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Evaluation of the Implementation of the Substance Misuse Strategy for Wales

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Views expressed in this report are those of the researchers and not necessarily those of the Welsh Government

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EXECUTIVE SUMMARY

Background

This report presents the findings of a short study to evaluate broadly the implementation to date of *Working Together to Reduce Harm: The Substance Misuse Strategy for Wales* 2008-2018. The strategy covers use of alcohol, illicit and licit (prescribed and over-the-counter) drugs within its remit, and emphasises that the harmful use of alcohol in Wales is far more widespread than that of illegal drugs. Its dominant focus is the reduction of harm associated with substance misuse. Four priority action areas are identified in the Strategy: preventing harm; support for substance misusers; supporting and protecting families; and tackling availability.

Aims and methodology

The main aims of the evaluation were to determine whether or to what extent:

(1) All aspects of the Strategy have been implemented, particularly with regard to treatment;

(2) The intention to provide “wrap around services” (eg accommodation, education, training, employment) for clients during and at the end of treatment, has been fully implemented;

(3) Good practice has been followed;

(4) Resources have been allocated effectively with regard to what is known about the effectiveness of different types of substance misuse interventions;

(5) Statistics are being used effectively to monitor the efficiency and effectiveness of treatment agencies, including the progress of individual clients over time.

(6) There is evidence of reductions in harm arising from the implementation of the Strategy.

At the time of the fieldwork significant changes were underway in the substance misuse field in Wales, including a shift from local to regional level commissioning of services, a revision of the national Key Performance Indicators, the bedding in of a new data recording system, and the transfer of control of Home Office funds (distributed via the Welsh Government) for substance misusing offenders from the Drug Intervention Programme (DIP) to the incoming elected Police and Crime Commissioners (PCCs). The evaluation focuses mainly on the system prior to these changes, but also comments on their likely implications.

The results are based on the following methods and sources of information:

(1) reviews and analysis of existing internal and external documents and reports;

(2) a focused review of the general research literature on ‘what works’ in relation to substance misuse;

(3) scrutiny of available statistical data from national databases;

(4) analysis of previous evaluations of aspects of substance misuse interventions in Wales;

(5) formal recorded interviews with 52 key stakeholders in Wales, including government officers, commissioners, GPs and consultants, and managers of service providers and criminal justice agencies, though not service users;

(6) informal discussions with many others in the field.

Limitations in time, resources and available evidence meant that not all of the above aims could be fully addressed. The findings are based predominantly on the views and experiences of stakeholders rather than quantitative data.

The first part of the report examines the history, aims and content of the Strategy and the extent to which it is based on evidence about effective ways of tackling substance misuse. The second part investigates the implementation of the Strategy, looking at the 'fitness for purpose' of the structures and governance arrangements through which it has been put into practice; the coherence (or fragmentation) of the system of interventions that has been produced; and evidence of and views about this system's overall 'effectiveness'. The report concludes with recommendations for change in light of the findings.

Part One. The Strategy: Content and Evidence Base

Part One first looks briefly at how the Substance Misuse Strategy was developed, including the roles played by key individuals and groups, the extent to which they built on previous strategies, how much consultation they undertook, and what ideas or evidence they drew upon. The evidence gathered suggests that the design of the Strategy was guided by clear principles (including a focus on harm reduction, a balance between drugs and alcohol, and partnership approaches) which had wide support in Wales and drew on a range of ideas, experience and evidence. Wide consultations were undertaken across government and with external stakeholders, and APoSM, a panel of experts in substance misuse representing a diverse range of organisations, played an important advisory role. Research evidence was used extensively, if not always in a systematic fashion.

An analysis of the content of the Strategy document shows that it is broadly consistent with global evidence about effective ways of tackling substance misuse. Based on a 'systematic review of systematic reviews', it is clear that there is good international evidence to justify the strong focus on support to substance misusers, and particularly the use of pharmaceutical interventions to provide maintenance, as well as psychosocial interventions. There is also some support for the use of schools-based preventive interventions, and for the use of brief interventions for alcohol misusers.

Most stakeholder interviewees were knowledgeable about the Strategy, and most considered it a good document, particular mention being made of its broad scope, the inclusion of alcohol, and its readability and clarity. A small minority felt there was insufficient attention to particular issues or client groups, including offenders and non-traditional service users. Some respondents thought that the 10-year time frame was too long to remain fully relevant as circumstances and views changed. However, others welcomed the longer time frame, not least as a barrier against over-hasty reactions to 'fashionable' ideas or political imperatives.

Part Two. Implementing the Strategy: Systems, Structures, Governance, Impact

Part Two begins by identifying a number of fundamental tensions and dilemmas that impact upon efforts to tackle a problem as large and complex as that of substance misuse. These include:

1. Differing views about the relative effectiveness of – and hence the relative weight to give to - different ways of responding to substance misuse.

2. Differing views about how and how far to adapt the implementation of the Strategy in response to changing expert views, new evidence, or political or media concerns, as well as the emergence of new drugs or new patterns of substance misuse.

3. Tensions between the aim of implementing reasonably consistent services across Wales, and the aim of responding effectively to local needs.

4. Tensions in commissioning between competition, collaboration, and the need for continuity.

These tensions emerged repeatedly in various guises in the interviews with stakeholders.

Allocation of resources

Chapter 5 describes the main funding streams for substance misuse services in Wales, and explores the fairness and effectiveness of the various mechanisms by which the available resources were and are allocated to particular activities. These include the drawing up of broad Implementation Plans; decisions about what specific services will be delivered or commissioned; and decisions about which providers will deliver them. It is concluded that the Substance Misuse Branch has always had considerable influence - mainly through its ownership of the three-year Implementation Plans, the intermediary role played by the Substance Misuse Advisory Regional Teams (SMARTs), and its ultimate control of the 'purse strings' - on the broad shape of the services to be commissioned in local areas. Nevertheless, within this framework, there was ample space for local decisions about the precise nature of the interventions to be commissioned and which agencies would deliver them – until recently such power resided mainly in the hands of commissioners at CSP level. There were wide variations across the country in the nature, quality, fairness, effectiveness and transparency of the processes followed, and ranges in practice from areas where competitive commissioning was the norm, to those where most contracts were routinely renewed without competition. Most interviewees agreed that there were some excellent commissioners and some whose practices left much to be desired. It was also pointed out that there was no satisfactory way of complaining about the latter.

On the question of whether the advent of Area Planning Boards (APBs), the regional commissioning bodies replacing CSP level commissioners, are likely to produce a more strategic approach, more consistency and a higher quality of commissioning, stakeholder views were mixed. Most interviewees felt that they had the potential for

better decision-making and more strategic approaches, although some fears were expressed that they could be pushed off track by powerful individuals, for example advocating the interests of particular local areas within the region. It was also pointed out that definitive guidance about the role and powers of APBs had been slow in materialising, and that in its absence considerable differences had already emerged across Wales in how the Chairs interpreted their tasks. However, following a Welsh Government review of APBs, such guidance was issued shortly after the completion of our research.

The system as a whole: coverage, balance, coherence and fragmentation

Chapter 6 presents a broad picture (based on Welsh Government records) of the results of the planning and commissioning arrangements described in the previous chapter. It first attempts to 'map' the totality of services, projects and interventions that have been implemented in Wales through the various funding streams, and uses the results to assess how well these cover the main areas identified in the Strategy, the overall balance between them, and whether there are any significant gaps. Despite some gaps in the information it was clear that, while the services funded span the whole range of interventions proposed in the Strategy document, by far the greatest emphasis (in terms of both numbers of projects and allocation of funding) was placed on just one of the four action areas in the Strategy, 'support for substance misusers'. This covered a range of services, the most common being treatment through prescribing or psychosocial interventions. Comparatively little investment was made in 'Preventing harm' or 'Tackling availability'. Despite this apparent imbalance, most interviewees were reasonably happy with the distribution of funding between action areas. Perhaps the strongest area of disagreement was between interviewees with health and other backgrounds, over the level of priority that should be given to clinical treatment as against psychosocial interventions and 'wrap around' support.

In terms of the operation of the system as a whole, there was wide agreement among stakeholders that it varied widely in quality and cohesion across Wales, services in many areas being handicapped by fragmentation and duplication, and that an individual's 'journey' through them was often not smooth or 'seamless'. Too often, it was disrupted by agency rivalries, complex funding arrangements, or lack of communication and coordination. Some held out hope that such problems would be ameliorated by the advent of APBs. At the same time, some serious concerns were voiced about the possible loss of services for offenders – and knock-on effects on the system as a whole - if the incoming PCCs decided to spend the funds previously used to run the Drug Implementation Programme (which will no longer be ring-fenced) elsewhere.

Oversight, monitoring and change management

Chapter 7 examines the structures and information systems through which oversight is maintained both of the activities of individual agencies and of the implementation of the Substance Misuse Strategy as a whole. This may be for purposes of monitoring compliance with contracts, assessing effectiveness, ensuring accountability, or informing policy change.

Few interviewees expressed confidence in the accuracy and value of the KPIs used to monitor performance at local and individual provider level, and most welcomed the imminent shift to more outcome-focused measures. Most providers and

commissioners also agreed that the fairest and most productive means of understanding how well an agency was carrying out its tasks was to consider formal performance indicators alongside more qualitative data, service user feedback, and discussions at monitoring meetings.

A small number of service providers pointed out that, whereas their work was closely scrutinised, that of commissioners was not, and that there should be more formal complaints mechanisms for providers dissatisfied with procedures or decisions.

Deficiencies were also identified in terms of oversight of the implementation of the Strategy as a whole. The Implementation Board was seen as potentially the key body to comment on how well implementation of the Strategy was going, and to challenge government officers if problems were apparent. However, the Board was widely described as too big and unwieldy, losing focus, and prone to becoming bogged down in detail. A need for a broader kind oversight of the Strategy – involving strategic thinking about the general 'direction of travel' - was also identified, especially at a time when new patterns of substance misuse were emerging and new responses (such as the 'recovery' agenda) were being advocated. The key body mentioned in this context was APoSM which, having played a prominent part in the development of the Strategy, appeared to have had relatively little influence thereafter.

Chapter 7 ends with a brief overview of the kinds of data available with which to assess the effectiveness of the implementation of the Strategy. It is argued that the national database (WNDSM), suffers with major problems of inaccuracy and missing data, and that – although TOP data are potentially valuable in measuring a range of short-term outcomes of treatment - it does not allow longitudinal monitoring of the progress of service users. Where research and evaluation are concerned, a number of isolated studies were found, but they were not collected in one place and there appeared to be no systematic research plan. It is concluded that there is a case for such a plan to be built into the Implementation Plan.

What can be concluded about the effectiveness of the implementation of the Strategy?

Chapter 8 addresses the most difficult question in the report: what do the available data and evidence tell us about the overall effectiveness of the implementation of the Substance Misuse Strategy? As it was not part of the remit to conduct any original research, this can be tackled only by drawing upon previous studies and evaluations, published information from the national database, and information and opinions emerging from stakeholder interviews.

It is concluded that, although the Welsh Government is clearly committed to using monitoring, evaluation and research to develop and improve its substance misuse services, there is relatively little strong evidence about the effectiveness of individual projects, particular types of intervention, or indeed the implementation of the Strategy as a whole. This is largely because of weaknesses in the design of the various instruments and databases for collecting information, combined with poor compliance among practitioners in supplying requested data accurately and fully. Furthermore, while a number of internal and external evaluations have been undertaken, these have generally not been planned systematically and have often been dogged by problems of the availability of appropriate data. They have also often been short in duration and commissioned too late in the day to ensure that appropriate data collection systems are developed from the outset.

In short, in terms of what can be said with confidence about the effectiveness of the implementation of the Strategy, the list is rather short. It is clear from WNDSM data that waiting times for assessment and treatment have reduced, and from TOP data that, among those entering treatment, there have been at least short-term improvements in alcohol and drug use, physical and psychological health, and quality of life, although large amounts of missing data call these findings into some question. The available published research also contains a few positive findings, especially short-term reductions in substance misuse and progress in relation to social problems, but again caveats must be entered because of weaknesses in data and methodology. The overall conclusion has to be that the whole area of data collection, monitoring and evaluation is one that needs close and systematic attention. Indeed, it could be argued that a planned programme of research and evaluation should be built into the Strategy and its Implementation Plans.

Conclusions and recommendations

Chapter 9 summarises the findings of the research, and presents ten broad conclusions and a set of recommendations arising from them, as follows:

Conclusions

1. The Strategy is essentially sound, and has widespread support. The emphasis on alcohol as well as illicit drugs is also widely praised.

2. All main elements of the Strategy have been implemented, although considerably more resources have been devoted to 'supporting substance misusers' (in the shape of treatment and psychosocial support) than to the other action areas of the Strategy. This distribution of resources is supported by stakeholders, with a few exceptions.

3. There is strong international evidence for the effectiveness (in terms of reduced substance misuse) of opiate substitute prescribing and psycho-social interventions. Of course, although this applies at a general level it does not necessarily show that the specific interventions implemented in Wales are effective.

4. Good progress has been made in the provision of 'wrap around support', especially through the implementation of the ESF-funded Wales Peer Mentoring project, which aims to help ex-substance misusers into employment. However, wrap around support services remain patchy across the country, and links between treatment units and those providing such services could be improved.

5. The commissioning processes through which, until recently, resources were distributed to service providers through CSPs, were variable in fairness, effectiveness and transparency, and decisions were often difficult for providers to challenge.

6. The main body charged with oversight of the implementation of the Strategy, the Substance Misuse Strategy Implementation Board, is widely agreed to be ineffective.

7. APoSM played an important role in the development of the Strategy, but has been ineffective and underused in terms of broad oversight of whether shifts in direction are needed as ideas and circumstances change.

8. While we did not interview substance misusers ourselves, there was fairly broad agreement among stakeholders that service users' experiences could vary widely between areas, and that insufficient collaboration and coordination between different providers could lead to duplication and fragmentation of the services they received. This finding is echoed in the recent Healthcare Inspectorate Wales (2012) review of substance misuse services, which reported that although there are many examples across Wales of excellent practice to avoid such problems, there remains much 'patchiness' and inconsistency between areas.

9. The WNDSM is not currently producing information that adequately assesses performance or measures outcomes. There is some statistical evidence that the implementation of the Strategy has had a positive impact, especially through reductions in waiting lists and drop-outs from treatment, but although there are a few useful measures of trends presented in the annual reports (such as encouraging figures showing a continuing reduction in alcohol-related deaths), there is as yet relatively little reliable evidence about broader and longer term outcomes or trends, most obviously in relation to the long term impact of treatment on individuals' levels of substance misuse or their quality of life.

10. There is no clear research and evaluation strategy built into the Substance Misuse Strategy or the implementation plans. Generally speaking, research appears to have been commissioned in an *ad hoc* fashion, and the results are not collected together in an easily accessible form. While most centrally commissioned projects and pilots have been evaluated, this is not the case with routine interventions across the country.

Recommendations

Recommendation 1
We recommend that the aims, membership and terms of reference of the Implementation Board are urgently reviewed, with a view to equip it to exercise more effective oversight of the implementation of the Strategy and to challenge the government's performance in this area when necessary.

Recommendation 2
We recommend that the aims, operation and membership of APoSM are reviewed in order to equip it to make a more proactive and effective contribution to debates about possible shifts in approach or emphasis during the lifetime of the Strategy. (There is also a case for a formal APoSM-led 'mid-Strategy review'.) Consideration should be given to creating a paid position for the Chair and/or for members who undertake specific investigations, and to allocating more resources for support to the Board (eg for literature searches, small-scale research commissioning, or data analysis).

Recommendation 3
We recommend that consideration is given to the creation of a formal complaints procedure in respect of commissioning and other decisions made by APBs.

Recommendation 4
We recommend that a thorough review is carried out of the WNDSM in order to determine what kinds of information are most useful for the monitoring of service provision and the meaningful measurement of outcomes, with a view to ceasing the collection of redundant information and focusing on data that has a clearly useful purpose. Priority should also be given to finding the most effective ways of tracking the progress of individuals across different providers over time.

Recommendation 5
We recommend that actions are taken to ensure that compliance with data entry requirements moves closer to 100 per cent, especially in relation to pieces of information that (we suggest) are flagged as essential. Dialogue with those responsible for providing the data should include explanations of how the databases have been improved, as well as more feedback of the results of analysis, in order to convince them that their entries are used productively.

Recommendation 6
We recommend that more analysis is conducted on TOP data and the results are published in a more accessible form.

Recommendation 7
We recommend that a coherent research and evaluation strategy is built into implementation plans. Evaluations should include not only centrally commissioned projects, but, for example, comparative studies of the quality of implementation and the impact of psycho-social interventions that are routinely implemented across the country; a small fund could also be made available on a competitive basis to support evaluations of local innovative practice.

In addition, while recognising the limitations imposed by current budget restraints, we believe that there is a strong case for developing a planned programme of broader research, for example into changing patterns of substance abuse in Wales, or into drug or alcohol problems among specific social groups. Such studies – in the oversight of which, we recommend, APoSM should play a major role – would provide a strong evidence base for the development of future Substance Misuse Strategies for Wales.

Recommendation 8
We recommend that evaluations of interventions funded by the WG are well signposted and displayed together in an appropriate place on the WG website. There is also a case for creating a numbered series of studies with standard covers. Consideration should also be given to collecting together evaluations that have been commissioned or produced at local level and placing the best of them on the website too.

Recommendation 9
We recommend that continuing careful attention is paid by the Substance Misuse branch to the working practices and governance of APBs, which we regard as critical to the effective implementation of the Strategy. This should build on, and monitor the implementation of, its recent guidelines (issued after the completion of our research), focusing on issues such as the membership of APBs; their powers; their strategic and commissioning roles; their relations with CSPs and the Substance Misuse Branch;

their administrative and information support systems; and their governance, including complaints procedures.

Further consideration should be given and, if thought appropriate, advice should be issued about how best to assess need across a region; how to ensure that balance is maintained between expenditure on, say, medical treatment and ‘wrap-around services’ as funds shrink; and the kinds of commissioning processes that should be followed (eg in terms of balance between specifying services precisely and allowing flexibility; or the extent to which services should be ‘competed’).

Recommendation 10
We recommend that contingency plans should be drawn up to help fill the serious gaps in service provision that will arise if PCCs in one or more areas decide to use the existing DIP funds for other purposes.

Recommendation 11
We recommend that continuing serious consideration is given to ways of improving service users’ experience of substance misuse interventions by ‘joining up’ services more effectively: for example through further development of information sharing arrangements, common referral and assessment instruments, coordinated ‘hand-overs’ at exit points from particular services, and more single points of contact, ‘one stop shops’ and co-location of agencies. Further efforts should also be made to improve links and streamline referral routes between treatment agencies and those providing ‘wrap around’ services such as assistance with housing, training and employment.

PART ONE:

THE STRATEGY, BACKGROUND, CONTENT, EVIDENCE BASE

CHAPTER 1: INTRODUCTION

Background and aims of the research

This report presents the findings of a short study aimed at making a broad assessment of the effectiveness of the implementation to date of the Substance Misuse Strategy for Wales 2008-2018.[1] Within this remit, the main objectives were to determine whether or to what extent:

(1) All aspects of the Strategy have been implemented, particularly with regard to treatment (eg outreach services, responding to new patterns of substance misuse and waiting times);

(2) The intention to provide "wrap around services" (e.g. accommodation, education, training, employment) for clients during and at the end of treatment, has been fully implemented;

(3) Good practice has been followed;

(4) Resources have been allocated effectively with regard to what is known about the effectiveness of different types of substance misuse interventions;

(5) Statistics are being used effectively to monitor the efficiency and effectiveness of treatment agencies, including the progress of individual clients over time.

(6) There is evidence of overall reductions in harm resulting from the implementation of the Strategy.

These aims are wide-ranging and extremely ambitious for a project with a seven-month lifespan. To make the task more complex, at the time of our fieldwork significant changes were already underway in the substance misuse field in Wales, including:

- a shift from local to regional level commissioning of services, involving the creation of seven new Area Planning Boards (APBs) and consequent opportunities for more strategic and 'joined up' oversight of the previously unaligned health and community safety budgets;
- a revision of the national Key Performance Indicators (KPIs);
- the bedding in of the Treatment Outcome Profile, aimed at more effective data capture about outcomes for individuals;
- the transfer of control of Home Office funds (distributed via the Welsh Government) for offenders with substance misuse problems from the Drug Intervention Programme (DIP) to the incoming elected Police and Crime Commissioners (PCCs).

Methodology

Given the complexity and scope of the task, we had to make a pragmatic assessment of what was feasible and what methods of data collection and analysis would produce the most useful results within the limited time available. As we were unable to conduct primary evaluative research ourselves, we were reliant mainly on secondary data and existing documentary material. However, we placed greatest emphasis on conducting a series of in-depth interviews to mine the knowledge and views of a wide variety of

[1] *Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018.*

'key stakeholders' in Wales. Limits on time and resources caused us to omit from this exercise one of the most important voices, that of service users themselves, and we acknowledge that this is a weakness of the study. However, a recently published report by Health Inspectorate Wales (2012) includes the results of such interviews, and the findings support a number of our conclusions.

In summary, the results are based on the following methods and sources of information:

(1) reviews and analysis of existing documents and reports, including the Strategy itself, implementation plans, lists of funded projects and services, and other internal and published policy and practice documents;

(2) a focused review of the general research literature on 'what works' in relation to substance misuse, against which to assess the Strategy and implementation plans;

(3) scrutiny of available statistical data from national databases;

(4) analysis of previous evaluations of aspects of substance misuse interventions in Wales;

(5) formal recorded interviews with 52 key stakeholders, including government officers, local and regional commissioners, managers of third sector provider agencies, GPs and consultants, police, probation and prison managers, members of advisory groups and other external experts (though not service users);

(6) informal discussions with many others in the field.

Further details of the methods used will be given at appropriate points in the text and a full account can be found in Appendix 1.

Structure of the report

The report is divided into two main parts. The first part examines the history, aims and content of the Strategy and the extent to which it reflects evidence about the most effective ways of tackling substance misuse. The second part investigates the implementation of the Strategy, looking at the 'fitness for purpose' of the structures and governance arrangements through which it has been put into practice; at the coherence (or fragmentation) of the system of interventions that has been produced; and at evidence of and views about this system's overall 'effectiveness' and impact. The report concludes with a summary and recommendations for change in light of the findings. There are also a number of Appendices, which will be referred to in the text where relevant.

The content of individual chapters can be summarised as follows.

Chapter 2 briefly describes the history and development of the current Strategy. It shows how it built on previous strategies and explores the processes by which it was designed, including the part played by particular individuals and groups, consultation and the use of evidence.

Chapter 3 examines the text of the Strategy document in some detail to determine what precisely it proposed, and the extent to which its content is in tune with global evidence on the effectiveness of particular approaches and types of interventions. It

also presents findings from interviews with key stakeholders, looking at how familiar they were with the document and their views about its quality and usefulness.

Chapter 4 introduces the second part of the report and highlights some of the fundamental tensions that challenge the effective implementation of the Strategy.

Chapter 5 examines the structures and systems through which the allocation of resources is planned and implemented, with particular attention to the extent to which commissioning processes were and are efficient, fair, transparent and consistent. It also looks at ways in which changes in direction or approach are proposed and managed.

Chapter 6 seeks to determine whether all the proposals contained in the Strategy have been implemented, how expenditure is divided between the different action areas, and the extent to which the overall system of interventions is 'joined up' or fragmented, especially from the viewpoint of substance misusers seeking treatment and support.

Chapter 7 examines the mechanisms in place for monitoring and oversight of the performance of individual providers, local areas and the system as a whole, as well as the availability and quality of data to assess effectiveness.

Chapter 8 reviews statistical material drawn from the national database (WNDSM), as well as previously published research and evaluation, and asks what, if anything, can be concluded from them with any confidence about the effectiveness of the implementation of the Strategy.

Chapter 9 summarises the findings and conclusions, and presents recommendations emerging from the research.

CHAPTER 2: HISTORY AND DEVELOPMENT OF THE STRATEGY

This chapter sets the context for the report by looking briefly at how the current Substance Misuse Strategy was developed, including the roles played by key individuals and groups, the extent to which they built on previous strategies, how much consultation they undertook, and what new or different ideas or evidence they drew upon. Chapter 3 will look in more detail at the content of the Strategy document that emerged, and the extent to which it appears to reflect global evidence about the most effective ways of tackling substance misuse.

Background to the 2008 Strategy

Over the last 25 years, there have been three substance misuse strategies in Wales. The first, *Forward Together: A Strategy to Combat Drug and Alcohol Misuse in Wales*, was published in 1996. In 2000, shortly after devolution, a second Strategy, *Tackling Substance Misuse in Wales: A Partnership Approach*, was published. This had four key strands, which closely matched those of the 1998 UK Strategy *Tackling Drugs to Build a Better Britain*. However, the Welsh version was somewhat broader in aims and approach. It included responses to problems created by alcohol, over-the-counter and prescription medication, and volatile substances, in addition to illegal drugs.

The current Strategy, *Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018*, was published in 2008, shortly after the Westminster Government launched its new Strategy, *Drugs: Protecting Families and Communities*. It was given a specified lifespan of ten years. Details about the processes by which the Welsh Strategy was generated are not readily available in published documents. Our main source of information on this topic was therefore interviews with people who were involved at the time.

