agencies. Oversight and assurance will be provided by Substance Misuse Area Planning Boards (APBs) and Health Boards (HBs) via their lead role in local mental health partnership boards (LMHPBs).
Practice implications/gaps (i.e. relevance to Gwent services)	• Part two of the framework has been drafted specifically for use by front line clinicians providing unambiguous guidance which allows staff to quickly identify their responsibilities and the action they need to take in response to the requirements of the framework.