The respondents agreed, first of all, that the two previous strategies had been heavily dependent on the approaches adopted in England. For example:

> [There was] quite a lot of turmoil in the late 90s and early 2000s because constantly, there was this pressure to fall in line with England; fall in line with the Tackling Drugs to Build a Better Britain and prior to that, take, Tackling Drugs Together.

Nevertheless, it was acknowledged that there had always been some distinctive elements about the Welsh approach, particularly the stronger focuses it placed on alcohol, harm reduction and working in partnership.

> Wales was trying to hold on to this wider sense of substance misuse and to hold on to the significance of alcohol being the major challenge rather than illegal drugs. So that's the context. So that is why the 1998 Tackling Drugs to Build a Better Britain, which was a UK drugs strategy, produced the partnership approach Welsh strategy in 2000...

This was said to stem partly from the fact that Wales had had for some time a substance misuse committee to comment on policy issues. An early version of this was the Welsh Advisory Committee on Drug and Alcohol Misuse (WACDAM), a committee of about 35 members representing many agencies (e.g. prison service, education, health, and third sector) and chaired by a GP. Shortly after devolution in

1999, the new First Minister replaced WACDAM with the Substance Misuse Advisory Panel (SMAP). This in turn was replaced in 2001 by the Advisory Panel on Substance Misuse (APoSM), with the specific remit of advising the Minister on the current state of knowledge and evidence about substance misuse issues. Like WACDAM, APoSM was (and still is) comprised of people with a variety of types of knowledge and expertise relating to substance misuse, including representatives from police, prison, probation, health, voluntary sector agencies, statutory treatment services, pharmacists, nursing, youth services, social services, education, and public health. As we shall see, this committee played an important part in the design of the 2008 Strategy.[2]

During the period of the implementation of the second Strategy and the early work on the current Strategy, there were considerable political changes in the UK, in terms of the strengthening of devolution in both Scotland and Wales. As a result, the pressure for Wales to follow the English Strategy decreased and some of the distinctive characteristics of the Welsh approach began to come to the fore.

> [The second strategy] ... started in 2000 and it was an eight-year strategy to 2008 in order to fall in line with the timeframe of the English strategy (1998-2008); but by the time the English strategy came to be refreshed, there was less pressure to follow the English model. So suddenly, 2008 was an opportunity for Wales to build its Working Together to Reduce Harm and to give greater significance to misuse of alcohol.

The design of the new Strategy

The main responsibility for managing the design of the new Strategy fell upon the Substance Misuse Branch within the Welsh Government (then the Welsh Assembly Government). At the time, substance misuse policy came under the remit of the Minister for Local Government and Communities, so the key civil servants involved were the Head of the Community Safety Division, supported by the Head of Substance Misuse Treatment Services.

At an early stage, the Head of Division established a cross-governmental steering group to oversee the development of the Strategy. In collaboration with this group, the Substance Misuse Branch established various consultation arrangements. These included commissioning research and setting up liaison arrangements with key stakeholders and partners. There were also formal consultation arrangements required with ministers and senior Welsh Government officers as well as interest groups. It was considered particularly important to liaise with the different departments to try to align the Strategy with their policies and avoid 'silo' thinking.

As already demonstrated, those responsible for designing the Strategy did not start work in a vacuum. There were already in place two previous strategies, plus the continued presence of an advisory committee to generate ideas about methods for tackling substance misuse. Hence by the time the work began in earnest (interviewees generally suggest some time in 2006), there was already a sense of direction among the key players and a firm base to build on:

[2] Further information about the composition and role of APoSM and of two other key bodies in the substance misuse landscape in Wales (the Welsh Government Substance Misuse Branch and the Substance Misuse Strategy Implementation Board), can be found in Appendix 2.

> So ... so over that period we had a good feel as a team, which included … a social worker, included access to a … psychiatrist here and to an advisory panel and substance misuse, what the key issues were? So we knew where the agenda was in Wales, we weren't as a team coming to it as a blank sheet of paper and don't know what's going on. You know, we did have a reasonable view of where things were, and we were doing a lot of engagement with stakeholders on what the key issues were that they were faced anyway.

In particular, there was broad agreement about the underpinning philosophy and aims of the new Strategy: namely, that *harm reduction* was to be at its heart. This was largely because most of those involved believed this to be the most effective approach, but also partly due to a view that the Welsh Government should focus most strongly on implementing policies in areas in which powers had been fully devolved. This view also strengthened the case for a much stronger focus on alcohol, for which many individuals had been pushing for some time:

> [W]e came in at the start and agreed with ministers this was about reducing harm, it wasn't about saying this is a criminal act and you shouldn't do it. ... [S]o we were starting from a different place; we were not getting into the habit of what should be, in terms of drugs; what were legal and what weren't? You know, that was clearly a non-devolved issue. We did want to push the agenda on alcohol quite significantly, which was a non-devolved issue in terms of licensing and availability.

From that point on, ideas were refined and the detailed design of the approach was worked out. We asked respondents who had been involved at the time where the more detailed ideas in the Strategy came from. Several sources were mentioned, including the knowledge gained from existing programmes in Wales which appeared to be working well, and formal and informal meetings with people with particular expertise or experience. One interviewee commented on the 'huge strengths' of bringing together a very disparate group of people with different histories, experiences, knowledge and understanding.

Use of evidence

In addition to drawing upon lessons from the previous strategies, undertaking consultations with the field, and using the widely-held belief in harm reduction as a guiding principle, the design team also made efforts to collect and consider evidence from academic and other sources. This was initially planned as a systematic exercise but appears to have ended up as fairly piecemeal. One interviewee who had been closely involved described how a team of researchers, external to the WG, were commissioned to collate the evidence on 'what works' and to flag up areas of good practice. The plan, it seems, was that the review of the evidence base would be used to guide the development of the Strategy. For various reasons, however, the review ended up being completed in-house by members of the WG Substance Misuse Branch. In practice, this involved them collecting whatever evidence they could find from a range of sources including APoSM, partner agencies, other substance misuse strategies from across the UK, the National Institute of Health and Clinical Excellence, as well as from colleagues in Whitehall and across the Welsh Government. For example, one interviewee reported how in some APoSM meetings, papers were presented outlining the findings of new research on the effectiveness of specific interventions, such as on the use of leaflets and counselling in Accident and Emergency units.

Overall, respondents with knowledge of the process agreed that evidence had been used, but in a pragmatic rather than systematic way, using 'what was available' and 'what was around at the time'. Nevertheless, the use of a range of sources was well documented. One respondent noted the influence of what was happening elsewhere in other administrations in the development of the Strategy. This respondent also described the use of consultation events involving key stakeholders from across the field and an evaluation of the previous Strategy. The interview responses therefore clearly support the notion that evidence from a range of sources was used to guide the development of the Strategy. However, the extent to which the evidence wholly reflected the contemporary state of knowledge on the effectiveness of interventions is less clear.

Conclusion

The aim of the chapter was to provide some brief insights into the history and thinking behind the development of the 2008 Substance Misuse Strategy, as well as the process by which it was designed. This was in part to provide necessary background information and context for the discussion to follow, but also to examine the logic of the methods by which actions were proposed.

Overall, the evidence we obtained supports the conclusion that the methods and general approach to generating the Strategy document were well suited to the task. Those involved in designing the Strategy were guided by some clear guiding principles which had wide support in Wales and drew on a range of ideas, experience and evidence. They consulted effectively both across government and with external stakeholders, took advice from an advisory panel of independent experts and tested out ideas widely before committing them to the document. Overall, the general principles they adopted (harm reduction, a balance between drugs and alcohol, and a partnership approach) appear to have been a good choice, in that they had some history and meaning to Wales, were in harmony with previous approaches in Wales, and already had support from key players. The one aspect of the design process that appears to have created problems was the use of the broader evidence on the effectiveness of substance misuse interventions: while efforts were made to draw upon evidence from a range of sources, this was undertaken (not necessarily through the fault of the design team) in a piecemeal rather than systematic fashion.

CHAPTER 3: CONTENT AND EVIDENCE BASE OF THE STRATEGY

Introduction

In this chapter we look more closely at the content of the Strategy and investigate the extent to which it reflects global evidence about the effectiveness of various approaches to tackling substance misuse, the latter being based on our own 'systematic review of systematic reviews' of such evidence. We also present some results from our interviews with stakeholders, looking at how familiar they were with the Strategy document and their views about its quality and usefulness.

Content of the Strategy document

The Strategy is set out in the published document: *Working Together to Reduce Harm: The Substance Misuse Strategy for Wales 2008-2018*. The broad objectives of the Strategy are set out early on, placing strong emphasis on the reduction of harm. The first paragraph states that a key priority is to reduce the harms caused by substance misuse, and goes on to specify the types of harms to individuals, families and communities.

Four priority action areas are identified in the document:

1. The 'preventing harm' action area focuses on helping children, young people and adults to resist or delay starting substance misuse. This is to be achieved through education of young people and the provision of information to older people about the harms of substance misuse.

2. 'Support for substance misusers' aims to reduce harms by improving their health and assisting their recovery. This primarily entails ensuring that there is ready access to treatment or other support services.

3. 'Supporting and protecting families' aims to reduce harms to children and adults caused by substance misuse in the family. This is to be achieved mainly through the provision of professional support to families which have been damaged by substance misuse.

4. 'Tackling availability' aims to reduce the harms associated with ease of access to substances at the individual and community level. This action area causes some difficulties for the Welsh Government in that it has relatively little direct influence over policing and other control mechanisms. The recommended approach is to work closely with those who do.

The focus running through these four priority areas is social and individual support. Even the last of the four does not strongly emphasise criminal sanctions and exclusion.

Specific interventions recommended

As it is intended to provide broad guidance over a ten-year period, the Strategy naturally does not contain a great deal of detail on the kinds of interventions recommended, but nevertheless it is possible to identify a number of these. In order to examine these more systematically, we undertook a content analysis of the document, using the coding rules shown in Appendix 3 Figure A3.1. In essence, interventions were defined as actions that aimed to reduce substance misuse either directly or

indirectly. These are presented in Appendix 3 Tables A3.1-4, listed under each of the four main priority action areas.

Under the first action area (Preventing harm) the Strategy document proposes three main types of action: diversionary activities, education, and information. There is little said about diversionary activities, which normally include sports and out-of-school activities for young people, and only one specific example was found. Much greater attention is paid to information and education approaches. The document refers several times to the All Wales School Liaison Core Programme (AWSLCP), which is now implemented in nearly all schools in Wales. The aims of the AWSLCP are listed on the WG website as 'to reduce offending, anti-social behaviour, and substance misuse, to encourage positive citizenship and to give young people the knowledge to avoid becoming victims of crime.' Emphasis is also given to a range of actions aimed at engaging into gainful activity young people not in education, employment or training (NEETs). A similar level of attention is paid to methods of improving the availability of information on substance misuse, including the DAN 24/7 helpline, media campaigns, and information packs for parents, universities and colleges, and young people.

Interventions specified under the second action area (Support for substance misusers) are much more varied and cover a range of activities including harm minimisation, treatment, aftercare, support, and prevention. Treatment services named include the prescribing of opiate substitutes, brief interventions for the treatment of harmful alcohol use, increased availability of drop-in centres and outreach services, and psychosocial interventions including cognitive behavioural therapy. A considerable amount of attention is also paid to 'wrap around' services – including assistance with accommodation, training and employment - to provide social support and to aid recovery.

The third action area (Supporting and protecting families) is more focused in terms of the types of interventions proposed. Four main types of action are proposed: information, prevention, psychosocial interventions, and various other kinds of support. 'Information' refers to actions to make people more aware of the types of services available for the families of substance misusers. Three major programmes are named under prevention: the 'On Track' programme to provide interventions to at-risk children and their parents, the 'Families First' programme to limit the harm to children of substance misusing parents, and the domestic abuse strategy to tackle the links between substance misuse (particularly alcohol use) and violence in the home. Psychosocial interventions mentioned include the use of therapeutic communities to provide support for family members and carers who work with people who misuse substances. Finally, the other types of support mentioned refer again to interventions to support the families and carers of substance misusers, including the Evaluated Early Parental Intervention Projects (EEPIP) and the Option 2 model (which offers crisis intervention to families where there are child protection concerns related to parental substance misuse).

The fourth action area (Tackling availability) covers a range of interventions, many of them concerning policing and other enforcement activities aimed at reducing the supply of drugs, but also brief (treatment) interventions for offenders arrested for alcohol-related crime, and interventions for controlling disorder including environmental design especially relating to alcohol misuse, such as late-night transport policy, management of city-centre areas, street lighting, street cleaning and CCTV. The proposals also include enhanced neighbourhood policing programmes to

involve the community in tackling substance misuse and in providing information about agencies working in the area.

Is the Strategy evidence based?

The extent to which strategies (of any kind) are evidence based is an issue that has attracted considerable political and research attention in recent years. It has become accepted that, particularly where large sums of money are involved, any proposals for implementation should be grounded in research evidence and have proven effectiveness. We concluded in the previous chapter that the Welsh Government Substance Misuse Branch certainly made efforts to collect and use evidence in designing the Strategy. In this section we investigate whether the contents of the resulting Strategy document can fairly be described as evidence based. We begin with some comments about the capacity of research to answer the broad question of whether there is evidence to support the choice of 'harm reduction' as the underpinning philosophy of the Welsh Strategy, in comparison with possible alternatives, such as a primarily 'criminal justice' or 'abstinence' focused approach. We then look briefly at the extent to which evidence is explicitly referred to in the Strategy document. Finally, we consider to what extent the latter's advocacy of particular types of intervention is in tune with the weight of research evidence about the most effective ways of tackling substance misuse: to achieve this we present our own systematic review of published systematic reviews of international research on specific kinds of intervention.

Fundamental choice of approach

As mentioned several times, the designers of the Welsh Strategy clearly nailed their colours to the mast of a 'harm reduction' approach to tackling substance misuse – a philosophy which had – and still has – widespread support in Wales. The document does not define this approach completely clearly, and it has many ramifications. However, there is little doubt that it incorporates two core underlying beliefs that have considerable consequences for the kinds of interventions which receive priority in practice. These are (a) that, while attempts should be made to reduce the supply and availability of harmful substances, substance misuse should be treated primarily as a social and psychological problem rather than a crime problem, and (b) that while, for some misusers, abstinence may be a realistic goal in the short term, many have such deep and interrelated social and psychological problems that the most effective strategy may be to reduce the harm they do to themselves and others by 'maintaining' them (for example, through prescribing opiate substitutes) for considerable periods during which their other problems can be addressed.

It will be demonstrated in Chapters 5 and 6 that - in line with the above beliefs - psychosocial and social interventions, along with prescribing, feature heavily in commissioning and spending plans. The question which needs to be considered briefly here, however, is whether there is any research evidence to support this fundamental choice of a 'harm reduction' over either a primarily 'criminal justice' or 'abstinence' focused approach to underpin the Strategy. This is, of course, a question which is likely to become more pertinent if, as seems likely, the 'recovery' agenda now advocated by the Westminster government takes stronger root in Wales: despite some confusion and disagreement about its meaning, this is generally agreed to give greater priority to the goal of abstinence and to question the value of long-term 'maintenance'.

Unfortunately, there is no simple research or evidence-based answer to questions about which fundamental approach to substance misuse problems is most effective.

In essence, this is primarily a normative question rather than an empirical one, and a topic for political and moral debate *informed* by evidence, rather than *driven* by evidence. The answer depends largely on what outcomes one wishes to achieve in the short or long term, and what value one attaches to each.

Explicit references to evidence

We turn now to the relevance of evidence to more concrete aspects of the Strategy, including specific action areas and individual kinds of intervention. First of all, in order to measure how often evidence is explicitly referred to in the Strategy, we conducted a systematic search of the Strategy document (specifically Chapter 4, which presents details of the four priority action areas) for any reference to the word 'evidence' or its close synonyms. The results of this analysis are presented in full in Appendix 3 but are described briefly here. In the 33 pages of Chapter 4, the words 'evidence', 'research', 'findings' or 'statistics' were used on 26 occasions in total.

The use of evidence in the Strategy was investigated further by examining the academic references cited in the Strategy. Overall, 58 references to research literature were found in Chapter 4. Of note is the fact that the distribution of references was found to be somewhat uneven across the four action areas, with the majority relating to 'Support for substance misusers' and the minority relating to 'Tackling availability'.

While these are obviously crude and indirect indicators of evidence-based policy, they do suggest that (confirming the comments of interviewees referred to in the last chapter) considerable attention was paid to research findings, especially in relation to treatment and support.

Are the recommended actions in the Strategy supported by the wider literature?

To investigate whether the recommended actions listed in the Strategy were (or still are) in line with knowledge and evidence about the effectiveness of interventions, we conducted a review of the research literature. Our approach was to conduct a 'systematic review of systematic reviews' to determine the broad range of research findings. In total, 55 systematic reviews covering nearly 2,000 evaluations of interventions were included in the analysis. We then extracted from this review selected evaluations to show the methods used and to provide examples of good practice. In this section we briefly summarise the results. More detailed findings and information about the method used are presented in Appendix 4.

Most of the systematic reviews that we found (48 of the 55) were in respect of interventions that could be classified as falling within the 'Support for substance misusers' action area of the Strategy. The 48 reviews, which are listed in full in Appendix 4 Table A4.1, can be broadly divided into two main groups, one involving pharmaceutical interventions (n=23) and the other involving psychosocial approaches (n=25).

As Table 3.1 shows, it emerged that of the 23 reviews of pharmaceutical interventions, 13 (57%) had a 'positive' conclusion, meaning that strong evidence was found in a significant number of studies for the effectiveness of the intervention studied in terms of impact on the level substance misuse among service users. Four (17%) found 'mixed or uncertain' results, while the remaining six (26%) identified 'no effect'. Of the 25 reviews of psychosocial interventions 15 (60%) had a 'positive' conclusion, five (20%) 'mixed or uncertain' and five (20%) found 'no effect'. In other words, in both

cases a strong majority of reviews found predominantly positive results in terms of reductions in substance misuse.

Table 3.1 Type of intervention by outcome

	Positive	Mixed or uncertain	No effect	Total
Pharmaceutical	13 (57%)	4 (17%)	6 (26%)	23 (100%)
Psychosocial	15 (60%)	5 (20%)	5 (20%)	25 (100%)
Total	28 (58%)	9 (19%)	11 (23%)	48 (100%)

It can be seen in Appendix 4 Table A4.1 that about half of the reviews of pharmaceutical interventions refer to *maintenance* in the form of methadone or other substitute medications and that nearly all of these found a predominantly positive effect. An example of a methodologically robust evaluation of a successful methadone maintenance programme, and a brief description of the programme, are presented in Appendix 4. By contrast, the two systematic reviews found of detoxification interventions were less positive, one finding no effect and one uncertain effects - though the amount of evidence here is insufficient to draw any firm conclusions.

The psychosocial programmes reviewed were variable in nature, but a high proportion was shown to have positive results. Among particular types of intervention with the strongest evidence of effectiveness (in terms of reduced substance misuse) were those incorporating Cognitive Behavioural Therapy (for an example, see Appendix 4). Interestingly, too, there was strong evidence for the effectiveness of several aimed at alcohol misuse, including a range of 'brief interventions'. As will be mentioned in Chapter 8, it is somewhat ironic that one area in Wales with a strong commitment to evidence-based policy terminated the provision of such an intervention (based on arrest referral) on the basis of the results of a short evaluation it commissioned, which found no impact on re-arrest rates. This illustrates that the pursuit of 'evidence-based policy' is by no means a straightforward matter: findings from evaluations will differ according to variations in the robustness of the research methodology, the precise nature of the intervention, the quality of its implementation, and the country or area in which it is implemented. Hasty reactions to a single evaluation, therefore, are not always advisable, and are best considered alongside qualitative information and, if possible, first-hand knowledge of the scheme in question.

There were insufficient numbers of reviews found concerning interventions in the other three action areas to draw confident conclusions about their effectiveness,[3] but it is worth noting that all three of the reviews that we found relating to schools programmes (and hence classifiable under the 'Preventing harm' action area) had favourable outcomes for at least one of the types of school based interventions evaluated[4] (see

[3] It is likely that we found relatively few such reviews owing to limitations we placed on the kinds of outcomes that would merit the inclusion of the review in the final list. For example, it may be that there we missed a number of reviews of enforcement-based interventions whose outcomes were assessed in terms of reconviction rates or reductions in the supply of drugs.

[4] Faggiano F, Vigna-Taglianti F, Versino E, Zambon A, Borraccino A, Lemma P. School-based prevention for illicit drugs' use. Cochrane Database of Systematic Reviews 2005, Issue 2. Art. No.: CD003020. DOI: 10.1002/14651858.CD003020.pub2., one of the three systematic reviews analysed,

Appendix 4 Table A4.2). Although it should be noted that the studies were based solely on US data, these positive results offer some encouragement for the inclusion of schools-based programmes in the implementation of the Substance Misuse Strategy for Wales. A recent evaluation of the All Wales School Liaison Core Programme (Stead et al. 2011) was unable to determine changes in substance misuse behaviour as no comparison group was used, while an evaluation of a similar programme in England (Blueprint Evaluation Team, 2009) was likewise inconclusive. However, there is some rigorous evidence from other countries of the effectiveness of schools-based prevention programmes. A good example is the Life Skills Training in Schools programme in the United States, which focused on reducing excessive alcohol use (Foxcroft and Tsertsvadze, 2011). This was found to be more effective than both teacher-led and standard programmes in reducing the frequency of drunkenness and consumption of alcohol per occasion (further information on this programme can be found in Appendix 4).

Finally, although the amount of evidence was similarly limited, some strong effects were found in the systematic reviews for family-based programmes, which have also been quite prominent in the Welsh Strategy. Once again, a relevant example of such a programme and a summary of the robust evaluation which demonstrated its effectiveness, are presented in Appendix 4.

Conclusions

In conclusion, our 'systematic review of systematic reviews' provides strong international evidence for the effectiveness of a number of pharmaceutical and psychosocial interventions, notably maintenance and brief interventions for alcohol. We also found some good evidence for the effectiveness of schools-based programmes, although these reviews were relatively small in number, and focused primarily on schemes in the United States. Overall, then, our (admittedly rapid and partial) review of the broader literature gives us a fair degree of confidence that the primary focus of the Strategy and Implementation Plans on harm reduction through pharmaceutical and psychosocial methods of treatment and support (which will be elaborated in more detail in Chapter 6) has a strong evidence base. This does not mean that interventions in the other action areas are ineffective: our searches simply did not identify sufficient reviews to make such confident claims about their effectiveness (or not). It is likely that a different kind of search, allowing a wider range of outcome types, would produce a greater number of relevant reviews (see footnote 3 above).

Finally, it is important to reiterate that while the above findings probably hold good at a broad level, there is no straightforward answer to the question of whether what is being implemented is truly evidence based. This is because it is rarely possible to compare wholly 'like-with-like'. Interventions are always different at the level of implementation, including the specific practices used, the motivations of the staff and clients, the funds available, and so on. The results of large numbers of evaluations often end up to some extent equivocal. The problem of large numbers of evaluations coming up with large numbers of different results is to some extent endemic in all social evaluations. It is therefore not always clear how policy decisions should be made in response to research evidence. Just one of the issues to ponder is how much evidence does there have to be in support of an intervention to warrant implementation: is one positive finding enough or is it necessary that the majority or

found that only skills training appears to be effective in deterring early-stage drug use, while knowledge based, and affective focused programmes, were not.

nearly all studies provide a positive result? Our own view is that it is unrealistic and unnecessary to seek unanimous or even majority support in the evidence base for an intervention to be implemented. We believe that 'sometimes effective' is good enough to justify initial implementation. On this basis, we reiterate, what we have outlined in this chapter provides enough evidence that much of what is being implemented under the Wales Substance Misuse Strategy (indeed, as we shall see, the kinds of programmes on which most money is being spent) has a reasonably strong evidence base.

Stakeholders' reflections on the Strategy

We end the chapter with an overview of comments about the Strategy by key stakeholders. We asked all our interviewees about their level of familiarity with the document and, where they felt able, to identify its strengths and weaknesses.

Knowledge of the Strategy

The first point to note is that all our interviewees knew something about the Strategy document. In fact, most of them had a hard, colour copy that had been given to them by the Welsh Government, and some of them brought this (often well thumbed) document with them to the interview. One interviewee who was a member of APoSM noted that the Strategy had been 'widely circulated' to key stakeholders and that the first print was disseminated to such an extent that the WG ran out of copies.

Generally speaking we found that there was a good level of awareness and understanding of the contents of the Strategy document. Most interviewees could name the action areas and a significant minority had extensive knowledge of detail (for example, being able to list all of the KPIs published in the annex!). For the most part, knowledge of the Strategy appeared to be greatest amongst the WG staff, members of boards and committees, and service providers working in managerial positions. It was less extensive – but in most cases adequate - among staff who were more peripheral to government and/or in organisations with less direct focus on substance misuse as their main area of business (for example police, probation and prisons). It should of course be acknowledged that most of our interviewees were in relatively senior positions, and these findings may not reflect the level of knowledge among more junior staff. Indeed, one respondent suggested that knowledge about the Strategy tended to diminish the closer one got to the ground level and service delivery. This interviewee indicated that not many of her staff would have seen it or read it, and identified 'a huge gap between the Strategy and practice on the ground'.

While knowledge about the Strategy was generally good, knowledge about the Implementation Plan was much weaker. In fact, some of our respondents did not even know that it existed (which is perhaps a little odd given that a hard copy of the plan was tucked into the back of the main Strategy document). This point will be discussed in more detail in Chapter 5.

General opinions of the Strategy

We found remarkably little criticism of the Strategy across all our interviewees: most agreed strongly that it was basically a good Strategy. Its most commonly mentioned strength was its breadth of coverage, both in terms of the range of interventions recommended and the fact that it paid serious attention to problems associated with a variety of substances including illegal and legal drugs, prescription and over-the-counter drugs, and above all alcohol. The point was also made to us several times

that the problems caused by different kinds of substances are often linked and need to be viewed and tackled together.

> Oh, I think it's first class in the way that Wales took on all substances apart from nicotine, cigarettes, because if you still look at the English strategy then it's very much divided and that's a nonsense, you know. Polydrug use is far more common. What's the point in separating? Absolutely nonsense! So from day one, you know, we felt that the Welsh government had the right approach to it... and to have an integrated strategy.

Likewise, a health professional supported the breadth of the Strategy, highlighting the fact that 'there are so many issues linked to substance misuse'. On a slightly different tack, a local commissioner of substance misuse services reported that the breadth of the Strategy gave the CSP greater latitude in identifying the best interventions for the local area. He explained that its wide scope enables CSPs 'to interpret it' and 'to experiment with where they feel their priorities are'.

Support was also expressed for what was perceived as a clear distinction between the substance misuse strategies of England and Wales. As mentioned earlier, until the current Strategy, the Welsh strategy was more or less a copy of the English strategy. It was argued that Wales now had its own distinctive strategy which provided a stronger sense of ownership and purpose.

> What I would say though is when it did come out, [I was] probably happier with it and supportive of it … than I thought I would be. .. I think there is a definite distinction between Wales and England, which I think is good. It doesn't feel like we're on the coattails of what they've been doing in England. ... I don't know, there's - for me there's always being a sense of ownership about it, that it is something to do with us in Wales. It sounds really cheesy but that's how it feels to me anyway.

Finally, there were many positive comments made about the clarity of the report in terms of its structure, written style, and presentation. One respondent felt that it had been written in a way that was 'not too academic, that people can relate to their targets'.

While the great majority of respondents spoke positively about the Strategy, some felt that it gave insufficient emphasis to particular issues. Often the appeal was for greater attention to areas or client types about which the respondent had specialised knowledge. For example, one respondent mentioned the special needs of elderly clients and those with learning disabilities.

> … my plea is always don't … forget the complex end and also not to forget the emerging groups that are a bit more complicated, like the over 65s. …like people with learning disabilities. There isn't a provision for these people in Wales really, you know. ... There are these really complicated groups that are emerging that need to be part of strategy as well.

Another interviewee drew attention to the problems of offender health and was concerned that 'such a big area of business' had received such limited reference in the Strategy. The interviewee was of the view that offender health has 'got to feature … because if they're not managed properly … they will be a bigger burden on health

somewhere else in the system or in the future'. A third argued that insufficient emphasis was given to the reduction of drug-related crime and offending. However, such concerns were not widely shared.

Duration of the Strategy

There was some debate about whether the 10-year lifespan of the Strategy was a good or bad thing. Some of our respondents felt that it was too long given the evolving nature of substance misuse.

> I think having the ten year strategy is also quite challenging in an area such as substance misuse, because it's, it moves very quickly. And even to the point of actually what drug of choice, substance of choice, do individuals take. And I think if we looked at that now that, you know, opiates look to be reducing, and that's quite a big focus within the strategy. We've got the psychoactive drugs, that are obviously much more predominant than they were, and steroid use is more predominant.

A particular concern was that it was not only substance misuse that was changing, but so too were many other factors that affected the work of services. One respondent pointed out that 'things have moved on a lot' since the Strategy was launched and that 'we are now five years down the line really, if you count the time it took to write it as well'. Several respondents were concerned that the Strategy had been written before the recovery movement had come to prominence. One manager of a third sector treatment agency explained that she was 'particularly disappointed' by the Strategy's lack of emphasis on recovery. She noted that 'there is a real lack of that impetus in the strategy for people to be driven out of the system in terms of recovery'. Similarly, another manager of a voluntary sector agency highlighted the need to 'freshen up' the Strategy by giving it a 'lick of paint' to make it relevant to 2012. She explained that 'I don't think that it needs much. But, … things like the recovery agenda … the new and emerging [drugs], the changing in perhaps the way people use drugs, that kind of stuff'.

Another common concern reported related to the imminent changes to the structure of substance misuse services in Wales, including the introduction of APBs, the possible loss of DIP funding and the election of PCCs. Some respondents felt that this new structure should be reflected in the Strategy and some proposed that the Strategy should be re-written to better represent the current system.

> I think it ... it needs to be rewritten in light of PCCs, area planning boards, you know, these, these have all come about since 2008 … So it's a very new world... and an area planning board's agenda should reflect the strategy and, you know, there should be a mechanism for ensuring that what's being delivered down on the ground does reflect the Welsh Government's objectives. And with the PCCs coming in now and, you know, if DIP funding for example does go to health… those area planning boards then are going to be vital to commissioning of the services in the future … There's a ... yet another new world coming now down the line that I feel needs very strong leadership from the strategy.

On the other hand, the counter-argument was put that the 10-year duration of the Strategy guarded against over-hasty reaction to new ideas, events or 'flavours of the month'. In fact, one of our respondents was extremely animated about the issue and

supportive of the timescale stating that '10 years is a godsend …I wish it was 20 years'. This positive view was linked largely to the belief that a longer period provides more stability to workers and ensures that any new movements (e.g. recovery) are properly investigated before being adopted on a national basis. A similar point was noted by another respondent who was concerned that in Wales 'we suffer from follow on syndrome, because … something's happened in Scotland, something's happened in Northern Ireland, something's happened in England that looks good, 'oh we'll do that''. A longer timeframe would therefore help to guard against any knee-jerk responses to any new developments in the field.

More broadly, the benefits of stability were mentioned by several respondents. One described how a shorter strategy could result in 'a period of flux' that might disrupt service provision. This respondent felt that the longer 10-year strategy provides everyone with a clear 'direction of travel', and that if significant adjustments had to be made, these could be achieved via the three-year Implementation Plans (discussed in Chapter 5). It was recognised, however, that there is a limit to how much change the Strategy could tolerate and that a review would be necessary if the substance misuse 'world' had moved on too much.

Conclusion

In examining the contents of the Strategy in some detail – a necessary step before assessing (in this chapter) the extent to which it is based on evidence about effective practice and (in later chapters) how much of it has been implemented - we found that, while several specific programmes and services were mentioned as desirable, the Strategy document was understandably not overly prescriptive in recommending how its aims should be achieved. This makes it difficult to address in a robust fashion the question of how much it is evidence based, and our conclusions on this issue are inevitably broad and tentative.

Clearly, evidence played a fairly prominent part in the creation of the Strategy. Analysis of the text of the document identified many references to research findings, while as outlined in Chapter 2, key stakeholders who had been involved in (or were knowledgeable about) its development, stated that evidence from a range of sources had been collated by in-house researchers and used to guide the direction of the Strategy. However, whether reviews of the evidence base were systematic and exhaustive is less clear.

The issue of whether the proposals outlined in the Strategy matched the conclusions of the broader knowledge-base was investigated by way of a 'systematic review of systematic reviews'. The review demonstrated that there was strong international evidence to justify the focus on support to substance misusers, and particularly the use of pharmaceutical interventions to provide maintenance, as well as psychosocial interventions. There was also some support for the use of schools-based preventive interventions, and for the use of brief interventions for alcohol misusers, despite the fact that recent evaluations in Wales and England had been inconclusive on the effectiveness of both of these. It is acknowledged that our review did not cover interventions of the kinds found in the other three action areas in the Strategy (preventing harm, supporting families, and tackling availability) as thoroughly as it covered support to substance misusers, so we cannot draw any firm conclusions about them beyond the above. We also emphasise that the interpretation of evidence drawn from studies of a wide variety of 'variations on a theme' (clearly, categories like 'brief interventions' or 'maintenance' cover a range of practices, delivered to a range of

standards) is by no means a straightforward task, so serious caution must always be exercised before making any firm judgements that a particular type of intervention ‘works’ and another ‘doesn’t work’.

Finally, we found that all interviewees knew something about the Strategy and many were quite knowledgeable about it. Knowledge was strongest among those in the Welsh Government and in senior management positions in provider agencies. All respondents recognised positive elements to the Strategy, with frequent mentions being made of its broad scope, the inclusion of alcohol, and its readability and clarity. The main criticisms made concerned lack of sufficient attention to particular issues or client groups, including offenders and non-traditional service users. Some respondents thought that the 10-year time frame was too long to remain fully relevant as circumstances and views changed. However, others welcomed the longer time frame, not least as a barrier against over-hasty reactions to ‘fashionable’ ideas or political imperatives.

PART TWO

IMPLEMENTING THE STRATEGY: SYSTEMS, STRUCTURES, GOVERNANCE, IMPACT

CHAPTER 4: FUNDAMENTAL ISSUES IN IMPLEMENTATION

Introduction

In the second part of the report, we now shift attention from the design and content of the Strategy to its implementation. We consider the variety of systems, structures and institutions through which the Strategy is implemented, through which its delivery is monitored and evaluated, and through which changes to its focus or priorities are proposed and operationalised. Some of the mechanisms involved are historical legacies of previous political and organisational systems, while others have been created recently through central policy initiatives. Their effectiveness, or 'fitness for purpose', will be examined not only individually, but collectively as a 'whole system' – i.e. how well they dovetail together to ensure that best use is made of the available resources in accord with the aims and spirit of the Strategy.

To structure the discussion, we shall begin in this chapter by briefly placing it in the context of a number of fundamental tensions or dilemmas that inevitably create major challenges for any collective attempt to turn broad strategic principles into a coherent set of concrete interventions in a field as large, complex and controversial as that of substance misuse. In the following chapters we shall then look in turn at the following key aspects of implementation:

(Chapter 5) The allocation of resources and the structures, processes and people involved, including:

- the creation of overarching Implementation Plans;
- concrete decisions about what kinds of services to fund and how to allocate resources between them;
- decisions about which agencies will deliver what;
- the impact of APBs on the quality and consistency of decision-making.

(Chapter 6) The overall 'system' of services and interventions produced, including:

- an overview of what is actually funded and implemented;
- the balance between the different action areas in the Strategy;
- perceptions of the extent to which the system is 'joined up' or fragmented;
- the likely impact on this of APBs and PCCs.

(Chapter 7) Monitoring, accountability and the management of change, including:

- mechanisms for monitoring and assessing individual providers' performance;
- systems of accountability around commissioning decisions;
- mechanisms for assessing and improving the effectiveness of the system as a whole (for example, reducing duplication or fragmentation);
- mechanisms for implementing and managing changes in priorities or practice;
- the quality of the available data for informing such processes.

(Chapter 8) What the available data and research tell us about the effectiveness of system for tackling substance misuse in Wales, including:

- what can be gleaned from WNDSM;
- what can be gleaned from TOP;
- what can be concluded from published research and evaluations.

Fundamental tensions in implementation

While it is tempting to see the 'implementation' of the Strategy as a centrally-driven, linear process, this is far too simplistic a picture. The above-mentioned systems and structures – and the way they operate in practice - are perhaps best understood as the cumulative (and often changing) product of the efforts of large numbers of people across Wales to resolve some fundamental tensions and dilemmas that face any country wishing to tackle a problem as large and complex as that of substance misuse. In a world of finite resources, one cannot expect such tensions ever to be satisfactorily resolved – indeed, as resources shrink in the current financial climate, arguments about priorities are likely to become more intense – but we hope to make some very broad judgements about how well the substance misuse 'community' as a whole (from central government to provider agencies) has managed them in Wales since 2008.

The fundamental tensions referred to include:

1. Differing views about the relative effectiveness of – and hence the relative weight to give to - different ways of responding to substance misuse. While the Strategy document makes it clear that all four of its main strands are important components of a comprehensive and balanced approach, this does not answer practical questions about, for example, how much should be spent on medical treatment and how much on education or on psychosocial interventions or on 'wrap around' services.

2. Differing views about how and how far to adapt the implementation of the Strategy (or even to undertake 'mid-term' revisions of the Strategy itself) in response to changing expert views, new evidence, or political or media concerns. These may range from major ideological arguments around, for example, whether (and if so, how) to move from a 'harm reduction' to a 'recovery' approach to treatment, to whether and how to respond to apparent long-term shifts in patterns of substance misuse (for example, a decline in heroin use and an increase in the use of other kinds of drugs reported by drug agencies across South Wales) or indeed to issues that suddenly receive media attention (such as the use of 'khat' and mephedrone).

3. Tensions between the aim of implementing reasonably consistent services across Wales, and the aim of responding effectively to local needs. This tension of course has a major financial dimension, in that economies of scale can be achieved, for example, by commissioning services on a regional rather than unitary authority level, but at the same time this may have negative repercussions at the local level, including possible neglect of specific local needs and the possible 'squeezing out' of small providers (which may have strong local connections with communities and other agencies) in favour of larger organisations which can deliver across wider areas.

4. Tensions between competition, collaboration, and the need for continuity. Clearly, service providers are ultimately in competition for the available funding, yet at the same time it is strongly in the interests of service users to experience treatment and support as far as possible as a 'seamless' rather than fragmented process, which requires providers to collaborate closely. Equally, while it is important to allow organisations to compete for contracts at intervals, over-frequent changes of provider are not only disruptive in terms of changes in premises, staff transfers,

etc, but may produce a hiatus in service delivery with serious consequences for service users.

As will be demonstrated, all the above tensions emerged repeatedly in a variety of guises throughout our interviews with stakeholders.

CHAPTER 5: THE ALLOCATION OF RESOURCES: PLANNING AND COMMISSIONING

In this chapter we discuss the strengths and weaknesses of the various mechanisms by which the available resources are allocated to particular activities. These include the drawing up of broad Implementation Plans; decisions about what specific services will be delivered or commissioned; and decisions about which providers will deliver them. We draw mainly on our key stakeholder interviews to explore views about how fairly and effectively the relevant structures, processes and decision-makers perform these functions. To some extent this will be a historical exercise, given the termination of local commissioning arrangements, but we shall also consider the likely impact of the advent of APBs. In Chapter 6, we shall present an overall picture (based on Welsh Government records) of what the funds are spent on, and summarise stakeholder views on the extent to which the resulting mix of interventions 'on the ground' may be described as balanced or integrated, and to what extent as fragmented or plagued by gaps and duplication.

Implementation Plans

The Substance Misuse Branch within the Welsh Government publishes formal Implementation Plans, as well as preparing more detailed annual Branch plans which are not published. The original three-year (2008-2011) Implementation Plan contained five sections: four corresponding to the four main action areas specified in the Strategy document and a fifth entitled 'Delivering the Strategy and supporting partner agencies'. Under each of the main headings it summarised several actions to be taken, along with target implementation dates, and a proposed lead authority. The actions were sometimes broken down into target actions or groups (such as 'encouraging engagement with services' or 'children and young people'). The number of actions for each heading ranged from 10 (Supporting and protecting families) to 41 (Support for substance misusers). This Plan was succeeded in 2011 by an interim one-year Plan. The latest Implementation Plan, covering the period 2012-15, is still in draft form at the time of writing.

At first sight, the creation of an Implementation Plan might seem to be almost as important as the Strategy itself in shaping practical responses to substance misuse problems in Wales: it identifies specific kinds of activity for attention and development, thereby playing an important preliminary role in defining priorities and influencing decisions about the allocation of resources. Certainly, civil servants we interviewed regarded the exercise of revising the plan as a useful opportunity to think more broadly about where efforts should be targeted, or as a powerful tool to help drive desired change:

> But again, I think, the implementation plan gives us a vehicle for change.
>
> I think the fact that, you know, things move on, we have new and emerging drugs, and differing challenges and things like the internet. They weren't about at the time [of the Strategy] and so there is a need to adapt to those changes. And I think, in part, the implementation plan that sits alongside the Strategy, is where we're able to do that. So although it's still the, the implementation plan for the ongoing and remaining commitments within the Strategy, it's also used for us to sort of respond to the challenges that come along from time to time.

Consequently, one might have expected many of our external stakeholder interviewees to have taken a keen interest in the contents of the Plan, or indeed to have made efforts to ensure that they were consulted when it was being put together. However, beyond a small number who had frequent contact with the Substance Misuse Branch and sat on national committees, we found a surprising lack of knowledge about – or indeed interest in - the Implementation Plans, even at senior levels. Indeed, two members of APoSM we interviewed had not even known of its existence. Moreover, among those who were aware of the documents, there was little sense of concern evident that priorities might be being defined by civil servants without adequate consultation with the field. Considering the widespread discussion and consultation that took place in 2007-8 around the development of the Strategy, as well as the high level of familiarity we found with its contents, this relative lack of knowledge about and interest in the Implementation Plans seems difficult to explain.

At a purely practical level, part of the explanation may be that the format of the Plan – essentially a spreadsheet with a list of briefly described actions – is not reader-friendly, and without close examination it is difficult to grasp its overall shape and significance. However, the crux of the matter may be that it consists less of a set of prescriptive statements about what kinds of services should be implemented, than a brief guide as to how to take forward the development of certain broadly defined groups of activities. Thus the substance of the Plan could be described (with a few exceptions) as identifying the means for establishing interventions, rather than proposing specific interventions. This is illustrated in the extract from the 2008-11 Plan shown in Figure 5.1.

Figure 5.1 Extract from the 2008-11 Implementation Plan

Harm Reduction	
2.7	Develop a protocol and guidance to introduce the use of naloxone
2.8	Develop protocols within emergency care settings to develop, test and introduce interventions to reduce unnecessary deaths to those at most risk and encourage entry to services
2.9	Assess the scope and benefits to undertaking systematic reviews of deaths where the Coroner has judged alcohol to be the major contributing factor
2.10	Assess the range of safe, effective and cost-effective services targeted at injecting drug users in Wales against international practice to inform the delivery of the NPHS blood-borne virus action plan for Wales and to work to reduce overdose and drug-related deaths in Wales
2.11	Consider how harm reduction services can respond to the needs of stimulant users
2.12	Assess the need for needle and syringe facilities and plan and deliver accessible services that meet need

In short, although the national Implementation Plan clearly plays a major part in subsequent decisions about the allocation of funds to centrally designed and commissioned interventions, (examples being the Take Home Naloxone Project and the All Wales School Liaison Core Programme – see Chapter 6), its influence on how funds are allocated by planning boards and commissioners at local and regional level has generally been weaker and less direct. Most interviewees were more interested in, and concerned about, the decisions taken at these more local levels, where by far the largest proportions of funds for substance misuse services are distributed, and where the decisions taken determine precisely what kinds of services or interventions will be delivered, and by whom. This is illustrated by the following comments from a local commissioner and third sector provider, respectively:

> So, yes, their implementation plan does help us but it, it's different to ours because it's much more strategic, it's much broader, you know, what they expect you to do.
>
> I think there's a national implementation plan if I remember rightly. And then, er, we have in Dyfed a Dyfed strategy for the three counties and then we have individual implementation plans for each county that reflect the strands of the strategy. …That localises it more.

It is to local planning and commissioning that we turn our attention in the next two sections.

Planning and commissioning at local and regional level

As outlined earlier, while the Welsh Government undertakes some central commissioning of substance misuse projects (see Chapter 6), the bulk of concrete decisions about what specific services will be funded and who will deliver them, are made at a more local level. As noted earlier, these arrangements are currently in a state of transition, as responsibility for the distribution of Welsh Government funds is transferred from local Community Safety Partnerships (CSPs) to regional Area Planning Boards (APBs), and control of the Home Office funds (distributed via the Welsh Government) previously earmarked for the Drug Intervention Programme (DIP) is transferred (without ring-fencing) to the new elected Police and Crime Commissioners (PCCs). In this section, we briefly describe the various funding streams and local planning and commissioning arrangements that pertained during the first three years of the implementation of the Strategy. We then present our interviewees' views about the strengths and weaknesses of these arrangements and the APB-based system that is replacing them.

Funding streams and responsible bodies

During the early years of the implementation of the Strategy, the largest slice of the budget – the Substance Misuse Action Fund (SMAF) - was distributed through Community Safety Partnerships (CSPs) or, more specifically, the Substance Misuse Action Teams (SMATs) or Joint Commissioning Groups within them. In 2011-12, this amounted to £22.6 million, which was divided among the 22 CSPs in accordance with a central funding formula, before being passed on to local providers through a variety of commissioning, grant-awarding and other processes. The other main block of funding, amounting to about £17 million in the same year, was distributed by Local Health Boards: this is known as the '0.4%', the percentage of the overall health budget historically reserved for spending on substance misuse services.

However, in April 2010 the planning and commissioning system embarked upon a major change aimed at greater coordination between the use of the health and community safety budgets as well as across unitary authority areas. This entailed the formation of seven regionally-based Area Planning Boards, comprising representatives from both CSPs and Local Health Boards. Two years later, further changes to the commissioning system were made following a formal review of APBs as part of the Minister's comprehensive Substance Misuse Review Programme. The review recommended 'a strengthened and enhanced role' for APBs and in April 2012, responsibility for distributing the SMAF revenue budget and approving the ('0.4%') Health budget was formally transferred from CSPs to APBs. The new system will become fully operational across Wales from April, 2013.

It is also important to mention the separate funding streams for offender-related services emanating from the Home Office and National Offender Management Service (NOMS). Again, major changes are under way in relation to these funds, but during the first three years of the Strategy, the arrangements were as follows: Probation Trusts commissioned services for the treatment and testing of offenders serving community sentences with a Drug or Alcohol Rehabilitation Requirement (DRR or ARR); NOMS commissioned prison-based Counselling, Assessment, Referral, Advice and Throughcare (CARAT) services; and Home Office funding (distributed via the Welsh Government) for the Drug Intervention Programme, which offers treatment and support to substance misusing offenders on a voluntary basis, was managed and distributed by DIP boards and commissioners at regional or sub-regional level. As is also the case across England, there has been considerable variation in the degree of consultation, collaboration and coordination (including joint commissioning) that has taken place in Wales between Health Boards, CSPs, APBs, and those responsible for offender-related services. This will be discussed in the next chapter.

Annual plans

Under the system in place until the arrival of APBs, decisions about the kinds of services on which funds would be spent at local level were made mainly by CSPs and Health Boards, albeit in both cases subject to ratification elsewhere. Technically, CSPs had to 'sign off' Health Board plans, although in most cases, we were told, this was 'on the nod' – not least because other CSP members often found them opaque and lacking in detail and hence had trouble in understanding and interrogating them fully. CSP annual plans for spending their slice of the funding had to be agreed by the Welsh Government Substance Misuse Branch. Achieving this agreement was helped by the intermediary role played by the Welsh Government's Substance Misuse Advisory Regional Teams (SMARTs), who visited CSPs on a regular basis to discuss their ideas and plans, and to ensure that they were in tune with both the Strategy and the central Implementation Plan.

As a member of the Substance Misuse branch put it:

> That's part of the role of the SMART in a sense as well. So when they're attending the planning meetings, to push the role, the Strategy. Well, not so much encouraging them to read the Strategy, but more in terms of what our expectations of partners are within the implementation plan.

Generally speaking, CSP members we interviewed felt that they had good relations with the SMARTs, who were willing to engage in dialogue and entertain new ideas, and also that they had met with relatively little disagreement or excessive interference from the Branch in relation to the signing off of their local plans. There were a few exceptions, especially where CSP members felt that certain areas of the Strategy were given less priority by the Substance Misuse Branch than others. One experienced member in particular, who had chaired a CSP, felt that the Branch was too focused on treatment, and paid only 'lip service' to two of what he called the 'four pillars' of the Strategy, prevention and enforcement. He claimed that efforts over several years to switch more of his local CSP funds into these fields had met with opposition and indeed vetoes from the centre. However, if anything, there was more criticism in the opposite direction – i.e. that there was too *little* central influence and control over local plans, and that local and regional commissioners were insufficiently accountable for their actions. The latter issue will be discussed further in the next section and Chapter 7.

Interviews with Branch staff confirmed the general view that they were happy to leave most decisions to local areas, so long as the latter did not stray too far from the basic framework provided by the Strategy and the Implementation Plan. On the whole, they said, they did not need to reject or alter local plans submitted to them, as the SMARTs had already ensured in a more informal and collaborative way that most CSPs adhered to the broad parameters laid down. One senior civil servant also noted that, strictly speaking, the Branch had no powers to tell CSPs how to design their plans, but in the final analysis it could refuse to sign off those it was not happy with.

A further point made by several interviewees in relation to local planning was that in many areas, relatively few members of the CSP had strong knowledge about, or indeed interest in, substance misuse issues, and therefore were content to leave most of the decision-making to the SMATs or other small groups within the partnership. This had the disadvantage that the quality of substance misuse plans and their implementation could depend too heavily on the skills and judgement of a small number of individuals. Equally important, they were not always fully 'owned' by the partnership as a whole, thereby being administered and discussed in something of a vacuum, too isolated from other aspects of CSP work. As is well known, substance misusers often have multiple needs, which are best addressed holistically through close coordination with housing, education, employment, criminal justice and other local services. Without these links, some interviewees warned, there is a tendency for substance misuse plans to drift towards an excessive focus on 'treatment' at the expense of addressing clients' psychosocial and ('wrap around') social needs, thus unbalancing local provision and violating the spirit of the Strategy.

Finally, planning was said to be made more difficult in some areas by a lack of adequate data and resources to produce reliable local needs analyses and hence to allow decisions to be made on the basis of sound evidence. A more general discussion of problems concerning data and evidence can be found in Chapter 7.

Commissioning

Local planning includes not only decisions about what kinds of services to fund, but decisions about how and by whom they will be delivered. The term 'commissioning' is often used in the latter context, although as we shall see it conceals a wide variety of ways of making such decisions. We interviewed at least nine individuals who had some direct experience, past or present, as commissioners at national or local level. Most other interviewees had a fair amount of knowledge about or experience of commissioning systems, often through personal contact with commissioners, and it was a topic on which robust views were expressed.

With some exceptions, there was broad agreement that local commissioning in Wales under the 'old' system had a number of serious flaws (though, as we shall see below, less agreement on whether the introduction of APBs would repair them). Areas of criticism included concerns about inconsistency (and sometimes unfairness) in the processes that determined choices of provider; variable levels of competence and experience among commissioners; and insufficient transparency of and accountability for decision-making. A few comments will be made on these topics below. The most fundamental set of criticisms, however, related to the cumulative results of the complex and patchwork system of planning and commissioning that has grown up in Wales. Quite widespread concern was expressed about the overall shape, balance and coherence of the services provided: in particular, about duplication and fragmentation arising from insufficient 'joining up' of work commissioned from different

providers and different funding streams, and the negative impact of this on how the system is experienced by service users. This will be discussed in Chapter 6.

Local commissioning processes

Local commissioning processes, in the broad sense of ways of deciding how funds will be distributed to service providers, were found to be highly diverse. At one extreme were CSPs in which competitive tendering had become the norm. At the other were areas where there was a general expectation of almost automatic renewal of agreements, usually via the 'rolling over' of contracts or service level agreements with agencies that had been providing particular services, in some cases for twenty or more years. The extent to which individual CSPs tended in one or other of these directions appeared to be influenced by a variety of factors, including traditional local practice, the local authority's interpretations of procurement rules, and individual preferences of commissioners.[5]

As was recognised by many stakeholders, both the above extremes can have major disadvantages. Regular 'competing' of large numbers of services not only involves both commissioners and potential providers in expensive and time-consuming bid preparation and assessment processes, but over-frequent changes of provider can be highly disruptive for staff and clients. On the other hand, a general assumption that contracts will be automatically renewed, risks complacency among the incumbent providers and accusations of unfairness from rivals who believe they would provide a more effective and innovative service. There was general agreement that the goal should be a happy medium – sometimes referred to as 'intelligent commissioning' – with a flexible mix of competitive tendering, contract renewal, and other ways of ensuring that services are delivered by the most suitable agencies over appropriate lengths of time.

Under this kind of approach, commissioners may decide that as a general rule, agencies that are performing well should be allowed to continue (with only occasional re-tendering exercises), while those who are not performing well should expect to face competition. This, however, raises the further question of how, in order to make such decisions, commissioners can know how well or badly particular agencies have been performing. Some providers argued that formal monitoring data are often misleading, and that commissioners who did not visit projects or take into account more qualitative evidence, could receive a false impression of the quality of services 'on the ground', and hence make poor and uninformed decisions (for further discussion of issues around monitoring and evidence, see Chapters 7 and 8).

Once a decision has been taken to re-commission a service (or indeed commission a new one), the approach adopted may range from a process in which innovative thinking is welcomed and potential providers are asked to put forward their own ideas about what to provide and how, to one in which they respond to a tender specification setting out a list of closely prescribed and defined activities which they are required to deliver at a competitive price. The latter kind of approach is more often (though by no means always) associated with 'procurement' than with 'commissioning' processes, and may be governed by rules laid down by local authorities, such as allowing no account to be taken of the incumbent agency's previous performance in delivering the service, and obliging the commissioners to make decisions on the basis of transparent

[5] Although the Welsh Government issues a guidance document for commissioners, this leaves a great deal of discretion to the local areas and seemed to have relatively limited influence on how they approached the tasks.

scoring systems. As some interviewees pointed out, while superficially fair, such systems can be over-rigid and prevent commissioners from using their judgement, thereby sometimes leading to results not in the best interests of service users or of the coherence of local networks of provision. They also tend to favour larger organisations with the capacity to employ specialists skilled in bid preparation, which may help them score the highest points without necessarily being the most suitable provider in reality. One interviewee whose agency had recently lost its contract to deliver a particular service commented as follows:

> Basically [we lost it] on a 1% or 0.9%, I think it was on one of them, because they don't take in past history, even though our commissioner loved our service. However, there we go, procurement is procurement… They score them and they go like, oh that was a better answer, I'll give them three extra points on that and obviously when it's all added up, oh my god, they've won, they've beaten us, because they've given a slightly better answer. [The provider that won it] write tenders all the time…
>
> However, when you look at the impact... services sort of go awry for six months, they then need a building, which is 300 grand, which we wouldn't have needed that money. So the added cost for changing provider, when your service is doing well, is insane..

Finally, some sense of the variety of commissioning practice can be gleaned from the following extract from an interview with a manager from a third sector provider:

> Q So are there any of your projects, services that just get rolled over automatically?
>
> A Yes.
>
> Q Why is it that some do and some don't?
>
> A You'd have to ask the commissioners that.
>
> Q Is it different commissioners?
>
> A Yeah.
>
> Q So some commissioners will just roll them on and others...?
>
> A Pretty much.
>
> Q Okay. So it's certain services in certain areas then... is there no competition? Or is there nobody who would bid for them?
>
> A Yeah, there's loads of people who would bid for it. God yeah.
>
> Q Okay. But the commissioners are obviously happy with the service?
>
> A Yes, and they seem to get round procurement rules.
>
> Q Yeah, so it's extensions or something.

A You know, different local authorities have different procurement, but there's a difference between commissioning and procuring services.

Q Yes.

A And even all the tendering processes are totally different, where you go. You know you'll have one who'll ask you for three books like this, another will... a couple of responses. Some will ask for a PQQ, so they'll filter down. Then a full invitation to tender. Some will do it at the same time.

Q Okay.

A It's all different.

While recognising the confusion and frustration that could be created by such a complex and inconsistent set of practices across Wales, members of the Substance Misuse Branch were clear that it was not their role to interfere, influence or scrutinise commissioning processes:

> I think the difficulty we've got in substance misuse is that a lot of our services are delivered by the voluntary sector and there are rules around, you know, putting things out to open competition. So it is a fine line, really, as to what we should… what is planning and what is commissioning?... That is one area that we would leave to local decisions to be made… the SMARTs are there in an advisory role and they shouldn't be making decisions on that. So it would be down to individual, in the main, local authority and procurement processes, and they'd have to adhere to that.

DIP and Health Boards: Cultural differences around commissioning

While most of the above discussion relates predominantly to the commissioning of services by CSPs from third sector providers, it is important to remember that (a) services specifically for offenders were funded through DIP commissioners and Probation Trusts, and (b) a significant amount of funding was distributed through Health Boards. Issues around the integration (or not) of services funded in these ways with those commissioned through CSPs will be discussed in the next chapter. However, it is first important to highlight some of the 'cultural' differences in attitudes to the commissioning of services that were apparent in comments made by interviewees from different professional backgrounds. Notably, while most of those with a criminal justice background (including probation, prisons and police managers, as well as DIP commissioners) were supporters of the competitive commissioning processes which governed the distribution of DIP funds, it was clear that most of those with a health background (including addictions consultants, nurses and members of Health Boards) found the concept of competitive commissioning somewhat unpalatable. Such processes were rarely employed by Health Boards. Indeed, rather than commissioning specific projects from a range of providers, the bulk of their '0.4%' was used to sustain NHS units which provide a range of clinical services to substance misusers – in particular, NHS addiction treatment units, which were seen as part of mainstream health provision and no different to any other specialist unit such as cardiology. These arrangements and the thinking behind them were not always understood or agreed with by interviewees without a health background and we found quite a lot of cynicism about them, with several – including members of CSPs who had

had to sign off Health Boards' annual substance misuse spending plans – expressing concerns about a lack of transparency.

While 'high end' treatment services (which often prioritised clients with complex medical needs) were funded through the Health Boards, some other clinical services – principally, detoxification and the prescribing of opiate substitutes - were commissioned partly out of CSP funds as part of 'packages' of services delivered under the auspices of third sector agencies. There were conflicting views on this. On the one hand, although concerned about expensive clinical interventions eating into the funds available for other kinds of support, most interviewees with a third sector or criminal justice background considered it helpful for individual clients if, for example, their appointments to see support workers included a prescribing service on the same premises. On the other hand, most of those with a health background expressed some concerns about too much control over such services being placed in the hands of people with little or no medical knowledge.

Some negative comments were made about the 'hiring' by other agencies of medically qualified practitioners (chiefly GPs) to supply detoxification or prescribing services, which had led in some areas to bad feeling between practitioners. For example, cases were cited of organisations winning CSP contracts to deliver a range of services including prescribing, and only then approaching medically qualified individuals or groups (some of whom had been part of rival bids) to ask if they would prescribe for them. More importantly, major ethical and clinical governance issues (central, of course, to any doctor's or nurse's work) were raised in a situation where a DIP contract specified that funding for prescribing was limited to 24 weeks for any client. This created a dilemma for GPs appointed to supply the prescribing service, as they were unwilling to 'abandon' their clients before they had completed treatment, but made a clinical judgement in some cases that it would be not in the client's best interests to reduce their opiate substitute dose so quickly. The problem was ameliorated after more flexibility was agreed, but this example provides a good illustration of the very different approaches to dealing with substance misuse found in different professions, and how much impact these can have, through the control and operation of commissioning processes, on practice on the ground.

Finally and by contrast, there seemed to be agreement on all sides that the commissioning of Tier 4 residential treatment services, traditionally undertaken by various CSPs using ring-fenced funds, was inappropriately located at local level, and should be managed centrally. For example, the following comments were from a government officer and a third sector provider, respectively:

> There are services like residential rehabilitation for drug and alcohol misuse that should be centrally driven. I mean you can't have 22 residential units, you can't have 22 in-patient detoxification units. So there are services which need to be centrally determined.
>
> Well I don't know if there is a Tier Four strategy but they should have a Tier Four strategy. It's not good enough for some areas to say, well we don't really do residential. What do you mean, you don't do residential? If the Welsh government are saying you need treatment, we need treatment. And if it's residential, you need residential, and don't put them in a psychiatric unit unless they are mentally ill, you know. That' something I feel really passionate about,

> and really as a treatment provider, again the lack of integrity, they've had research programmes on it, but they don't want to listen.

Quality of commissioners

While some individual commissioners were praised for their skills, knowledge, fairness and/or approachability, the overall picture of local commissioning presented by our interviewees was one of significant variability in quality. Typical comments included:

> I know some very good commissioners. I also know some not very good commissioners who would tend to be swayed more by personality than by what is best for the service users in that population.

> Commissioners have a lot of power and sometimes I find myself really struggling with what I have to do to keep the commissioners happy. Because if I don't keep them happy, what are they going to do to my funding? I find that one of the most distressing parts of my job, because you know our values here are around honesty, transparency and about working towards plans, working towards strategies, evidencing that. Yet sometimes it comes down to the personality of that person and whether they like you or not. I don't know how you can put into place something to stop that happening.

Several pointed out that the job was not of high status and only moderately well paid, and therefore did not always attract sufficient candidates with the desirable level of expertise and experience. Indeed, one senior manager of a third sector agency said that he had toyed with applying for the role, which he considered vital to the successful implementation of the Strategy, but could not afford to take the drop in salary!

A small number of providers complained of bias on the part of commissioners towards or against particular local providers (in one case, indeed, the phrase 'bordering on corruption' was mentioned – though in a general sense, without concrete allegations). Some were also said to be 'pushing their own agenda', not necessarily in tune with the Strategy. For example, one experienced service provider commented:

> There are commissioners who I think are great, who I think are very knowledgeable, who are very fair, who are transparent, and understanding of what it is to deliver services, and yet you know there are some commissioners who come from a very different background and have their own agendas to push. They can only push them with service providers. You find the commissioners that seem to have the heavy management of them, because they've got no power, they then have power over the providers. Your Strategy doesn't mean anything if someone's coming along and telling you to do something [that doesn't fit with it].

This raises the issue of the accountability of commissioners for their actions and decisions – a topic that will be addressed in Chapter 7.

Commissioning through APBs

Most of our interviewees felt that the current transfer of responsibility for commissioning from CSPs to APBs will lead eventually to an amelioration of the problems described, although many remained unconvinced that matters would improve as much as they would wish.

The general view was that the quality, consistency and transparency of decision-making were likely to improve. At the same time, however, a number of concerns were expressed. Some of those who had been involved in commissioning at CSP level were worried that service users in their areas would 'lose out' relative to others when decisions were made at a regional level. Likewise, some felt that valuable local knowledge about the substance misuse needs of the area, and about small providers and their links with other local services, would not be available at regional level, which could lead to poor decision-making. For example:

> I mean, I'm sceptical of the APB because it's supposed to be there to save money supposedly and to commission more effectively on a regional basis. I've yet to see that working out. All it's done to date is create another bureaucratic monster which none of us can afford to feed really. If we're commissioning one main provider in North Wales on a local basis, we can commission that as one, but what you don't want to lose is the local flavour of what that service means.

Some interviewees also felt that the expected increase in consistency across Wales might not materialise, as different APBs were already interpreting their role in very different ways – for example, seeing themselves either as primarily strategic bodies or as primarily commissioners:

> I still think across South Wales with the three APBs there is a real confusion about what they do. I mean each one is completely different. There's no consistency… The *** area seems to be more of a commissioning group. The *** group seems to be more of a strategic lead group and then the ***, well I think it's still coalescing…

Another worry was that the membership and size of APBs was not necessarily conducive to effective decision-making:

> The APB has well over 30 people. It can't make decisions – it's too big. And because it's too big it gets dominated by personalities and there are two particular personalities really that will just lead the decisions wherever they want them to go. So I don't see it functioning particularly well.

Finally, some concerns were expressed about the lack of a clear statutory basis for APBs. For example, an APB chair commented:

> I think the whole concept of an Area Planning Board which doesn't have any statutory responsibility is really puzzling people. They're really struggling with it from a governance point of view. So one of my understandings is that, within the concept of the Strategy, if you like, the brief for substance misuse has now moved from the local government minister to the health minister. And yet, the statutory requirements for the implementation of the Strategy, if you like, remains at the local authority level. The Area Planning Board is required to pull that together, and I think everybody's struggling with governance, you know, how do you do good governance via a non-statutory partnership? I think that, that's troubling people.

Further comment on APBs, specifically about their potential for adopting a more strategic approach and creating a more 'joined up' system of service provision in Wales, will be made in the next chapter.

Conclusion

It can be concluded from the evidence presented in this chapter that the Substance Misuse Branch had a fair degree of influence - mainly through its ownership of the three-year Implementation Plans, the intermediary role played by the SMARTs, and its ultimate control of the 'purse strings' - on the broad shape of the services to be commissioned in local areas. Nevertheless, within this framework, there was still considerable space for local decisions about the precise nature of the interventions to be commissioned and, above all, for decisions about which agencies would deliver them. Until recently, indeed, most of the power in this respect lay in the hands of local commissioners - principally, Substance Misuse Lead Officers based within CSPs. This power was increased in some areas by the relative disinterest of other CSP members in substance misuse, so that the SMLOs were given virtually a free hand. Partly as a result of this (together with differences in attitudes and rules adopted by local authorities in relation to commissioning), there were wide variations across the country in the nature, quality, fairness, effectiveness and transparency of the processes followed, and ranges in practice from areas where competitive commissioning (often following strict procurement rules) was the norm, to those where most contracts were routinely renewed without competition. Most interviewees also agreed that there were some excellent commissioners and some whose practices left much to be desired. It was also pointed out that there was no satisfactory way of complaining about the latter.

It was further noted that both DIPs and Health Boards had different practices and cultures guiding the way allocated money – the former generally favouring competitive tendering and the latter often funding substance misuse treatment in a similar way to the funding of many other health services, i.e. via the allocation of annual budgets to NHS units.

On the question of whether the advent of APBs was likely to produce more consistency and a generally higher quality of commissioning, views were mixed. Most interviewees felt that they had the potential for higher quality decision-making and more strategic approaches, although some fears were expressed that they could be pushed off track by powerful individuals, for example advocating the interests of particular local areas within the region. It was also pointed out that definitive guidance about the role and powers of APBs was yet to be produced, and that there were already considerable differences across Wales in how the Chairs had interpreted their tasks. Some of these issues, it should be noted, were flagged in the Welsh Government's recent APB review, and at the time of our interviews, stakeholders were awaiting further guidance.

CHAPTER 6: THE SYSTEM AS A WHOLE: COVERAGE, BALANCE, COHERENCE, FRAGMENTATION

Introduction

In this chapter we look at the overall results of the planning and commissioning arrangements described in the previous chapter. We begin by attempting to 'map' as best we can the totality of services, projects and interventions that have been implemented in Wales through the various funding streams referred to, and to use the results to make a broad assessment of the extent to which what has been implemented covers the main areas identified in the Strategy, of the overall balance between them, and whether there are any significant gaps. This turned out to be an extremely difficult task, and the available data are inadequate to allow it to be carried out fully and accurately: as far as we know, nobody has attempted to do it before.

We then present stakeholder perceptions of the overall 'balance' of the system in terms of the amount of attention and resources devoted to different kinds of interventions. We also explore their perceptions of the extent to which different parts of the system work together harmoniously or, conversely, to what extent it is blighted by 'silo' mentality, fragmentation or duplication. Finally, we summarise their views on the possible impact of APBs and PCCs.

Mapping the system: what is actually funded and implemented?

Programmes funded through CSPs

The main part of our mapping exercise was based on Welsh Government data, listing projects and activities funded by CSPs during one twelve-month period (2011-2012). More details about the database used and our methods of analysis can be found in Appendix 5.

Among a total of 378 entries, we were able to identify 244 separate projects or activities that could be categorised with a reasonable degree of confidence into one or other of the four action areas in the Strategy document. Most of the other entries referred to a variety of staffing and management costs (including training, waste management etc) which we were unable readily to assign to specific interventions. A summary of the 244 identifiable projects and activities is presented in Table 6.1.

Table 6.1: Identifiable projects and activities recorded in the 2011-2012 CSP funding allocations, by action area

Action area	Intervention type	Projects and activities n	Projects and activities %
1. Preventing harm	Education & prevention	35	14
2. Support for substance misusers	Harm reduction	15	6
	Treatment	85	35
	Other support	77	32
3. Supporting families	Support	19	8

4. Tackling availability	Enforcement	13	5
Total		244	100

Overall, the greatest number of projects and activities (177 out of 244, or 73 per cent) were adjudged to fall under the 'Support for substance misusers' action area. By contrast only 14 per cent fell under 'Preventing harm', eight per cent under 'Supporting and protecting families' and five per cent under 'Tackling availability'.

The projects and activities in the 'Support for substance misusers' action area can also be broadly divided into three sub-groups, as shown in the second column of the table. The subcategory of 'treatment' (85 cases) emerged as the most frequently listed activity of all. This in turn consisted of fairly equal numbers of activities identified as prescribing and psychosocial approaches. Prescribing included brief interventions, when they involved detoxification, GP shared care schemes, or the generic category of prescribing. Psychosocial interventions included alcohol services as well as brief interventions and general treatment. The second largest sub-category (77 cases) concerned other support services to substance misusers. In many of these cases it was unclear precisely what services were offered, but the remainder refer to specific activities such as counselling, drop-in services, outreach, and supporting service user groups.

The third largest group of projects and activities (35 cases) related to the action area of 'Preventing harm'. These focused predominantly on schools-based education and on methods of educating the public. They also included 'diversionary activities', which usually related to schemes for young people (more detailed breakdowns are shown in Appendix 5 Table A5.1 and A5.2). No projects or activities had targeted substance misuse in further or higher education, or unemployed young people. However, an action research intervention, aimed at reducing excessive alcohol consumption in Welsh Universities (A pilot study of alcohol policy and social norms in Welsh Universities) is listed in Table 8.2 on page 81, where the intervention is listed as "local").

Of course, to look at the *numbers* of interventions alone could be misleading, as it is possible that some are much larger and more expensive than others. It is therefore also important to look at a breakdown by expenditure. Table 6.2 shows such a breakdown, using the same four categories as in the above analysis. It also shows 'other' costs shown in the lists, but not attributable to particular kinds of intervention.

Table 6.2: Total cost activities recorded in the 2011-2012 CSP funding allocations

	Allocation use	**n**	**Mean**	**Sum**	**% all**
Projects and activities	Preventing harm	35	21,626	756,911	4
	Support for substance misusers	177	65,967	11,544,219	64
	Supporting families	19	87,286	1,658,425	9
	Tackling availability	13	25,271	328,522	2

Total		244	50,038	14,288,077	**79**
Other	Staff Costs	73	35,355	2,580,965	14
	Running Costs	52	25,407	1,321,172	7
Total		125	60,762	3,902,137	21

Notes: Running costs include costs relating to office supplies such as computer software, computer hardware and photocopiers.

It can be seen that, as in the breakdown by numbers of projects, by far the largest proportion of the total CSP budget – at least 73 per cent - was spent on interventions aimed at supporting substance misusers and their families. In comparison, relatively little was spent on preventing harm and tackling availability. It is worth noting that, although comprising only 19 projects, activities aimed at supporting families received nearly ten per cent of the budget; by contrast 35 'preventing harm' interventions received only four per cent. Even so, a broadly similar picture of the distribution of resources emerges, looked at through either lens (i.e. numbers of activities, or expenditure).

Of course, CSP-distributed funds – although the largest - form only part of the total spend on substance misuse related activities in Wales, and we should not jump to conclusions from an examination of this funding stream alone. We now briefly examine (to the extent that data are available) what kinds of activities were implemented through the other main funding routes that were in operation for the first three years after the Strategy was published: those channelled via the Health Boards, DIP, Probation Trust, and direct from central government.

Health Board funded services

Most other clinical services were funded from health budgets controlled by the Local Health Boards. In most cases, these funds were allocated, without competitive tendering, to NHS units, although in some areas limited funding was also distributed to third sector providers.

During the course of our interviews it became clear that, while a ballpark figure of £17 million was quoted as the total dispersed in this way, little concrete information was available about what exactly it was spent on. In fact one member of the Substance Misuse Branch described the situation as a 'mystery' and indicated that 'nobody's ever known what the 0.4% is'. The Branch was unable to provide us with any breakdown of the services funded, it being stated that, 'We don't really manage that, it's a Health Board issue'. Respondents working in the Health field were also unable to help, beyond noting that most of the funds were spent on clinical services which formed part of the NHS.

For our purpose here of attempting to 'map' the totality of substance misuse services, this lack of information is not helpful. However, we can at least conclude that the great majority of Health Board funded services can be classified under the action area heading of 'Support for substance misusers', and more specifically, 'treatment'.

Centrally funded interventions
In addition to interventions funded by the SMAF and health budgets, a number of national services and experimental projects were commissioned centrally by the Substance Misuse Branch. Precisely how many such projects have been funded from this central budget was difficult to determine. We know, however, that at least 12 projects have been funded either wholly or in part from the central pot since 2008. These include, in no particular order:

1. the Take Home Naloxone project
2. the Transitional Support Scheme
3. the CRAFT project
4. Early Parental Intervention Pilot projects
5. the All Wales School Liaison Core programme (co-funded between the Welsh Government and the 4 police forces in Wales)
6. the 'Include' Turnaround programme
7. the Option 2 project
8. the Pilot study of alcohol policy and social norms
9. Alcohol Brief Interventions
10. the Strengthening Families programme
11. the Recovery project
12. Operation Tarian (co-funded with South Wales Police)

The projects are varied in nature and target a range of different kinds of actual or potential substance misuser. The Take Home Naloxone programme, for example, targets people at risk of opiate overdose while the Transitional Support Scheme targets short-term prisoners on release from prison.

We are unable to give an accurate figure for the total cost of centrally funded projects and interventions. It should be noted that almost all have been subject to formal evaluation (see Appendix 6 for summaries of the known evaluations), and the additional costs of commissioning independent evaluations should also be factored in. Overall, it is likely that the annual amount spent on delivering and evaluating these projects amounts to several million pounds.

In terms of the balance of spending between Strategy action areas, these centrally funded activities may even up the picture a little, as a number of the projects listed have primarily preventive aims, and one of the most expensive (Tarian, which has received £642,000 in Welsh Government funds annually since 2008/9) is concerned with tackling availability.

DIP funded interventions
Another important source of funding for substance misuse services in Wales has been the annual grant from the Home Office (distributed via the Welsh Government) to run the Drug Interventions Programme (DIP) for offenders. DIP funding is being discontinued as such, and will now form part of the (non-ring-fenced) budget of the newly elected Police and Crime Commissioners, with no guarantee that it will be spent on similar activities to those it currently funds (see below).

The DIP is described on the WG website as 'a crime reduction initiative which provides a much needed support structure to encourage offenders out of crime and into treatment'. In practice, it involves identifying Class A drug-misusing offenders at every stage of the criminal justice system from arrest onwards, and encouraging them to

engage in treatment, support or aftercare. To support regional delivery of the programme in Wales, four Regional Management Boards (RMBs) were created, one for each police force area. The RMBs each produced their own local implementation plan to guide the commissioning of services delivered by the Criminal Justice Integrated Teams (CJITs). In 2012, five treatment agencies were involved in the delivery of DIP:

- South Wales - G4S and CRI
- North Wales - Arch Initiatives
- Dyfed Powys - Prism and Kaleidoscope
- Gwent - CRI

The Dyfed Powys DIP website provides a useful summary of how clients can access the DIP and what interventions are available to them:

> Contact with DIP will be made through the courts, probation, police, prisons, a 24 hour Helpline, self-referral or through referral from other key agencies. Clients will have contact with a drug worker who will conduct an initial assessment and develop with the client a Care Plan that matches available services to the client's needs. This may include harm reduction advice and information, one to one motivational interviewing, relapse prevention and referral to volunteer and mentoring schemes, specialist substitute prescribing schemes and wrap around support such as housing, education and training and family support. (http://www.dyfed-powysdip.org.uk/about.html)

DIP funding has decreased in recent years. The annual report for 2010/11 shows that just under £6m was spent on DIP services across Wales. The figures are broken down by police force area and show that most of the money was spent in South Wales (£2.9m) followed by North Wales (£1.2m), Gwent, (£1.1m) and Dyfed Powys (£800k). The bulk of the money was allocated to fund the CJITs (£5.3m) and the remainder was allocated to RMBs. The report indicates that no DIP money was allocated towards the national telephone helpline (DAN 24/7) or to the Transitional Support Scheme for ex-prisoners. Similarly, no DIP money appears to have been allocated to cover any central costs.

The picture that emerges from this brief overview of DIP funded activities is, once again, of a primary focus on 'Support for substance misusers'. Even though controlled largely by commissioners working in the criminal justice field, very little of the DIP budget appears to be spent on either 'preventing harm' or 'tackling availability'.

DRRs and ARRs

Services ordered by the courts for substance misusing offenders - mainly Drug or Alcohol Rehabilitation Requirements (DRRs and ARRs) are paid for by the National Offender Management Services, and commissioned from local providers by Probation Trusts (Wales Probation in the case of Wales). However, following the Probation Review (2012), these arrangements, too, are likely to change.

Projects funded from other sources

In addition to the sources of funding described above, we were aware from our own knowledge of the field that other sources had also been used to fund substance misuse services in Wales. These included large grants (in the millions of Euros) obtained from the European Social Fund to fund key wrap around services such as

the all-Wales Peer Mentoring project (sponsored by the Welsh Government) and the Coastal project (sponsored by six South West Wales local authorities), both of which were designed to help economically inactive (former and stable current) substance misusers gain qualifications and employment. They also included grants without any links to central or local government, which meant that no formal list of relevant projects was available to us. Such information is likely to be stored at the local level within individual agencies, and APBs are also now tasked with monitoring all services in their area regardless of funding stream, but we were unable to conduct a survey to explore the matter in detail. We did ask our interviewees (where relevant) if they had received funding from other non-government sources, and one respondent reported that his third sector organisation had obtained £250,000 from the Big Lottery to help fund the purchase and development of a new building. It is likely that others have been successful from this or other charitable sources, which suggests that the overall figure for externally obtained funds runs into several millions.

Again, we cannot be sure of the distribution of externally acquired funds across the four action areas in the Strategy, but what we know suggests that, as with all the other funding streams, the main area of investment has been in 'Support for substance misusers'.

Conclusion

The services funded from the various sources above span the whole range of interventions proposed in the Strategy document. However, analysis of the kinds of projects and activities implemented with funds distributed through CSPs, suggests that by far the greatest emphasis (in terms of both numbers of projects and allocation of funding) was placed on support for substance misusers. This covered a range of services, the most common being treatment through prescribing or psychosocial interventions. While centrally distributed funds may even up the picture a little, in that they include considerable investment in projects aimed at prevention and tackling availability, those distributed through Health Boards and the DIP are once again directed mainly at treating and supporting substance misusers.

In other words, although we do not have full information at our disposal, it can be concluded with some confidence that the majority of the available resources are directed at just one of the four action groups in the Strategy – 'Support for substance misusers'. It is unknown to what extent this distribution of resources reflects conscious prioritisation from the centre, and to what extent it is an unplanned outcome of numerous individual decisions at local level.

Stakeholder views about the substance misuse 'system'

We now look at the views of stakeholder interviewees both about the overall coverage and balance of the system for responding to substance misuse in Wales, and about the extent to which it is coherent and 'joined up'.

Coverage and balance

We found a range of stakeholder views about the overall balance of the system. As mentioned in the last chapter, a small number of interviewees felt that one or other of the action areas of the Strategy not concerned with support – i.e. Preventing harm and Tackling availability – were under-funded and under-prioritised. However, these were firmly in the minority, and there was a strong consensus that treatment and support of substance misusers and their families should be the central priority. Even so, there was a fair degree of disagreement about whether the appropriate balance had been

achieved between different kinds of treatment and support. Unsurprisingly, views on this tended to vary according to professional background. Many of the interviewees who did not work in the health system felt that too much of the budget went towards clinical treatment and that, in a period of financial retrenchment, it was the more 'social' kinds of interventions – particularly those delivered by the third sector – that were more likely to suffer cuts.

On the other hand, several of those with a clinical background felt strongly that the balance was tilted too much towards psychosocial interventions, when (in their view) no strategy could be successful without effective medical treatment at its heart. This did not mean that they denied the value of counselling or social support, but they felt that this should be a secondary service, building on the foundations of clinical treatment. For example, one described prescribing as the 'glue' of the system. It not only kept substance misusers on course for ultimate freedom from addiction, but gave them a strong incentive to keep appointments on a regular basis: the latter created a useful base from which partner agencies could offer 'wrap around' services such as housing and employment advice. As mentioned in the previous chapter, several interviewees with a health background were critical of commissioners who did not fully understand clinical treatment and saw prescribing almost as an adjunct to psychosocial interventions, rather than vice-versa. This was seen by some as a result of too little guidance from the Welsh Government.

Duplication and fragmentation

One of the most common topics that emerged in our interviews with stakeholders was the problem of fragmentation of service delivery. A high proportion conceded that, for the service user, the experience of substance misuse interventions was often far from the ideal of a coherent and 'seamless' process with a sense of a planned journey towards a clear goal. Rather, although many individuals working in the system made efforts to link up with other agencies, there were frequent problems of gaps, delays in handovers, duplicated assessments, and so on (similar conclusions were reached in the Healthcare Inspectorate Wales report published in 2012, *Substance Misuse Services in Wales: Are They Meeting the Needs of Service Users and Their Families?* – see Chapter 8 below).

The problems identified included both gaps within 'treatment' itself and between treatment and 'wrap around' or follow-up services. Examples of the first of these include failed links or delays between criminal justice related treatment (in prison, or under the DIP) and ordinary community treatment services. We have already mentioned in the previous chapter the 24-week limit on funding for prescribing imposed by a DIP: this would not have caused problems had there been a way of ensuring that after 24 weeks service users were transferred to the care of another agency to continue their treatment, but this was not the case. More generally, treatment providers would often not allow people such as ex-prisoners to 'jump the queue' to continue work they had begun in custody, though criminal justice staff argued that they should be a priority group (it should, however, be noted that such services appeared to be more 'joined up' in North Wales).

Examples of the second include completing treatment with a clinical provider (such as an addictions unit) but then finding it difficult to access social support services. The advent of the all-Wales ESF-funded Peer Mentoring project was said by some to have ameliorated this problem somewhat by offering opportunities for employment to service users who had completed clinical treatment. However, it was also clear that

some agencies were not referring as many cases as they could to this service, partly because of inter-agency rivalries and partly – particularly in the case of medical staff – because of sceptical views about its value (it was argued both that a focus on employment did not meet the needs of many service users at this point in their lives and even that peer mentoring was not a 'professional' enough follow-up to treatment).

Will APBs improve the system?
As noted in the previous chapter, we found qualified support for the new APB structure in terms of its potential for better quality and more consistent decision-making. Perhaps more important, however, is the question of whether APBs will adopt a more strategic and 'joined up' approach to planning and decision-making and thereby bring about significant reductions in the fragmentation, duplication and inconsistencies in practices across local authority areas. Most interviewees expressed at least cautious optimism on this score. For example:

> I mean I'm not actually on the APB but I've always been an advocate of the APB. I think the problem we've had in North Wales is that we've had six SMATs. The money is not insignificant but compared to the global pot for local authorities and other agencies it's quite small. So we've had some quite junior people managing pots of money and managing commissioning and managing what we do. My hope is that the APB with it being a North Wales body will have people of sufficient seniority on that who can actually make strategic decisions into the next five or ten years.

> You know, the APB hopefully will coalesce into a sort of regionally commissioned service and there'll be equality of access for individuals… There is huge disparity. You know, if you're ten miles down the road in Neath or if you're ten miles up the road in Swansea or vice versa in Bridgend, there doesn't seem to be any consistency on who's eligible for what and what the timeframes are, so hopefully that will change with the APB.

> As to a strategic development and, you know, overall … there's got to be a pan Gwent vision. It just doesn't make sense that if you live in one area you can access in-patient detox; if you live in the other area you can't.

Whether or not the widely shared goal of a more coherent and user-friendly service would be achieved was generally thought to depend on whether the key people on the APBs, including of course the Chairs, were of sufficient strategic vision and strength of purpose to overcome the many obstacles that could throw them off course, not least pressure from local areas and interest groups (some of which will be represented on the APBs) to meet their particular demands. For example:

> I've got concerns around the APB, as I've probably voiced throughout this interview… I think some of it's about having the right level of participation. I think if you're doing strategy, you've got to have, you know, senior representatives from each organisation that firstly treats substance misuse as a priority, see it as an important, you know, part of the business, and then are committed to looking outwith their own box, so when you're trying to spend money on, you know, often regional services, you can have local services, but you don't deliver everything on the doorstep. You've got to have people willing to just let go, you know, and not be defensive. And I'm

not sure that we've achieved that anywhere near yet, and it feels to me very defensive from a local perspective of people trying to hang on to what they've got, not wanting to give up things in relation to the greater good.

But I do think really if they want to see something which really, truly looks like cohesive regional planning and commissioning they need to give the APB a statutory power to do that. And at the same time take that away from the local authorities.

The impact of PCCs

Finally, it is important to consider briefly the possible impact on the 'system' that will be produced by the transfer of DIP funds to the elected PCCs. Numerous stakeholders from a range of professional backgrounds expressed concerns that, unless the PCCs have a good understanding of the importance of DIP services to the provision of substance misuse services as a whole, the consequences could be serious. The following comments from interviews give some flavour of the strength of these concerns:

But of course with the PCCs coming now that money may disappear. We may get it back through the PCC for substance misuse, on the other hand the new commissioner may decide otherwise, so we could lose that amount, which I think in our case is about 52 grand.

Really dried up, I mean we've had huge funding cuts over the last three years. And it will be at least the same going into next year, that's before the PCC even decides what they want to do with the money. And unfortunately it's always the wrap around stuff that goes first because it's the hardest to evidence and it's generally the stuff that's not written down as being required. So you always end up pulling back to kind of core service delivery when you know that there's an equal value to both but there isn't always an evidence base for more alternative engagement really.

I'm really worried, and not on a personal basis, but on a basis of, you know, what's going to happen? This … you know, worked years and years really hard to get these systems up and working and effective for people and then all of a sudden it's … it might all come crashing down overnight. It's really worrying.

Obviously I remember the days before DIP, and I wouldn't like to go back to those sorts of days so, you know, we are quite concerned about that. I understand that the APB is doing a paper at the moment ready for the PCC coming in to explain the background to DIP and the integrated offender management and how we use some of the SMAF and the health funding to work with offenders and that if you take one bit away you're going to destabilise the rest and that it's working quite well. So I think they are trying to be proactive to say, you know, it's working, please leave it along at the minute. So that is a concern.

Conclusion

This chapter has presented a brief overview of the substance misuse projects, services and activities actually funded and implemented in Wales. We found it impossible to identify all such activities, which include services provided by the NHS which are difficult to separate out from the rest of the health budget, and various one-

off projects funded through, for example, the Big Lottery and other external grants. Nevertheless, we were able to gain a fairly full picture of what was commissioned through the CSPs. A certain amount of imbalance was apparent in terms of investment in the different action areas of the Strategy document. The bulk of the funds allocated were concentrated in activities and projects categorisable as 'Support for substance misusers': principally, treatment, psychosocial interventions and other support services. Less investment (in terms of numbers of activities and amounts of funding) was made in 'Preventing harm' or 'Tackling availability'. Similar patterns were found in the other funding streams, although the centrally funded projects included several with a prevention aim, and one large one (Operation Tarian) with an enforcement aim.

Despite this apparent imbalance, most interviewees were reasonably happy with the distribution of funding between action areas, although (unsurprisingly) some of those working in specific fields felt that too little of the budget was spent on their own kind of work. Perhaps the strongest area of disagreement was between interviewees with health and other backgrounds, over the level of priority that should be given to clinical treatment as against psychosocial interventions and 'wrap around' support.

In terms of the operation of the system as a whole, there was wide agreement that it suffered from both fragmentation and duplication, and that an individual's 'journey' through it was often not smooth or 'seamless'. Too often, it was disrupted by agency rivalries, complex funding arrangements, or lack of communication and coordination. Some held out hope that such problems would be ameliorated by the advent of APBs, but concerns were expressed that the latter's effectiveness might be undermined by continuing pushing of local needs at the expense of a more strategic regional approach, or by inappropriate choices of Board members.

Finally, serious concerns were voiced about the possible loss of vital services for offenders – and knock-on effects on the system as a whole - if the incoming PCCs decided to spend the current DIP funds (which will no longer be ring-fenced) elsewhere.

CHAPTER 7: OVERSIGHT, MONITORING, ACCOUNTABILITY AND CHANGE MANAGEMENT: EFFECTIVENESS OF THE STRUCTURES IN PLACE AND QUALITY OF AVAILABLE DATA

In this chapter, we examine the structures and information systems through which oversight is maintained both of the activities of individual agencies and of the implementation of the Substance Misuse Strategy as a whole. This may be for purposes of monitoring compliance with contracts, assessing effectiveness, ensuring accountability, or informing policy change. We begin with an overview of the mechanisms in place for these purposes, together with stakeholders' views about their fitness for purpose. This is followed by an examination of the main sources of data on which judgements about performance or impact may be based – again presenting stakeholder views. In the following chapter, we shall use such data ourselves to make the best judgements we can about the effectiveness of the implementation of the Strategy.

Monitoring and accountability at individual and local level

Monitoring of the performance of individual providers has until recently been left mainly to local commissioners and their teams, under the auspices of the CSPs. This is undertaken through a combination of standard performance indicators and more qualitative methods (including visits, discussions, reports, case studies, and so on) which vary widely between areas in their depth and rigour. If a particular agency appears to be seriously underperforming, this may be made known to the Branch – often via the SMART – who may intervene with a visit or advice. The Branch will also scrutinise the performance of agencies that receive SMAF funding through a review of the quarterly reports via the online funding tool. However, generally speaking the Branch is interested in performance at CSP level (which it then grosses up to national level), rather than at the level of individual providers.

Like many aspects of the system, approaches to monitoring performance are undergoing a process of change – not least a shift towards outcome rather than output focused indicators. What follows refers mainly to practice during the first three years of the implementation of the Strategy.

KPIs

Central monitoring of CSP performance is largely undertaken through measures of the overall performance of agencies in each CSP area against nationally set Key Performance Indicators (KPIs). Each month, all relevant agencies have to complete formal returns providing information about new referrals and updating records on existing clients. These are translated into entries on to the Welsh National Database for Substance Misuse (WNDSM) and the resulting data are analysed by NHS Wales Informatics Service (NWIS, formerly Health Solutions Wales) to produce current performance indicators for each CSP area. The Substance Misuse Branch uses a 'traffic lights' system to identify which areas seem to be performing satisfactorily and which not.

The original KPIs, which predated the 2008 Strategy by two years, are listed in Table 7.1.

Table 7.1 Key Performance Indicators

No.	Indicator
1	Increase local service capacity for people who misuse drugs, alcohol and other substances in line with stated priorities in local/regional commissioning plans in respect of: • open access services • structured community based services • residential and inpatient care
2	Reduce the number of incidences of unplanned ending of contact with services.
3	Achieve a waiting time of not more than 10 working days between referral and assessment.
4	Achieve a waiting time of not more than 10 working days between assessment and the beginning of treatment.
5	All young people referred from a YOT to receive an appropriate assessment within 5 working days of referral.
6	All young people referred from a YOT to have commenced an agreed care plan no later than 10 working days from completion of the assessment.
7	Reduce the number of incidences of reported acquisitive crime (defined as those listed as 'trigger offences' for DToC areas)
8	All clients who are IDUs to be offered information, counselling, screening and where appropriate, immunisation against hepatitis B.

While some data are collected on each KPI, in practice the main focus has been on the second, third and fourth in the above list, which are the only ones that can be produced routinely by NWIS from the national database (others are produced at longer intervals by the Youth Offending Service, the police, and so on). If a CSP is perceived by the Branch to be underperforming in relation to any of these three measures, the local Substance Misuse Lead Officer (SMLO) may be asked to investigate further and the area may receive visits from the SMART or other Branch staff in order to discuss ways of improving the results. In some cases, too, providers whose individual performance figures have played a part in the poor CSP figures may be visited for similar discussions.

As will be discussed further below, many stakeholders had severe doubts about the value of these KPIs as representations of reality, and complaints about errors in the data were common. More fundamentally, it can be seen that the focus of performance management has for several years been primarily on processes around treatment provision, and in particular waiting times for assessment and treatment. This reflects the fact that, in the mid-2000s, waiting times were a topic of considerable concern. However, more recently it has been widely argued that these KPIs were excessively focussed on process-related targets, which could be misleading in terms of representing the true value and effectiveness of providers' work. These concerns led to a WG review resulting in a decision to introduce a new set of KPIs which, their designers claim, place a much stronger emphasis on outcomes. These can be summarised broadly as follows:

Table 7.2 Summary of Revised Key Performance Indicators

No.	Indicator
1	Engagement of services
2	Achieve a waiting time of less than 20 working days between referral and treatment
3	Reduction in substance misuse
4	Injecting risk
5	Quality of life
6	Successful closures

Stakeholder views

KPIs were generally viewed by our interviewees as a necessary consequence of receiving funding for service provision. Most respondents from third sector agencies seemed to accept them and worked hard to meet them. As hinted above, the main criticisms concerned the appropriateness and relevance of the existing suite of KPIs, and especially their narrow focus and absence of indication of outcomes. Also mentioned were a lack of clear connection between the KPIs and the Strategy, and a tendency of some SMLOs to make decisions on the basis of crude indicators rather than qualitative information.

While some of these criticisms may become largely redundant when the new KPIs are implemented, it is worth looking at a few illustrative comments:

> We can't tell actually at the end of the day whether someone goes out into the community and is drug-free. We haven't got that ability to do that.

> Can we have some more clinically focused, meaningful, intelligent targets rather than, you know, this huge machine that is producing huge amounts of information for different people in Welsh government?... I don't think we're being as smart as we could be around that.

Again, expressing concern at an over-reliance by commissioners on KPIs, an interviewee working in public health remarked:

> And what a waste of resources, they are brilliant at engaging with people. And it's such a shame, it's such an imbalance. You know, for me, whatever works but on the negative side of the KPIs, I came across an incidence literally last week where one needle exchange had been better resourced recently, than the statutory, the more recognised service. So it led to an increase in service users using one service and a decrease in another. So instead of addressing what was wrong with this one, they took away the equipment of this one so that this organisation could meet their KPI. Oh my God. Since when were KPIs more important that actually what's happening in the field?

On a more positive note, by no means all local commissioners used KPIs as their main way of judging performance. Three of those we interviewed expressed

considerable doubts about their accuracy, but said that they could be of some value if used intelligently alongside more qualitative data, including conversations with providers, to get a realistic picture of local performance:

> But what we also have is monitoring from service providers into the SMAT as well, each quarter… which is a lot more on the softer outcomes as well, which I think are very beneficial for us to see how effectively the service is being delivered. Which says, this is what's going great, this is what's been a real positive, you know, in the last quarter. These things haven't gone so great. And there is a lot more kind of meat on the bones I guess, in terms of being able to say, this is what is being delivered.
>
> We will set targets and… aside from the key performance indicators that are given by the Welsh Assembly - and they've changed this year so they're a little bit more outcome focused, although we are still measuring waiting times we're not measuring ten days from referral to assessment and ten days from assessment to treatment, we're now measuring twenty days from referral to treatment commence which is a much more realistic way of doing it and it's still the same time. So apart from all of those which are given and they have to report on, we also set them some targets locally for the kind of work we want them to do. Maybe with the young people's service we may want X amount of awareness raising sessions to work with the prevention and to pick up the schools and all the other partners. So we have quarterly updates from each service provider, which are based on the SLA and the targets we've set in there, so they will report to us quarterly on those which we have to report quarterly anyway to the Welsh government. We look at any checks and problems, we look at forecast spend, all of those kind of things. We're measuring their KPIs, we use traffic light system for that. So if we've got a problem then it's quite easy to do really because of the good working relationship. I can ring them up and say, "What's the problem? Can we call a meeting, we'll go through it?" So that kind of thing...

This kind of approach was clearly valued by service providers. For example:

> We actually follow people through to the services. So I'll present a case study this quarter, the next quarter I'll provide an update on that case study and we can then follow people up to the point of discharge. [The local commissioner] is much, much more keen to actually look at what are people getting from the services, it's not always about the numbers. And I think in other areas now, they're moving more towards outcome focused measures, as that's the Welsh Government Directive.

In fact, several providers undertook fairly sophisticated self-monitoring, using a variety of instruments to measure progress on a variety of fronts as well as service users' ratings and experiences of the support or treatment received. For example:

> A We've like... service user outcomes. So again you know... not drinking over safe levels, no longer using. So those sort of things. Then, how did you find accessing the service? So again, was the place you were seen in welcoming? How helpful did you find [the agency] staff? Did we help you achieve your goals? Did the support you receive make a difference? So

ultimately, you know, are we getting that front end right?... Did it make a difference? Anything that we could improve? What did we do well? So you've got some very simple...

Q What do you do with that then, with all that data?

A So we input it into a database and then we have performance management meetings on a quarterly basis where we will analyse... xxx will provide a report on this, and measure what we're doing.

Q But would you give that to your commissioners? Those kinds of reports?

A Yeah we could do. Some of them know that we're doing it; some of them don't, because this is something that we've done ourselves and we started it from 1st April this year. Yes, we will use that as a way in which to think about anything that we could improve… You know you can't be perfect at everything. I think being honest about the areas that we could improve and then evidencing that we've improved, is a much healthier way, you know.

Accountability of commissioners

While providers are held accountable for their activities and performance through monitoring against KPIs, commissioners are held accountable for their performance through the quarterly reports uploaded via the online funding tool. However, the extent to which the commissioning *process* was being monitored was unclear. This point was made forcefully by a small number of our interviewees, especially service providers who felt that they had been victims of poor commissioning decisions that had been made in a non-transparent or even biaised way.

One respondent called for a 'whistleblowing system' to bring cases of poor or biaised decision-making to light. While fairly isolated, such comments raise the general question of whether there should be a formal mechanism for oversight and accountability of commissioners, including a formal complaints system. As we have seen, the Welsh Government Substance Misuse Branch felt that it was not its responsibility to monitor the processes of commissioning at local level. However, with the introduction of APBs, it may be an opportune time to reconsider this issue. It is not unlikely that concerns about commissioning decisions and processes will continue, or even increase: APBs will control much larger amounts of funding, and some local areas may feel that 'their' resources have been diverted elsewhere. The following two comments from managers of voluntary sector agencies indicate that the accountability of APBs is an important issue for that sector:

> Yeah well maybe... and I think managing the APBs, accounting them to what they do and how they deliver it, and are they looking to the Strategy and if they're not following the Strategy and the Implementation Plan, why aren't they? Managing their ability to respond, to communicate, to be the thing that they are. I'm a member... now if I'm prepared to take on that responsibility, then everybody else should be. You know, I would take that responsibility seriously.

> Reminding Area Planning Boards that this is the Strategy and the Implementation Plan that we work to and that they are accountable to that, because there's lots of factors on that area planning board or individuals who

> have different agendas. I know that they're irrelevant but ultimately we do work to that Strategy. Reminding area planning boards would be a really good... you know, bringing back... getting back to basics.

Oversight of the system as a whole

So far we have discussed mechanisms – such as regular meetings with commissioners and the completion of KPI related statistical returns - for monitoring of the activities and performance of individual providers, as well as of local CSPs. However, it is also important to examine ways in which oversight is (or should be) maintained of the overall operation and effectiveness of the system for tackling substance misuse. This of course is a vital step towards finding ways to improve it.

The people with the best vantage point in this respect are the members of the WG Substance Misuse Branch, who not only prepare the Implementation Plans, but maintain regular contact with key stakeholders across Wales, receive 'intelligence' from the SMARTs, and control and analyse all the relevant monitoring data. However, most interviewees agreed that it was important for a wider range of stakeholders not only to share this kind of knowledge, but where appropriate to use it to question, challenge and hold to account WG officials in relation to their strategic plans and decisions about implementation, as well as to have some meaningful input into future policy decisions. While many said that members of the Substance Misuse Branch were exceptionally accessible and receptive to suggestions made through individual approaches, there was also widespread criticism of the formal structures for providing such inputs – in particular, what is ostensibly the main vehicle for this, the Substance Misuse Strategy Implementation Board.

The Implementation Board

According to the Welsh Government website (accessed 21/6/12), the aims of the Implementation Board are (1) to oversee, at a national level, the delivery of the Strategy, (2) to ensure that the Strategy is reviewed and refreshed in light of emerging developments or changes in patterns of substance misuse, and (3) to ensure that links are established and maintained with relevant groups. Membership of the Board comprises senior government officials, the Chair of APoSM, nominated members of CSPs, and other external stakeholders drawn from a range of organisations.

We asked all interviewees what they thought was the role of the Implementation Board and whether it was achieving its objectives. The responses can be divided into comments about: (1) the original aims of the Implementation Board, (2) the work of the Implementation Board in practice and problems associated with it, and (3) proposals for reform.

The original aim of the Implementation Board was, as described by one respondent, to defend vigorously the principles of the Strategy; especially the emphasis on partnership approaches, and to make sure that the government was working towards achieving these principles.

> [T]he Implementation Board was a genuine attempt to say we see this, the delivery of this strategy as a partnership thing, led by Welsh Government, and, actually, we want to, publicly with partners, make check that we're keeping the delivery of it on track. So we had, you know, all areas and key partner organisations, etc., represented on there. And it was their opportunity to

> challenge, actually, not only Welsh Government, but other partner agencies about what was happening.

In theory at least, the Implementation Board had substantial influence and could overrule decisions at high level; not so much as a result of formal powers, but as a result of its abilities to persuade and encourage senior officials and politicians.

> [A]t the end of the day, policy decisions need to be taken by ministers. So, but we would have been unlikely to do it without at least seeking their views, or doing something. You know, we're not likely to do something that the Implementation Board were completely anti, you know? So it was another way of engaging…

In practice, it appears that the Implementation Board did not act like this. The major omission is aptly summarised in the last sentence of the following comment by a Board member: the absence of an effective challenge on government action.

> [W]e'd also present data and information on what we were doing to deliver the strategy, what the indicators were telling us, where we were on, you know, delivering certain things at each meeting? What didn't come back was the challenge.

There were several problems noted by the respondents in relation to the structure and operation of the Implementation Board. The first was its size.

> They're huge meetings. It's probably the biggest out of all the meetings I go to,,, 25, 30 perhaps round the table.

There were also criticisms of the remit it has created for itself and the agenda followed. The following respondent refers to the Implementation Board as a 'receiving information' board and blames this on the inability of the group to prioritise its agenda.

> It's not what I would call a working board. It's a receiving information board I think… There's a huge agenda, so how do you pick what you're going to discuss? You can't have feedback from it all. And is the purpose of that board to monitor the implementation plan which I guess it is, so how's the best way to do that with such a big plan? Again, I think they should cut it in half and prioritise and deal with the wicked issues first and then work your way through.

Another respondent thought that the Implementation Board had 'lost its way'; meaning perhaps that it had moved away too much from its original remit. This reflected a frequently expressed view that it had become little more than a 'talking shop'. For example:

> Q How do you find it is operating?
>
> A Er, it's a talking shop.
>
> Q Talking shop. So its remit is to do what?
>
> A Well, theoretically to hold the deliverers of the action plan to account, but it didn't have much teeth or it doesn't have much teeth.

There were several proposals for reform. One was to scale back the Implementation Board in terms of size and agenda; with the view of achieving more explicit outcomes.

> [H]ow could it be improved? It's just such a big group, I guess it needs to be broken down into smaller ... and there are ... a bit ad hoc really, smaller working groups that get set up to look at something.

Another was to revert back to the original aims of the Implementation Board as an effective monitor on the Welsh Government to ensure that it was implementing the Strategy.

> Q So what would happen in an ideal board meeting then of the Implementation Board?
>
> A Well, I think ... we'd have to look at sort of compliance with the plan. I don't know how.

This view was reflected in the comments from a senior government officer who felt that the main duty of the board was to challenge the Welsh Government.

> It was my responsibility to oversee the implementation, and as part of discharging that responsibility, the Implementation Board was there to challenge me, actually.

Overall, the common view held by our respondents on the Implementation Board was that it was ineffective and had moved away from its original purpose. However, coupled with this, was the view that the Board could potentially play an important role in the management process, and hence that the way forward lay in the direction of reforming rather than abolishing it.

Change management

Clearly, while the adoption of a ten-year Strategy has the major advantage of stability, giving all stakeholders a clear and consistent 'steer' as to the main direction of travel over a long period of time, it is also the case that ideas and knowledge change, and that particular kinds of substance misuse problems decline in scale while others increase and new ones appear. For this reason, there needs to be scope for changing priorities and approaches to implementation within the overall framework of the Strategy, in some cases to a significant degree. In this section we comment briefly and present stakeholder views on the mechanisms for achieving this, including issues such as the use of new knowledge and the degree of consultation involved.

We have already in Chapter 3 referred to the production by the Substance Misuse Branch of (usually three-yearly) Implementation Plans as well as internal annual Branch Plans, noting the surprisingly limited amount of knowledge about, let alone involvement in the preparation of these among most interviewees outside the Welsh Government. These plans can shift the balance of resources considerably, as well as opening up new areas of policy and practice. An obvious forum for the discussion of such changes is the Implementation Board, but as we have seen, most felt that this was an ineffective mechanism for influencing policy. This suggests that too much control over change may be vested in the Branch alone. However, two other boards merit brief attention in this context: APoSM and the relatively recently created Substance Misuse Review Board.

APoSM

As discussed earlier, the primary role of APoSM is to advise the Minister on the current state of knowledge and evidence about substance misuse issues, and its contribution was particularly important when the 2008 Strategy was being written. However, its formal duties also include overseeing the implementation of the Strategy and advising on its development. It is therefore potentially very influential, throughout the lifetime of a ten-year Strategy, in driving changes in emphasis or decisions to incorporate new elements into the Implementation Plans. For example:

> It's a bit of a two-way thing, APOSM, you know, you'd put issues to them. But also they should be just generally saying is this strategy still relevant for the challenges for today? Are there emerging trends and issues that it doesn't pick up on, you know, new drugs, for example, and that sort of thing? Um, so it's, you know, it's there as, as an advisory body to be used and for them to, you know, and for them to advise as they think appropriate. You know, they have, to some extent, define their own role.

The example below raises the issue of the links between APoSM and the Implementation Board. While – in theory, at least - both have responsibilities for overseeing the implementation of the Strategy, the mechanisms by which information is fed from one body to another was unclear.

> I have always questioned the role of APoSM…alongside the Strategy Implementation Board... Because the one doesn't feed into the other, you know, neither feeds… into the other, they sit parallel and I've always said, "Well, why, you've got a group of people over here, a very high level strategic group in APoSM who are looking at different areas of work around alcohol, around, you know, psychoactive drugs, which are ... all areas of work that are part of the strategy and yet the Strategy Implementation Board ... didn't task them. These were there to support… the Minister. But surely the strategy is the Minister's strategy…

The Substance Misuse Review Board

In 2011, the Minister decided to ask for a fairly fundamental review of several aspects of the implementation of Substance Misuse Strategy in Wales. In order to manage the review and see through any changes decided upon, the Welsh Government set up a Substance Misuse Review Board with a brief to undertake:

- A funding formula review;
- A review of APBs;
- An evaluation of the implementation of the Strategy;
- A cost benefit analysis;
- An organisational development work stream

The membership consisted of senior WG officials, together with some experienced external stakeholders. The review was not widely publicised, and many of our interviewees had only vague ideas of the process or the Board's remit, although most were aware that the KPIs would be changing. The remit was described to us by a WG officer as follows:

> Well, there was a terms of reference set up for it, but it was, in a way, a bit of a stock-take on where they are and, and looking forward at what's… I think the minister wanted to know that the money that had been invested, is it delivering something? Is it having a positive impact? What's the evidence to show that? So it's not so much about have we delivered what we said we'd delivered? It's more about we may have delivered it, but is there an impact?

Information and evidence

No matter which individuals or Boards make decisions about performance or potential policy change, the quality of their decisions will depend heavily on the amount and quality of information they have to inform them. We now consider the main sources of data and evidence available for assessing the implementation and overall impact of substance misuse policies in Wales. At local level, these include a wide variety of information and recording systems, as well as small-scale evaluations, all of which may be extremely valuable in guiding and assessing local practice, but are rarely used as part of broader assessments of the implementation of the Strategy across Wales. At national level (on which we shall focus here), the most important sources of information are the Welsh National Database for Substance Misuse (WNDSM), which includes the Treatment Outcome Profile (TOP), and a variety of research and evaluation reports. In addition, as noted earlier, SMARTs produce a fair degree of qualitative 'intelligence' for the Branch through their visits to CSPs and local providers.

The Welsh National Database for Substance Misuse (WNDSM)

As already mentioned, the WNDSM is the main source of information for the measurement of providers' and local areas' progress against the national Key Performance Indicators. It is also a source of data for other statistics about substance misuse related activities in Wales, some of which are published by the Welsh Government in annual reports. We shall consider what can be learned from such data in Chapter 8. Here we simply describe how it is compiled and some of the problems associated with it, with a view to making a broad assessment of its value and fitness for purpose.

All substance misuse treatment service providers in Wales in receipt of Welsh Government funding via the CSPs, are mandated to comply with the reporting requirements of the WNDSM. These requirements are described in the annually revised report: 'The Welsh National Database for Substance Misuse: Guidance for Community Safety Partnerships and Service Provider Agencies'. The guidance states that it is a mandatory requirement that a record must be opened and entered onto the Welsh National Database for Substance Misuse for all individuals referred for treatment in Wales. This includes structured treatment (such as: detoxification, residential rehabilitation, substitute prescribing and related psychosocial interventions) and less structured treatment (such as: practical and social support, complementary and alternative therapies, brief interventions, and harm reduction).

The operation of WNDSM is overseen by the WG Management Information Board while the database itself is managed by NHS Wales Informatics Service (NWIS, formerly Health Solutions Wales). Agencies are required to submit data monthly to NWIS and compliance with the reporting procedures is mandatory for ensuring the continued receipt of Welsh Government funding. The data submitted to the national database include all new referrals received during the relevant month, plus amendments to records relating to previous submissions. Figure 7.1 summarises all

data collected on the database at July 2011. The first part of the database includes information on contact details and referral information and the type of treatment received. The 'personal details' section goes further by covering anonymised individual and demographic data while the 'current problems' section provides information on current and past substance misuse. The remainder of the database contains information collected using the TOP (see next section). The content of the WNDSM might therefore be defined as comprising three parts: the first covers personal and demographic information, the second covers outputs, and the third summarises outcomes.

Since July 2011, the database has included a NHS number as a unique client identifier. According to the guidance document, this allows better local record management and for clients potentially to be tracked across agencies and over time.

Treatment Outcome Profile (TOP)

The Treatment Outcomes Profile (TOP) is part of the WNDSM, but is sufficiently different to warrant its consideration as a separate topic. Its primary aim is to measure treatment outcomes by comparing clients' responses to questions about progress over the period of treatment. This focus on outcomes means that the TOP will play an important part in the production of figures for the new suite of KPIs, discussed earlier in the chapter.

The TOP was developed by the National Treatment Agency (NTA) in collaboration with National Addiction Centre. In April 2009, the Welsh Government adopted TOP and mandated its use for all clients aged 16 and over who were in receipt of structured treatment. The data are provided by the agencies delivering the structured treatment. The initial implementation of TOP was overseen by a National Working Group with members from the Welsh Government, CSPs, treatment services and NWIS. Monitoring of the TOP has since been transferred to the National Management Information Board.

The TOP data are entered initially into a questionnaire which covers recent substance misuse, methods of administration, criminal behaviour, employment, education, housing, health and quality of life; the last three being coded on a 20 point scale from poor to good. An individual is first assessed at the beginning of treatment. The data entered at this point includes the client's status in terms of four main risk factors. The assessment is then repeated every three months and at completion of treatment.

Figure 7.1 List of all data collection on the WNDSM (2011)

Revised Substance Misuse Common Data Set – 1 July 2011

Item No.	Data Item	Format / length	Page
	Personal Details		
1	Agency Code/Practice Code	An6	29
1a	Unique Client ID (NHS Number)	N10	29
1b	Project Code	An6	29
1c	Project Description	Max. An50	30
2	First Letter of Last name	A1	30
3	First Letter of First name	A1	30
4	Date of Birth	D10	30
5	Gender	A1	31
8	Local Authority	N3	31
9	Postcode	An6	32
10	Ethnic Category	A1	33
10a	Ex-Service Personnel	A1	34
11	Agency Client Number	An15	34
12	1st Language	N3	34 & 35
13	Number of Children under 18 Living Elsewhere	N2	36
14	Number of Children under 18 living with Client	N2	36
15	Number of Vulnerable Adults living with Client	N2	36
	Contact Details		
16	Date of Referral	D10	37
17	Referral Source	N2	38
18	Peer Mentoring Scheme	A1	39
19	Case Management	A1	40
20	Date Assessment Completed	D10	41
20a	Date of Assessment Originally Offered	D10	41
21	Date Treatment Began	D10	42
21a	Date of Treatment Originally Offered	D10	42
23	Date Contact Ended	D10	43
24	Reason Contact Ended	N2	44
	Current Problem Profile		
25	Primary Substance Used	N4	45
26	Primary Substance Source	N2	45

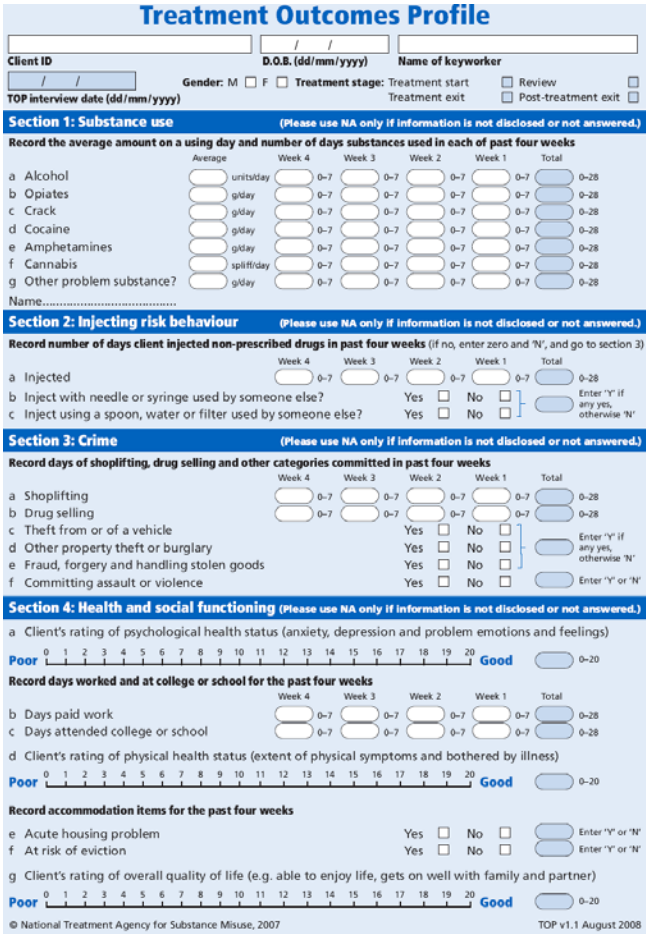
Item No.	Data Item	Format / length	Page
27	Primary Substance Route of Ingestion	N1	46
28	Primary Substance Frequency of use	N2	46
29	Primary Substance Age first used	N3	47
30	Secondary Substance Used	N4	47
31	Secondary Substance Source	N2	48
32	Secondary Substance Route of Ingestion	N1	48
33	Secondary Substance Frequency of use	N2	49
35	Other Substance used	N4	49
36	Other Substance Source	N2	50
37	Other Substance Route of Ingestion	N1	50
38	Other Substance Frequency of use	N2	51
40	Ever Injected	A1	51
41	Injected in the Last Month	A1	52
42	Ever Shared	A1	52
43	Age first Injected	N3	52
46	Age at first Treatment	N3	53
47	Weekly Alcohol Consumption Units	N3	53
	Health Details		
48	Pregnant	A1	54
49	Vaccinated Against Hepatitis B	A1	54
50	Vaccination Provided	A1	55
52	Diagnosed Mental Health Issues	A1	55
	Structured Treatment Modalities		
60	Inpatient Detoxification	A1	56
61	Community Detoxification	A1	57
62	Residential Rehabilitation	A1	58
63	Substitute Opioid (Methadone) and related Psychosocial Interventions	A1	59
64	Substitute Opioid (Buprenorphine) and related Psychosocial Interventions	A1	59
65	Psychosocial Interventions	A1	60

	Less Structured Interventions		
66	Practical / Social Support	A1	61
67	Complementary / alternative therapies and diversionary activities	A1	61
68	Brief Interventions	A1	62
69	Harm Reduction	A1	62
92	Record ID	A1	63
	Treatment Outcome Profile		
93	TOP Number	An6	63
94	TOP Interview Date	D10	63
95	Treatment Stage	A2	63
96	Average Alcohol	An3	64
97	Number of days Alcohol used	An3	64
98	Average Opiates	An3	64
99	Number of days Opiates used	An3	65
100	Average Crack	An3	65
101	Number of days Crack used	An3	66
102	Average Cocaine	An3	66
103	Number of days Cocaine used	An3	66
104	Average Amphetamines	An3	67
105	Number of days Amphetamines used	An3	67
106	Average Cannabis	An3	67
107	Number of days Cannabis used	An3	68
108	Other Problem Substance Used	An4	68
109	Average Other Problem Substance	An3	68
110	Number of days Other Problem Substance used	An3	69
111	Injected Total	An3	69
112	Inject with Needle or Syringe used by someone else? Inject using a spoon, water or filter used by someone else?	An3	70
113	Shoplifting	An3	70
114	Drug Selling	An3	70
115	Theft from or of a vehicle, Other Property Theft or Burglary, Fraud, Forgery and Handling Stolen Goods	An3	71
116	Committing assault or violence	An3	71
117	Psychological Health	An3	71
118	Days paid work	An3	72

119	Days attended College or School	An3	72
120	Physical Health	An3	72
121	Acute Housing Problem	An3	73
122	Risk of Eviction	An3	73
123	Quality of life	An3	74
	Modalities Start and End Date		
124	Inpatient Detoxification Start Date	D10	74
125	Inpatient Detoxification End Date	D10	74
126	Community Detoxification Start Date	D10	74
127	Community Detoxification End Date	D10	74
128	Residential Rehabilitation Start Date	D10	75
129	Residential Rehabilitation End Date	D10	75
130	Substitute Opioid Prescribing (Methadone) Psychosocial Interventions Start Date	D10	75
131	Substitute Opioid Prescribing (Methadone) Psychosocial Interventions End Date	D10	75
132	Substitute Opioid Prescribing (Buprenorphine) and Psychosocial Interventions Start Date	D10	75
133	Substitute Opioid Prescribing (Buprenorphine) and Psychosocial Interventions End Date	D10	76
134	Psychosocial Interventions Start Date	D10	76
135	Psychosocial Interventions End Date	D10	76
136	Practical / Social Support Intevention Start Date	D10	76
137	Practical / Social Support Intervention End Date	D10	76
138	Complementary / alternative therapies and diversionary activities Intervention Start Date	D10	76
139	Complementary / alternative therapies and diversionary activities Intervention End Date	D10	77
140	Brief Interventions Start Date	D10	77
141	Brief Interventions End Date	D10	77
142	Harm Reduction Intervention Start Date	D10	77
143	Harm Reduction Intervention End Date	D10	77

An = Alpha numeric Field
A = Alpha Field
n = Numeric Field
D = Date Field

Figure 7.2 Treatment Outcome Profile



Treatment Outcomes Profile

Client ID | D.O.B. (dd/mm/yyyy) | Name of keyworker

TOP interview date (dd/mm/yyyy) | Gender: M F | Treatment stage: Treatment start, Review, Treatment exit, Post-treatment exit

Section 1: Substance use (Please use NA only if information is not disclosed or not answered.)

Record the average amount on a using day and number of days substances used in each of past four weeks

	Average	Week 4	Week 3	Week 2	Week 1	Total
a Alcohol	units/day	0–7	0–7	0–7	0–7	0–28
b Opiates	g/day	0–7	0–7	0–7	0–7	0–28
c Crack	g/day	0–7	0–7	0–7	0–7	0–28
d Cocaine	g/day	0–7	0–7	0–7	0–7	0–28
e Amphetamines	g/day	0–7	0–7	0–7	0–7	0–28
f Cannabis	spliff/day	0–7	0–7	0–7	0–7	0–28
g Other problem substance?	g/day	0–7	0–7	0–7	0–7	0–28

Name.....

Section 2: Injecting risk behaviour (Please use NA only if information is not disclosed or not answered.)

Record number of days client injected non-prescribed drugs in past four weeks (if no, enter zero and 'N', and go to section 3)

	Week 4	Week 3	Week 2	Week 1	Total
a Injected	0–7	0–7	0–7	0–7	0–28
b Inject with needle or syringe used by someone else?	Yes ☐ No ☐				Enter 'Y' if any yes, otherwise 'N'
c Inject using a spoon, water or filter used by someone else?	Yes ☐ No ☐				

Section 3: Crime (Please use NA only if information is not disclosed or not answered.)

Record days of shoplifting, drug selling and other categories committed in past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
a Shoplifting	0–7	0–7	0–7	0–7	0–28
b Drug selling	0–7	0–7	0–7	0–7	0–28
c Theft from or of a vehicle	Yes ☐ No ☐				Enter 'Y' if any yes, otherwise 'N'
d Other property theft or burglary	Yes ☐ No ☐				
e Fraud, forgery and handling stolen goods	Yes ☐ No ☐				
f Committing assault or violence	Yes ☐ No ☐				Enter 'Y' or 'N'

Section 4: Health and social functioning (Please use NA only if information is not disclosed or not answered.)

a Client's rating of psychological health status (anxiety, depression and problem emotions and feelings)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0–20

Record days worked and at college or school for the past four weeks

	Week 4	Week 3	Week 2	Week 1	Total
b Days paid work	0–7	0–7	0–7	0–7	0–28
c Days attended college or school	0–7	0–7	0–7	0–7	0–28

d Client's rating of physical health status (extent of physical symptoms and bothered by illness)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0–20

Record accommodation items for the past four weeks

e Acute housing problem	Yes ☐ No ☐	Enter 'Y' or 'N'
f At risk of eviction	Yes ☐ No ☐	Enter 'Y' or 'N'

g Client's rating of overall quality of life (e.g. able to enjoy life, gets on well with family and partner)

Poor 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 Good 0–20

TOP v1.1 August 2008

Stakeholder comments

Interviewees gave numerous examples of problems with the data collection and monitoring systems. Several referred to its complexity and the frequent risk of errors, either on the part of those entering the data, or by those processing it centrally. It was also said that some providers failed to enter all cases, which compromised the overall accuracy of the figures. The following is a selection of fairly typical comments, from providers and a commissioner:

> … we have this over-complicated system that's not providing the correct data. So every time we go to the APB we look at the KPIs and … the informatics guy for the commissioners goes, "I'm still working with [Agency] because their data's still not right," and fair play the APB go, "Okay, you know, but we need them to be right next time." And we go back next time; they're still not right.
>
> It's been a headache for us [in Health], so I can imagine what it's been like, you know, for other agencies who haven't got that infrastructure to start with.
>
> So people are again entering different things because they don't quite understand what it is they're supposed to be entering. I think that's ironed

> itself out a little bit, but you still get this issue with the new KPIs coming in, to be absolutely clear on what their definitions are. You know, this, this ten day, it'll be ten days now from referral to treatment - what does treatment mean? ... you've got to be absolutely clear. So … if people are going to put what it, what it is they think it is in and then you're going to get, again this meaningless, meaningless data. But I think the TOPs is a disappointment because, you know, we were really encouraged that this was going to be a validated outcome tool. ... This was going to show people progressing or not progressing in treatment and yet we don't get those, we don't get that back. ... So why are they collecting it?
>
> Most of the community now is doing what they should be doing. One of the agencies wasn't and they had a bit of a shock because I read the riot act essentially to them and said, "Look, I don't want you spoiling it for the rest of us by not, you know, inputting the data. You're going to paint a very bad picture of what you do and I know that you do an excellent job, so why not prove it.

We mentioned earlier in the report that providers tend to use their own software for data entry and maintain separate local data files covering many more items than are submitted to the WNDSM. Data extracts are taken from these local systems and are submitted to NWIS for inclusion on the database. If errors are found, then reports are returned to the providers by NWIS. As noted earlier, some providers described how they had received reports from NWIS that did not reflect the data extracts that had been submitted. This may in part be related to the format in which the data were submitted. The person responsible for WNDSM is required to monitor all data submissions. This often means having to understand all the various software systems that are used for entering and submitting it. Local data management systems are often fundamentally different in design from the national system. Despite the problems this presents for the national database, providers tend to rely on their local systems for day-to-day management purposes. In part, this is a product of the fact that local systems are client based (as mentioned earlier), which is an essential feature for case management.

At the moment, data management in relation to substance misuse in Wales is essentially a two-tier system. At one level there are the comprehensive local level data systems used for case management, from which extracts are submitted to NWIS. At the other level there is the national level system where extracts submitted by treatment providers across Wales are combined. It should be noted that there has been a concern by the WG that the accuracy of local level data is unknown. One solution that has been attempted in Swansea is to upgrade local level systems to enable simple data extraction for the referral-based national system, while at the same time maintaining the more complex client-based features for the local system. However, the usefulness of this system is still under consideration.

In summary, there are concerns over the quality of data in the WNDSM (including the TOP). Potential biases, inaccuracies and missing data are key problems that reportedly hinder its ability to monitor performance accurately.

Research and evaluation

Finally, an important way of assessing performance and effectiveness is through research and evaluation. We were surprised to find that no central, authoritative list of commissioned research is held by the WG. It was therefore necessary for us to

develop our own list based largely on searches of the WG website (for published research reports and information about commissioned projects) and by contacting key stakeholders (including staff at the WG and Public Health Wales). Our investigations revealed that the WG have commissioned at least 18 research projects (see Appendix 6 Table A6.1). The projects are varied in nature and include evaluations of particular programmes as well as investigations into particular issues relevant to the Substance Misuse Strategy. In this section we make some brief preliminary comments about the coverage and quality of this research and its usefulness (both actual and potential) as an aid to general oversight of the system. What, if anything, it can tell us about the effectiveness of the system will be discussed in the next chapter.

While the list of projects may not be exhaustive, it is evident that the WG has commissioned a great deal of research on issues relevant to the Strategy. What is not so evident is the extent to which research and evaluation is undertaken and commissioned in a planned, systematic and coordinated manner, nor that research findings are carefully considered and acted upon. One interviewee made this point in relation to the monitoring of the Implementation Plan:

> So going back to the Implementation Plan, if you have a ten-year strategy, brilliant, you have a clear way to move forward for ten years. But if you have an Implementation Plan that is not got monitoring and evaluation built into it, you're already set up to fail because there's no accountability, you end up funding stupid projects that are very costly for actually what? What is the health gain? Describe the health gain. Describe how you're going to measure it. And describe what you're going to do if it isn't working. And I think that is where the implementation, in parts, has failed to deliver.

The same point can be applied more widely. The system by which substance misuse research is commissioned and managed at Branch level in the WG seems to be fairly *ad hoc*, and knowledge and oversight of the whole portfolio of substance misuse research appears to be missing at the current time. It can be argued that APoSM should play a more active role in overseeing research, and should develop closer links with Welsh Government researchers.

Conclusion

Few interviewees expressed confidence in the accuracy and value of the KPIs used to monitor performance at local and individual provider level, and most welcomed the imminent shift to more outcome-focused measures. Most providers and commissioners also agreed that the fairest and most productive means of monitoring and understanding how well an agency was carrying out its tasks was to consider formal performance indicators alongside more qualitative data, such as case studies, service user feedback, and discussions at monitoring meetings.

A small number of service providers pointed out that, whereas their work was closely scrutinised, that of commissioners was not, and that there should be at minimum some kind of complaints mechanism or 'whistle-blowing' procedure for providers who felt that poor procedures or decision-making was occurring.

Deficiencies were also identified in terms of oversight of the implementation of the Strategy as a whole. It was felt that the Implementation Board was potentially the key body to perform the role of reflecting periodically on how well implementation of the

Strategy was going, and to challenge government officers when problems were apparent. However, the Board was widely described as too big and unwieldy, losing focus, prone to becoming bogged down in detail, and in essence little more than a 'talking shop'. The need for a broader – but equally important – oversight role was also identified by several interviewees. Especially at a time when new responses to substance misuse were being advocated in some quarters - such as the 'recovery' agenda being pursued by the UK government – it was seen as important for some serious strategic thinking to be undertaken about the general 'direction of travel' to advise and guide the Welsh Government about any changes that might be considered. The key body mentioned in this context was APoSM which, it was pointed out, having played a prominent part in the development of the Strategy, appeared to have had relatively little influence thereafter.

The last part of the chapter briefly described and examined the kinds of data available at the time of writing, with which to assess the effectiveness of the implementation of the Strategy. It was found that the two main databases, WNDSM and TOP, suffered with major problems of inaccuracy and missing data, and that – although TOP was potentially valuable in measuring a range of short-term outcomes of treatment - neither allowed longitudinal monitoring of the progress of service users. Where research and evaluation are concerned, a number of relevant studies were found, but they were not collected all in one place and there appeared to be no systematic research plan (apart from to evaluate all centrally funded projects). In terms of knowing how effective, for example, particular kinds of psychosocial interventions have been across the country, it may be some small local evaluations have been carried out, but these are neither easily accessible nor likely to be conclusive or of high quality. There is a case for a more systematic research plan to be built into the Implementation Plan, which might include evaluations of this kind carried out across a number of selected areas.

CHAPTER 8: WHAT CAN BE CONCLUDED ABOUT EFFECTIVENESS?

In this chapter we tackle what is probably the most difficult question in the report: what do the available data and evidence tell us about the overall effectiveness of the implementation of the Substance Misuse Strategy? This question of course can apply both to process (or 'output') effectiveness and to the achievement of outcomes, and in each case can be answered through consideration of a variety of more specific sub-questions. For example on the one hand, has the implementation of the Strategy led to a reduction in waiting times, or to more members of 'hard to reach' groups coming forward for treatment? And on the other, has it led to significant numbers of people who had substance misuse problems leading more productive lives, or to a reduction in drug or alcohol related crime?

It was not part of our remit to conduct any original research aimed at answering such questions, and we can therefore draw only upon previous studies and evaluations, published information from the national database, and information and opinions emerging from our interviews with stakeholders. Moreover, as already discussed in Chapter 7, the available sources of data have serious weaknesses and gaps. We are thus unable to do any more here than to draw very tentative and limited conclusions and to emphasise the need for a serious rethink about the overall arrangements for the collection and analysis of data about, as well as the broader assessment and evaluation of, responses to substance misuse in Wales.

What does the WNDSM tell us?

We begin with a consideration of the kinds of answers that can be gleaned through analysis of the national database (WNDSM). We did not undertake any such analysis ourselves, so are restricted to data and findings published in annual reports and other government documents. We also consider the potential of the database – especially TOP – for producing more informative and reliable measures of effectiveness.

WNDSM findings

The main outlet for data from WNDSM is the annual report, *Substance Misuse in Wales*, published by the Welsh Government[6]. The most recent report (at the time of writing) was published in October 2011. It presents findings from the WNDSM as well as from a range of other sources including TOP, Patient Episode Statistics and the Drug Intervention Programme (DIP). The first part of the report focuses on the WNDSM and presents findings for the twelve month period ending 7th July 2011. It comprises a short introductory section that includes a brief executive summary and an overview of data quality issues, followed by nearly 50 pages of tables and charts. The second part of the report focuses on evidence from other sources and comprises roughly 30 pages of tables, which, unlike part one, includes some useful descriptive, explanatory text. The report ends with a series of annexes including a more detailed section on data quality that highlights various problems with the data (e.g. inaccuracies, missing information and double counting). In light of these problems the report advises readers to exercise some caution when reviewing the data.

[6] Each year, 'Substance Misuse in Wales' is published at the same time as the Minister's Substance Misuse Annual Report. While the former presents data from the WNDSM, the latter provides a narrative account of progress made towards implementing the strategy. The two documents are not clearly linked on the website or within the reports themselves.

The first set of tables show numbers of referrals into treatment, including variations by referral source; substance type; location; and sex, age and ethnic group of clients. The figures indicate that 28,720 referrals, in respect of 19,610 individuals, were received in 2010-11. Just over half (53%) of these involved clients whose main problem was with alcohol and 40% were in respect of clients whose main problem was with drugs. Among the latter group, heroin accounted for nearly half of all referrals (47%) followed by cannabis (21%) and amphetamines (7%). The majority of referrals were in respect of males (68%) and most referrals were classified as self-referrals (34% for alcohol and 26% for drugs). Patterns varied somewhat across the country: for example, the proportion of referrals for alcohol problems was highest in North Wales.

The report also presents figures showing variations in referrals over time. The statistics show that the number of referrals received in 2010-11 (28,720) had increased over the previous year (by nearly 2%) but had actually decreased by five per cent since 2007-08. Similarly, the number of assessments made in 2010-11 (21,627) had increased in the last year (by nearly 2%) but had decreased by six per cent since 2007-08. By contrast, the number of treatments commenced and the number of cases closed appear to have decreased steadily since 2007-08. In terms of changes in the profile of clients starting treatment, the figures show that the median age of new entrants rose over the four year period for both alcohol (from 37 to 40) and for heroin (from 29 to 32), but remained fairly constant for cannabis (20), amphetamines (32), cocaine (26), and crack (29). No comment is made in the report about possible reasons for any of these changes.

Data from the WNDSM also indicate that waiting times between referral and assessment for both alcohol and drugs both decreased over the four-year period. The latest figures indicate that 63% of referrals made in 2010-11 for alcohol and 73% of referrals for drugs were assessed within less than 10 working days. These compare with 54% and 56%, respectively, in 2007-8. Waiting times between assessment and treatment also decreased over time for both alcohol and drugs. In 2010-11 the majority of clients (90%) referred for either alcohol or drug problems were treated within less than 10 working days of being assessed compared with 82% in 2007-08. Nevertheless, a significant minority of clients were still waiting for quite lengthy periods to be assessed or to receive treatment.[7]

In addition to information about waiting times, the annual reports provide some information relating to another issue about which concern was expressed in the Strategy, that of drop-out rates from treatment. The 2010-11 report showed that the number of those who 'did not attend or respond to follow up contact during treatment' had fallen substantially since 2007-8, from 7,116 to 3,422. Other unplanned closures (covering cases where treatment had been withdrawn, clients had moved, been sent to prison, or had died) had also decreased.

[7] The report also provides figures on the length of time which all open cases (including those opened in previous years) had been waiting for assessment or treatment at 31 March 2011, and at comparable dates in the previous three years. These show that the total number of referred clients still waiting for assessment had increased by 56% from 3,369 in 2008 to 5,239 in 2011, and the number of assessed clients still waiting for treatment had increased by 60% over the same period (from 1,768 to 2,294). However, these figures in themselves do not necessarily signal any deterioration in services: as the report explains, the increases 'may be a reflection of the failure of some agencies to record the details of case closures' (p. 5).

The annual report states (p.3) that the WNDSM "is the official source of validated data for treatment service providers and Community Safety Partnerships to monitor and report performance against the national Key Performance Indicators (KPIs 2-6)". In theory, then, the annual reports provide a useful opportunity to publicise what progress has been made towards achieving the KPIs. However, the published figures address only three of them (see Table 8.1**)** and even these figures are presented without any direct reference to KPIs. The omission of any link between the data and the KPIs makes it difficult for the reader to judge performance to date. This might be seen as a missed opportunity.

In short, relatively little can be gleaned from the published WNDSM data about the effectiveness of substance misuse related interventions. The one clear (and encouraging) message it gives is that waiting times for assessment and treatment have reduced since 2008.

Table 8.1 Key Performance Indicators

No.	Indicator	WNDSM measure	Results (for all substances)
1	Increase local service capacity for people who misuse drugs, alcohol and other substances in line with stated priorities in local/regional commissioning plans in respect of: • open access services • structured community based services • residential and inpatient care	No measure	n/a
2	Reduce the number of incidences of unplanned ending of contact with services.	Reason for closure	18% increase 07/08-10/11 9% decrease 09/10-10/11
3	Achieve a waiting time of not more than 10 working days between referral and assessment.	Time between referral and assessment	67% of clients were assessed within 10 working days of being referred in 10/11
4	Achieve a waiting time of not more than 10 working days between assessment and the beginning of treatment.	Time between assessment and treatment	90% of clients were treated within 10 working days of being assessed in 10/11
5	All young people referred from a YOT to receive an appropriate assessment within 5 working days of referral.	Age of referral Time between referral and assessment	Not provided
6	All young people referred from a YOT to have commenced an agreed care plan no later than 10 working days from completion of the assessment.	Age of referral Time between assessment and treatment	Not provided
7	Reduce the number of incidences of reported acquisitive crime (defined as those listed as 'trigger offences'	No measure	n/a

	for DToC areas)		
8	All clients who are IDUs to be offered information, counselling, screening and where appropriate, immunisation against hepatitis B.	No measure	n/a

Note: Based on data published in *Substance Misuse in Wales 2010-11.*

TOP Findings

Findings from the TOP were published for the first time in 2011 in the annual report '*Substance Misuse in Wales 2010-11*'. The report states clearly from the outset that caution must be exercised in interpreting the results from this 'new dataset'. Of note is the reference to 'likely biases' within it. The results presented in the report relate to data collected since April 2009 when the tool was first adopted in Wales. Hence, the figures cover a two-year period (April 2009 to July 2011). The section of the report devoted to the TOP is fairly brief and limited to seven tables and one chart. The issues covered include changes, from start of treatment to exit from treatment, in the use of substances, client well-being, psychological health, physical health, and quality of life. As with the other WNDSM data, the only descriptive text presented is in bullet point form in the Executive Summary[8].

The figures show that more than 17,000 start-TOPs were collected over the two-year period. Of these, 6,387 (38%) completed first reviews, 3,117 (18%) completed second reviews, 1,700 (10%) completed third reviews and 1,007 (6%) completed four reviews. Over the study period, 12,228 cases were closed and in just over half of these cases (53%, n=6424) exit-TOPs were completed. It should be noted that figures relating to closures are not presented clearly in the report. The reader is required to study a chart with extremely small font to calculate the total number of cases closed and hence the proportion of all closures where exit TOPs were completed or not completed. The fact that exit-TOPs are missing in 47% of cases is not discussed in the report. However, other potential biases are recognised including the fact that cases remain open when in reality they should be closed and that some cases are closed without an exit-TOP being completed when clients have been transferred to another agency. The potential biases that these problems create are of concern and bring into question the value of the data in measuring the progress of clients.

Changes in the frequency of substance use are measured using only those cases where start and exit-TOPs were completed. Given that exit-TOPs were completed in 6,424 cases it is unclear why the total number of TOPs used in this analysis is 5,165 (assuming that the 417 main substance 'heroin' users are included in the main substance 'drugs' group and should not be double counted). The figures show that between start and exit-TOP, the average frequency of use in the last 28 days decreased for both alcohol and drugs. Among clients whose main problem was alcohol, use of alcohol decreased by 41%. Among clients whose main problem was drugs, use of opiates decreased by 45% and use of cannabis and amphetamines decreased by 34%.

The biggest changes in frequency of use were found to occur during the first three months of treatment. Clients whose main substance was alcohol reported a 34%

[8] Each year, 'Substance Misuse in Wales' is published at the same time as the Minister's Substance Misuse Annual Report. While the former presents data from the WNDSM, the latter provides a narrative account of progress made towards implementing the strategy. The two documents are not clearly linked on the website nor within the reports themselves.

decrease in alcohol use in the first three months and a further 17% decrease in the second three months. Similarly, clients whose main substance was drugs reported a 47% decrease in the frequency of opiate use in the first three months, followed by a decrease of 29% in the second three months and a further 19% decrease in the third period. Client well-being was found to improve from start to exit-TOP with physical health improving by 17%, psychological health by 30% and quality of life by 24%.

The figures are usefully broken down to enable the reader to see variations by drug type, key demographics as well as type of treatment. The biggest changes in physical health were among alcohol users, women, clients aged 50+ and those in residential rehabilitation. The same pattern of findings was also true for psychological health and quality of life.

Overall, the TOP data indicate that clients generally experience improvements following treatment. However, the problems with the data make it difficult to draw any firm conclusions. It may be that the 47% of clients for whom exit-TOPs were not included had very different outcomes to those who completed exit-TOPs. In other words, the findings reported may not accurately reflect the outcomes for all clients. Treatment service providers who are tasked with completing these forms would appear to need some encouragement (or perhaps assistance) to ensure that they are completed fully in all appropriate cases. The plan to launch new KPIs that are more outcome focused and can be monitored by the TOP may be a useful means of achieving higher completion rates.

Other substance misuse-related data

In *Substance Misuse in Wales 2011-12: Profile of Substance Misuse Related Education, Health and Criminal Justice Statistics (*formerly *Part II of Substance Misuse in Wales 2010-11)* other 'routinely collected' data are presented. This includes data from the Patient Episode Database Wales (PEDW), the Office for National Statistics (ONS), Education, DIP and the Home Office. Data from the new Harm Reduction Database (HRD), a national web-based data collection system for recording all needle and syringe activity, are also included in the 2011-12 report. It should be noted that the HRD 'went live' in September 2010 and as a result no trend data have yet been reported. In this section we summarise briefly the key outcomes emerging from these various sources.

Generally speaking, the picture is mixed. On some indicators, general improvements were recorded. For example, the number of exclusions from schools 'resulting from substance misuse' decreased from 454 in 08/09 to 387 in 10/11 (a decrease of 15%) - although this masks a more recent 2 per cent increase between 09/10 and 10/11. The number of alcohol-related deaths also decreased over time. In fact, the figures for 2011 represent the lowest number of annual deaths since 2006. However, the alcohol related death rate in Wales remained higher than in England, with the rate for females in Wales significantly higher than for females in England[9].

On other measures, improvements are relatively recent and follow a period of some deterioration. For example, drug-related deaths increased steadily between 2008 and 2010 but decreased (by 10%) in 2011 to 137. Similarly, hospital admissions for mental and behavioural disorders due to opioids increased from 2007 to 2010 but decreased by 10 per cent in 2011 (to 1215 cases). However, the picture varies by drug type as

[9](http://www.ons.gov.uk/ons/rel/subnational-health4/alcohol-related-deaths-in-the-united-kingdom/2011/alcohol-related-deaths-in-the-uk--2011.html)

admissions for disorders due to cocaine increased by 12 per cent between 2010 and 2011 while admissions due to multiple drug use increased by nearly one-fifth.

Criminal justice data provide an equally mixed picture. In 2011-12, a total of 13,655 drug offences were reported by police forces across Wales (an increase of just over 1%). By contrast, seizures of controlled drugs in Wales were reported to have decreased by 1 per cent between 08/09 and 09/10.

The meaning of these increases and decreases is not easy to interpret. An increase in drug offences may reflect improved policing or it may reflect an increase in offending. Similarly, a decrease in seizures may reflect a drop in availability or perhaps less effective policing. The same could also be said for hospital admissions. Does an increase in the number of admissions indicate that there are more problems or that the problems are being dealt with more effectively?

It was noted above that few data from the Harm Reduction Database have been presented in the substance misuse annual reports. What has been reported is that the proportion of new HIV infections linked to injecting drug use increased between 2010 and 2011 from 0.6 per cent to 1.9 per cent. Figures from the HRD relating to other blood borne viruses are not presented in the reports. However, data from the Unlinked Anonymous Monitoring Survey of people who inject drugs in the UK show that the total number of reports of Hepatitis C infections in Wales decreased between 2008 and 2010 (from 473 to 312) but then increased to 474 in 2011.

Finally, mention should be made of the recent Healthcare Inspectorate Wales report (2012), *Substance Misuse Services in Wales: Are They Meeting the Needs of Service Users and their Families?* This provides a rare insight into the perspective of service users, based on a survey of their views and experiences. One of the aspirations of the Strategy was to reduce the level of stigma attached to people with substance misuse problems, but the report suggests that its implementation has not yet led to any discernible improvement in this regard. The report also provides some support to the conclusion from our stakeholder interviews (chapter 6 above), that – despite improvements in terms of, for example, growth in 'single point of contact' arrangements and the development of common referral and assessment instruments - from the service user's point of view the system often does not appear 'joined up' or 'holistic', and there is a considerable degree of duplication and fragmentation of services. The report also speaks (p.22) of a 'postcode lottery' in terms of the availability and quality of services, with much on depending 'where and when you turn up' and interventions often being too short-term, while aftercare services, in particular, are described as 'patchy'. Overall, the Inspectorate's conclusions echo those of many of the stakeholders we interviewed: namely, that, while there is much in the implementation of the Strategy to be pleased about, responses to substance misuse in Wales cannot yet be described as a 'whole system', and need further strategic development.

Research and evaluation

Another way in which performance is monitored by the WG is through research and evaluation. As noted in the last chapter, our investigations revealed that the WG have commissioned at least 18 research projects (for a full list and summaries see Appendix 6). In this section we look at what can be concluded from these studies about the effectiveness of what has been implemented.

Our review of the research identified 13 evaluations of specific programmes or interventions. At the time of writing, four of the evaluations were on-going and only limited information was available about them. Nine evaluations, however, had been completed and final reports were in the public domain (see Appendix 6 Table A6.2 for methodological details). We were therefore able to review these reports to identify any findings concerning the effectiveness of the different interventions (see Table 8.2 below).

Table 8.2 Summary of results of known evaluations, 2008-2011

No.	Title	Type of evaluation*	Summary of results
1.	Evaluation of the Take Home Naloxone Demonstration Project	National	THN was found to improve knowledge, willingness and confidence to save lives among trainees. However, no difference between experimental and comparison areas in terms of numbers of lives saved.
2.	Evaluation of the All Wales School Liaison Core Programme (AWSLCP)	National	Qualitative data indicate that the lessons had a positive impact on pupils.
3.	Evaluation of the Transitional Support Scheme (TSS)	National	Qualitative data on 'distance travelled' indicate that many TSS participants had made progress. However, no difference was found between experimental and comparison groups in terms of reconviction rates.
4.	Evaluation of Early Parental Intervention Pilot Projects	National	Qualitative data indicate that four of the five projects helped alleviate the problems caused by substance misuse within the families they worked with. No 'robust' quantitative data were collected.
5.	Evaluation of the include Programme	Regional	A positive increase in behaviour scores were reported across all measured behaviours.
6.	Evaluation of the Prescribed Medication Support Service in Conwy	Local	The reduction in benzodiazepine prescribing was found to be three-times greater in the experimental practices than among control practices. Clients also reduced their medication and some stopped using altogether.
7.	Evaluation of Option 2	Regional	The programme did not reduce the number of children entering care but it did reduce the length of time that children spent in care. Money was also saved.
8.	Evaluation of the CRAFT pilot project	Regional	A range of positive effects on the psychological health and well-being of the concerned significant other were identified. Also, the majority of 'loved ones' were reported to have a reduction in their substance misuse.
9.	Evaluation of the PARIS system	Local	Substantial improvements in service provision (e.g. an increase in the number of interactions with agencies) were reported post the introduction of PARIS.
10.	Evaluation of the Strengthening Families programme	Local	On-going
11.	Evaluation of the ESF Peer Mentoring	National	On-going

No.	Title	Type of evaluation*	Summary of results
	Project		
12.	A pilot study of alcohol policy and social norms in Welsh Universities	Local	On-going
13.	Evaluation of alcohol brief interventions	Regional	On-going

Notes: National evaluations cover the whole of Wales. Regional evaluations cover two or more cities. Local evaluations cover just one city in Wales.

While the programmes varied considerably in terms of their aims and target populations, they were all found to have some kind of positive effect on the target group. For example, the Take Home Naloxone programme helped opiate users to improve their knowledge of overdose situations and gave them the confidence to administer naloxone and perform other life-saving actions. Similarly, the Early Parental Intervention Pilot programme helped to alleviate the problems caused by substance misuse within the families that it worked with. It must be emphasised that, as pointed out in Chapter 7, most of the studies have quite serious methodological weaknesses or are based on limited or unreliable data. Nevertheless, the research provides sufficient evidence to conclude that some of the interventions implemented as part of the Substance Misuse Strategy have had beneficial effects.

Stakeholder comments

Most interviewees recognised the importance of monitoring, research and evaluation, and some examples were given of locally commissioned evaluations. For example, two interviewees described how DIP commissioners had terminated an alcohol arrest referral scheme on the basis of a relatively 'quick and dirty' evaluation:

> The alcohol arrest referral evaluation that we did basically said, "It's not working." So we've dumped it and we don't have alcohol workers in custody anymore, which I think is a massive shame. And I think for me, personally, I don't think they did it for long enough, it was only a six month trial and I think certainly from an operational perspective, alcohol is the stuff that causes the problems, not drugs.

> The study proved inconclusive really, it was recognised that there was some benefit in that service, but that from a cost analysis point of view it was difficult to directly attribute intervention to the change in behaviour. And it wasn't a longitudinal study, so it was over a quite short period of time. So it pretty much told us what I expected it to tell us anyway and on that basis funding then didn't continue into this financial year.

The same area was also planning an evaluation of the impact of other DIP interventions on long-term drug abuse and reoffending rates. Another example referred to was:

> Well, we did an evaluation exercise in, it might be 2009, where we brought in some people from UWIC and did some evaluation about all the treatment provision within the city, and all the sense of what are they providing, whether it's fit for purpose and meets the needs. But that was something that we'd done specifically ourselves. I don't know if that's been done elsewhere.

As noted in the previous chapter, some providers collect and analyse their own data to evaluate their own performance and impact, in some cases using the results to supplement KPIs when presenting data to local commissioners. One provider told us of the following results from an exercise aimed at measuring impact over a longer term than usual:

> Each individual will have a unique personal identifier within the system so if they re-present they'll be flagged up as somebody who's been in before obviously, so …. And what we expected when we started it all off was it would be the same people endlessly coming round and round in a carousel, but that hasn't been true. I mean what's been surprising is that probably 10% of the caseload of those who keep coming back through the door, you know, are the problematic chaotic individuals. The other 90 to 80% of people who've come through the door over the last seven or eight years have presented once or twice … twice at the most, but mostly once.

This kind of information is clearly very valuable, and if the main findings were repeated over a variety of areas and interventions, would provide precisely the kind of evidence that is needed to demonstrate the long-term effectiveness of the implementation of the Welsh Substance Misuse Strategy. The need for longitudinal research was also agreed by a senior WG official, although he cautioned that the issue of resources is a major barrier:

> Q We've asked this question to lots of people, and there's lots of shrugs… But one thing quite a few people have said is it would be very nice to have some sort of handle on… not necessarily everybody goes through any kind of treatment ever, but sampling people who've been in a certain type of treatment and then following them through... to find out what's happened to people, some idea of the results of treatment or interventions. I can't find anything on that really.
>
> A You need some kind of - and this may be something for the, the longer-term outcome evaluation… - you need something like the NTORS study to get a real feel for that, you know?
>
> Q Are there any plans for doing anything like that?
>
> A I think we haven't made any firm decisions about the outcome evaluation. I mean, I don't think we're going to have the funding, or time where we could do something like NTORS. But if we could get a flavour for it, and that's the only real way you're going to get it, is to stay with people, you know, two, three years down the line to see what they're doing now, you know, are they still in substance misuse or have they moved on?

Finally, another interviewee with considerable experience of both practice and research, added the additional caution that even if such research is funded, it will have to wrestle with some tricky problems in interpreting the results, as 'improved outcomes' do not always mean what they suggest at first sight:

> Yes, the difficulty, this is one of the difficulties in measuring, I mean because if services are poor and they seem to be inaccessible people will not come forward for services. You improve services and make them more accessible

> and people come forward. If you measure the people that come forward suddenly you think, god the number of people who are substance misusers has increased. Well it's not, it's just that they are thinking that presenting themselves for treatment is now worthwhile…
>
> It's similar with children of substance misusers. If you offer services to families where there's substance misuse in parents you might actually see that more children end up in the care system because there is a higher level of engagement with those families and a greater awareness of the risks to the children.

Conclusion

The disappointing conclusion to this chapter is that, although the Welsh Government is clearly committed to using monitoring, evaluation and research to develop and improve its substance misuse services, there is relatively little strong evidence about the effectiveness or not of individual projects, particular types of intervention, or of the implementation of the Strategy as a whole. This is largely because of weaknesses in the design of the various instruments and databases for collecting information, combined with poor compliance among practitioners in supplying requested data accurately and fully. Furthermore, while a number of internal and external evaluations have been undertaken, these have generally not been planned systematically and have often been dogged by problems of the availability of appropriate data. They have also often been short in duration and commissioned too late in the day to ensure that appropriate data collection systems are developed from the start of the projects' operations. Few, too, have been able to construct appropriate comparison groups against which to measure any progress of intervention groups. As a consequence, few studies have been able to determine with any certainty whether or not the interventions they have examined have been effective.

In terms of what can be said with any confidence about the effectiveness of the implementation of the Strategy, the list is rather short. It is clear from WNDSM data that waiting times for assessment and treatment have reduced. It appears from TOP data that, among those entering treatment, there have been at least short-term improvements in alcohol and drug use, physical and psychological health, and quality of life, although large amounts of missing data call these findings into some question. The available published research also contains a few positive findings, especially short-term reductions in substance misuse and progress in relation to social problems, but again caveats must be entered because of weaknesses in data and methodology. The overall conclusion has to be that the whole area of data collection, monitoring and evaluation is one that needs close and systematic attention. Indeed, it could be argued that a planned programme of research and evaluation should be built into the Strategy and its Implementation Plans.

CHAPTER 9: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

Part One of the report provided a brief historical background to the 2008 Substance Misuse Strategy, exploring how it was developed and designed. It was found that it followed clear guiding principles and drew on a wide range of ideas, experience and evidence. The distinctive focuses on harm reduction, a balance between drugs and alcohol, and partnership approaches were in harmony with previous approaches in Wales, and had strong support across the country.

Analysis of the text of the Strategy, and interviews with people who had been involved in its design, showed that it had been informed by research findings on effective approaches, though in a piecemeal rather than systematic fashion. We also undertook a 'systematic review of systematic reviews', which demonstrated that there was strong international evidence to justify the focus on support to substance misusers, and particularly the use of pharmaceutical interventions to provide maintenance, as well as psychosocial interventions. There was also some support for the use of schools-based preventive interventions, and for the use of brief interventions for alcohol misusers, despite the fact that recent evaluations in Wales and England had been inconclusive on the effectiveness of both of these.

All interviewees knew something about the Strategy and many were quite knowledgeable about it. Most comments about it were positive, with frequent mentions of its broad scope, the inclusion of alcohol, and its readability and clarity. The main criticisms made concerned lack of sufficient attention to particular issues or client groups, including offenders and non-traditional service users. Some respondents thought that the 10-year time frame was too long to remain fully relevant as circumstances and views changed. However, others welcomed the longer time frame, not least as a barrier against over-hasty reactions to 'fashionable' ideas or political imperatives.

Part Two of the report explored various aspects of the implementation of the Strategy. It began by noting the existence of some fundamental tensions that challenge its effective implementation: for example, those between agencies and practitioners that take different views of the appropriate balance of priorities between clinical treatment and psychosocial support; between the aims of, on the one hand, implementing reasonably consistent services across Wales and, on the other, responding effectively to local needs; between the competitive commissioning of services and the need for inter-agency collaboration and continuity of services; and between the desire to 'stick to the Strategy' and pressure to adapt its implementation to changing expert views, new evidence, new patterns of drug use, or political or media concerns. It is noted that such tensions underlie many of the issues discussed in the later chapters.

Chapter 5 explored the strengths and weaknesses of the various mechanisms by which available resources are allocated to particular activities. This included the drawing up of broad implementation plans; decisions about what specific services will be delivered or commissioned; and decisions about which providers will deliver them. Stakeholder views were presented on how fairly and effectively these functions were performed through the various structures, processes and decision-makers in place for the first three years of the Strategy, as well as their opinions on the likely impact of the advent of Area Planning Boards. It was concluded that, while the Substance Misuse

Branch had a fair degree of influence over the broad shape of the services commissioned in local areas, there was still considerable space for local decisions about the precise nature of the interventions to be commissioned and which agencies would deliver them. Until recently, indeed, most of the power in this respect lay in the hands of local commissioners, who in some areas were given virtually a free hand. There were wide variations across the country in the nature, quality, fairness, effectiveness and transparency of the processes followed, and there were some excellent commissioners and some whose practices left much to be desired. Views were mixed on whether the advent of APBs would lead to more consistency and higher quality commissioning, views were mixed. Most interviewees felt that they had the potential for higher quality decision-making and more strategic approaches, although there were risks that needed to be watched and, at the time of interview, definitive guidance about the role and powers of APBs was yet to be produced.

Chapter 6 presented a brief overview of the substance misuse projects, services and activities actually funded and implemented in Wales. We found it impossible to identify all such activities, but were able to gain a fairly full picture of what was commissioned through the CSPs. A certain amount of imbalance was apparent in terms of investment in the different action areas of the Strategy document. The bulk of the funds allocated were concentrated in activities and projects categorisable as 'Support for substance misusers': principally, treatment, psychosocial interventions and other support services. Similar patterns were found in the other funding streams, although the centrally funded projects included several with a prevention aim, and one large project with an enforcement aim. Not many significant gaps were identified, although it was noted that little attention had been paid to substance misuse in further and higher education (with only one project aimed, at excessive alcohol consumption), and nothing targeted at unemployed young people. Despite the apparent imbalance, most interviewees were reasonably happy with the distribution of funding between action areas. The strongest area of disagreement was between interviewees with health and other backgrounds, over the level of priority that should be given to clinical treatment as against psychosocial interventions and 'wrap-around' support.

There was wide agreement that the system overall suffered from both fragmentation and duplication, and that an individual's 'journey' through it was often not smooth or 'seamless'. Too often, it was disrupted by agency rivalries, complex funding arrangements, or lack of communication and coordination. Some interviewees held out hope that such problems would be ameliorated by the advent of APBs, but concerns were expressed that their effectiveness might be undermined by continuing pushing of local needs at the expense of a more strategic regional approach, or by inappropriate choices of Board members. Serious concerns were also voiced about the possible loss of vital services for offenders – and knock-on effects on the system as a whole - if the incoming PCCs decided to spend the current DIP funds elsewhere.

In Chapter 7 we examined the structures and information systems through which oversight was maintained both of the activities of individual agencies and of the implementation of the Substance Misuse Strategy as a whole. Interviewees expressed little confidence in the accuracy and value of the KPIs used to monitor performance at local and individual provider level, and most welcomed the imminent shift to more outcome-focused measures. However, both providers and commissioners agreed that the fairest and most effective form of monitoring included a combination of formal KPIs, more qualitative information (including client feedback), and discussions with providers.

A small number of service providers pointed out that, whereas their work was closely scrutinised, that of commissioners was not, and that there should be at minimum some kind of complaints mechanism or 'whistle-blowing' procedure for providers who felt that poor procedures or decision-making was occurring.

Deficiencies were also identified in terms of oversight of the implementation of the Strategy as a whole. It was felt that the Implementation Board had been ineffective in this role and did not challenge government officers sufficiently when problems were apparent. The need for a broader oversight role over the 'direction of travel' was also identified, especially at a time when new responses to substance misuse, such as the 'recovery' agenda being pursued by the UK government, were being advocated, and it was argued that this would best be undertaken by APoSM – an expert body which had played a prominent part in the development of the Strategy, but appeared to have had relatively little influence thereafter.

The last part of the chapter briefly described and examined the kinds of data available with which to assess the effectiveness of the implementation of the Strategy. It was found that the national database, WNDSM, suffered from major problems of inaccuracy and missing data, and that – although TOP was potentially valuable in measuring a range of short-term outcomes of treatment - it did not allow longitudinal monitoring of the progress of service users. A number of relevant evaluations were found, but they were not collected together for ready access. There also appeared to be no systematic research plan, and there were few studies of the effectiveness of interventions that are routinely commissioned at local level across the country. There is a case for a more systematic research plan to be built into the Implementation Plan, which might include evaluations of the above kind carried out across a number of selected areas.

Finally, Chapter 8 considered what can be concluded from the available data (including our interviews) about the effectiveness of the implementation of the Strategy. The disappointing conclusion was that, although the Welsh Government is clearly committed to using monitoring, evaluation and research to develop and improve its substance misuse services, there is relatively little strong evidence about the effectiveness or not of individual projects, particular types of intervention, or indeed of the implementation of the Strategy as a whole. This is largely because of weaknesses in the design of the various instruments and databases for collecting information, combined with poor compliance among practitioners in supplying requested data. Moreover, while a number of evaluations have been undertaken, these have generally not been planned systematically. Most have been short in duration and dogged by a lack of useful data – a problem often exacerbated by research being commissioned too late to ensure that appropriate data collection systems are in place. Few, too, have been able to construct appropriate comparison groups, so conclusions are often unreliable.

As a result of the above problems, disappointingly little can be said with confidence about the effectiveness of the implementation of the Strategy. It is clear from WNDSM data that waiting times for assessment and treatment have reduced. It appears from TOP data that, among those entering treatment, there have been at least short-term improvements in alcohol and drug use, physical and psychological health, and quality of life. The available published research also contains a few positive findings, especially short-term reductions in substance misuse and progress in relation to social

problems. However, in all cases, caveats must be entered because of weaknesses in data and methodology. The overall conclusion has to be that the whole area of data collection, monitoring and evaluation is one that needs close and systematic attention. Indeed, it could be argued that a planned programme of research and evaluation should be built into the Strategy and its Implementation Plans.

Conclusions and recommendations

Before drawing together the conclusions and recommendations emerging from this report, it is important to emphasise that this has been anything but a straightforward piece of research. We have tried to cover a range of very broad and complex questions in a relatively short period of time, using a combination of (often unreliable) secondary data and a set of semi-structured interviews. The task was also complicated by the fact that substance misuse services in Wales were undergoing major changes during the period of our fieldwork, so some of the structures and processes described and commented on in this report have already been replaced or will shortly disappear. In these circumstances, we cannot realistically hope to come up with a set of robust and conclusive findings backed up by clear evidence. The main value (and uniqueness) of our study lies in the fact that we have gleaned the views of 52 of the people in Wales with the most knowledge and experience of substance misuse problems and the policies and practices devised to tackle them – albeit, as acknowledged earlier, weakened somewhat by the important omission of the direct voice of service users. What we have tried to do is to reflect as best we can their views about the strengths and weaknesses of the Strategy and its implementation. Our (tentative) recommendations are also based primarily on points about which we found fairly widespread agreement among them. Where possible, we have used evidence from other sources, but generally speaking we found very little reliable data or previous research evidence that assisted our task.

On the above basis, we list below ten broad conclusions and a set of recommendations arising from them.

Conclusions

1. The Strategy is essentially sound, and has widespread support. The emphasis on alcohol as well as illicit drugs is also widely praised.

2. All main elements of the Strategy have been implemented, although considerably more resources have been devoted to 'supporting substance misusers' (in the shape of treatment and psychosocial support) than to the other action areas of the Strategy. This distribution of resources is supported by stakeholders, with a few exceptions.

3. There is strong international evidence for the effectiveness (in terms of reduced substance misuse) of opiate substitute prescribing and psychosocial interventions. Of course, although this applies at a general level it does not necessarily show that the specific interventions implemented in Wales are effective.

4. Good progress has been made in the provision of 'wrap around support', especially through the implementation of the ESF-funded Wales Peer Mentoring project, which aims to help ex-substance misusers into employment. However, wrap around support services remain patchy across the country, and links between treatment units and those providing such services could be improved.

5. The commissioning processes through which, until recently, resources were distributed to service providers through CSPs, were variable in fairness, effectiveness and transparency, and decisions were often difficult for providers to challenge.

6. The main body charged with oversight of the implementation of the Strategy, the Substance Misuse Strategy Implementation Board, is widely agreed to be ineffective.

7. APoSM played an important role in the development of the Strategy, but has been ineffective and underused in terms of broad oversight of whether shifts in direction are needed as ideas and circumstances change.

8. While we did not interview substance misusers ourselves, there was fairly broad agreement among stakeholders that service users' experiences could vary widely between areas, and that insufficient collaboration and coordination between different providers could lead to duplication and fragmentation of the services they received. This finding is echoed in the recent Healthcare Inspectorate Wales (2012) review of substance misuse services, which reported that although there are many examples across Wales of excellent practice to avoid such problems, there remains much 'patchiness' and inconsistency between areas.

9. The WNDSM and TOP are not currently producing information that adequately assesses performance or measures outcomes. There is some statistical evidence that the implementation of the Strategy has had a positive impact, especially through reductions in waiting lists and drop-outs from treatment, but although there are a few useful measures of trends presented in the annual reports (such as encouraging figures showing a continuing reduction in alchohol-related deaths), there is as yet relatively little reliable evidence about broader and longer term outcomes or trends, most obviously in relation to the long term impact of treatment on individuals' levels of substance misuse or their quality of life.

10. There is no clear research and evaluation strategy built into the Substance Misuse Strategy or the implementation plans. Generally speaking, research appears to have been commissioned in an *ad hoc* fashion, and the results are not collected together in an easily accessible form. While most centrally commissioned projects and pilots have been evaluated, this is not the case with routine interventions across the country.

Recommendations

Recommendation 1
We recommend that the aims, membership and terms of reference of the Implementation Board are urgently reviewed, with a view to equip it to exercise more effective oversight of the implementation of the Strategy and to challenge the government's performance in this area when necessary.

Recommendation 2
We recommend that the aims, operation and membership of APoSM are reviewed in order to equip it to make a more proactive and effective contribution to debates about possible shifts in approach or emphasis during the lifetime of the Strategy. (There is

also a case for a formal APoSM-led 'mid-Strategy review'.) Consideration should be given to creating a paid position for the Chair and/or for members who undertake specific investigations, and to allocating more resources for support to the Board (eg for literature searches, small-scale research commissioning, or data analysis).

Recommendation 3
We recommend that consideration is given to the creation of a formal complaints procedure in respect of commissioning and other decisions made by APBs.

Recommendation 4
We recommend that thorough reviews are carried out of the WNDSM in order to determine what kinds of information are most useful for the monitoring of service provision and the meaningful measurement of outcomes, with a view to ceasing the collection of redundant information and focusing on data that has a clearly useful purpose. Priority should also be given finding the most effective ways of tracking the progress of individuals across different providers over time.

Recommendation 5
We recommend that actions are taken to ensure that compliance with data entry requirements moves closer to 100 per cent, especially in relation to pieces of information that (we suggest) are flagged as essential. Dialogue with those responsible for providing the data should include explanations of how the databases have been improved, as well as more feedback of the results of analysis, in order to convince them that their entries are used productively.

Recommendation 6
We recommend that more analysis is conducted on TOP data and the results are published in a more accessible form.

Recommendation 7
We recommend that a coherent research and evaluation strategy is built into implementation plans. Evaluations should include not only centrally commissioned projects, but, for example, comparative studies of the quality of implementation and the impact of psychosocial interventions that are routinely implemented across the country; a small fund could also be made available on a competitive basis to support evaluations of local innovative practice.

In addition, while recognising the limitations imposed by current budget restraints, we believe that there is a strong case for developing a planned programme of broader research, for example into changing patterns of substance abuse in Wales, or into drug or alcohol problems among specific social groups. Such studies – in the oversight of which, we recommend, APoSM should play a major role – would provide a strong evidence base for the development of future Substance Misuse Strategies for Wales.

Recommendation 8
We recommend that evaluations of interventions funded by the WG are well signposted and displayed together in an appropriate place on the WG website. There is also a case for creating a numbered series of studies with standard covers. Consideration should also be given to collecting together evaluations that have been commissioned or produced at local level and placing the best of them on the website too.

Recommendation 9
We recommend that continuing careful attention is paid by the Substance Misuse branch to the working practices and governance of APBs, which we regard as critical to the effective implementation of the Strategy. This should build on, and monitor the implementation of, its recent guidelines (issued after the completion of our research), focusing on issues such as the membership of APBs; their powers; their strategic and commissioning roles; their relations with CSPs and the Substance Misuse Branch; their administrative and information support systems; and their governance, including complaints procedures.

Further consideration should be given and, if thought appropriate, advice should be issued about how best to assess need across a region; how to ensure that balance is maintained between expenditure on, say, medical treatment and 'wrap-around services' as funds shrink; and the kinds of commissioning processes that should be followed (eg in terms of balance between specifying services precisely and allowing flexibility; or the extent to which services should be 'competed').

Recommendation 10
We recommend that contingency plans should be drawn up to help fill the serious gaps in service provision that will arise if PCCs in one or more areas decide to use the existing DIP funds for other purposes.

Recommendation 11
We recommend that continuing serious consideration is given to ways of improving service users' experience of substance misuse interventions by 'joining up' services more effectively: for example through further development of information sharing arrangements, common referral and assessment instruments, coordinated 'hand-overs' at exit points from particular services, and more single points of contact, 'one stop shops' and co-location of agencies. Further efforts should also be made to improve links and streamline referral routes between treatment agencies and those providing 'wrap around' services such as assistance with housing, training and employment.

Evaluation of the Substance Misuse Strategy for Wales

Appendices

APPENDIX 1:

Methods

Interviews with key informants

The aim was to interview people covering all stages of the implementation process. These included those involved in the design of the Strategy, the creation of the Strategy document; as well as key people in the Directorate, their advisers, and those tasked within the Welsh Government for organising its implementation. We also wanted to include representatives of the agencies and services that helped design and deliver the interventions, including the higher-level management and those working more closely with the end users. Respondents were selected by creating our own provisional list to cover the above categories, and then by a 'snowball' process of asking interviewees and other key stakeholders if they could recommend further suitable people to interview. We used our own judgement about whom to interview. The total number of interviews conducted was 52; a full list of the posts or roles of interviewees can be found in Table A1.1 (no names are given, as all interviews were conducted with the promise of anonymity).

The main interviewing method was face-to-face, semi-structured interviews. The interviews were conducted by members of the evaluation team using an interview guide. The issues included in the guide covered nine broad themes: (1) knowledge of the Strategy and plan, (2) actions taken in relation to the Strategy and Implementation Plan, (3) views on the Strategy and plan, (4) support given in relation to the Strategy and plan, (5) commissioning, (6) data, (7) effectiveness of interventions, (8) central management and leadership, and (9) strengths and weaknesses of the Strategy and proposals for change. Naturally, certain themes were more relevant to some interviewees than others, which meant that the focus and content of the interviews varied from person to person. The length of the interviews also varied ranging from approximately one hour to nearly three.

The interviews were analysed by transcribing them and entering them into NVivo. Keywords relating to each element of the analysis (e.g. 'commissioning', 'data management', 'Implementation Board' and so on) were searched and the relevant sections of the transcripts read and the key issues identified were coded.

Table A1.1: Interviews completed

No.	Organisation	Group	Transcribed
1	National Programme Manager DIP, WG	WG	Yes
2	Regional Advisor, WG	WG	Yes
3	Regional Advisor, WG	WG	Yes
4	Consultant Psychiatrist	Health	Yes
5	Director Department of Health, WG	WG	Yes
6	Chief Superintendent, Police	Police/APB chair	Yes
7	Commissioner	Local Authority	Yes
8	CARAT manager, HMP	Prison	Yes
9	Consultant Psychiatrist	Health	Yes
10	Voluntary Service Provider	VSO	Yes
11	Substance misuse officer, Police	Police	Yes
12	Manager, Voluntary Service Provider	VSO	Yes
13	Operational Manager, NOMS Cymru	NOMS Cymru	Yes
14	Drug Strategy Manager, HMP	Prison	Yes (notes)
15	Manager, Voluntary Service Provider	VSO	Yes
16	Youth Justice Board	Youth Justice	Yes
17	APoSM alcohol lead	Health	Yes
18	Substance Misuse Division, WG	WG	Yes
19	Substance Misuse Division, WG	WG	Yes
20	Manager, Drug Interventions Programme	DIP	Yes
21	CEO, Voluntary Service Provider	VSO	Yes
22	Regional Advisor, WG	WG	Yes
23	Prescribing GP	Health	Yes
24	Research Scientist	Public Health	Yes
25	CEO, Voluntary Service Provider	VSO	Yes
26	Royal College of Psychiatrists	Health	Yes
27	Manager, Statutory Service Provider	Health	Yes
28	Regional Advisor, WG	WG	Yes
29	Implementation Board Chair	WG	Yes (notes)
30	Liaison officer, Police	Police	Yes
31	Manager, Voluntary Service Provider	VSO	Yes
32	Manager, Substance Misuse Programme	Health	Yes
33	CEO, Voluntary Service Provider	VSO	Yes
34	Director, Voluntary Service Provider	VSO	Yes
35	Ex Voluntary Service worker	VSO	Yes
36	Commissioner	Local authority	Yes
37	APB Chair	Local authority	Yes
38	ARCH initiatives	VSO	Yes
39	DIP Commissioner	DIP	Yes
40	Manager, Probation	Probation	Yes
41	Senior Community Safety Officer	Police	Yes
42	SMAT Co-ordinator	Local authority	Yes
43	Probation	Probation	Yes
44	Nurse, Consultant Substance Misuse	Health	Yes
45	Commissioner	Health	Yes
46	Director, Voluntary Service Organisation	VSO	Yes
47	Manager, Statutory Service	Health	Yes
48	Head of Citizen Focus Policing	Police	Yes
49	APB Chair	Health	No*
50	Director, Voluntary Service Organisation	VSO	No*
51	Chief Inspector in charge of substance misuse	Police	No*
52	DIP Chair	DIP	No*

Notes: * Four interviews were not included in the formal NVivo analysis because they had not been transcribed in time. Key issues from these interviews were flagged up by the interviewer for inclusion in the report.

Analysis of the Substance Misuse Strategy for Wales report
One of the essential tasks of the evaluation was to find out what precisely the Substance Misuse Strategy was in terms of its aims and the interventions proposed. We did this by conducting a content analysis of the Strategy document. This involved extracting comments relating to the aims and interventions and pasting them into an Excel file. Each entry was then coded and the coded entries were copied into SPSS and analysed. The main purpose of this analysis was to map out what the Strategy was proposing should be done.

Analysis of projects and services implemented
To determine if what had been implemented in practice matched the proposals listed in the Strategy, our approach was to identify all interventions implemented from the main funding sources. These included: CSP (Community Safety Partnership) funding allocations, the WG (Welsh Government) central budget funding, Health Budget funding, as well as ESF (European Social Fund), Lottery funding, and funding from other charities. As a result of various difficulties in obtaining the data, (e.g. there is no clear list of projects funded out of the Health Budget) we limited our analysis to CSP funded projects and activities published in the substance misuse annual reports produced by the Welsh Government. The CSP funded project analysis was conducted by coding the interventions into Excel and analysing the results in SPSS. The results enabled us to see if the Strategy plans had been put into practice.

Focused review of the research literature
One of the aims of the evaluation was to determine whether resources have been used effectively in light of what is known about the effectiveness of different types of substance misuse intervention. Our approach to addressing this problem was to conduct a review of the research literature covering the four main action areas identified in the Strategy document: preventing harm, support for misusers, supporting families, and tackling availability. The focused review had three main parts. The first comprised a systematic review of systematic reviews to determine the broad range of research findings relating to substance misuse interventions. The second part described key evaluations, either included in the systematic reviews or otherwise known to us, to give greater insight into kinds of results obtained. The third part involved selecting a small number of case studies to provide further detail on the characteristics of the more successful interventions. The three reviews provided us with information with which to gauge whether or not the Strategy's proposals were in line with the evidence base.

APPENDIX 2:

Key bodies in the design and implementation of the Strategy
At the national level there are three main vehicles that support the implementation of the Substance Misuse Strategy. These are the Welsh Government Substance Misuse Branch, the Strategy Implementation Board and the Advisory Panel on Substance Misuse. The structure and remit of these three groups are described below.

The Welsh Government Substance Misuse Branch
At the centre of the whole implementation process is the Substance Misuse Branch. This is currently located in the Department of Health, Social Services and Children, and answerable to the Minister of Health and Social Services, who in early 2012 took over responsibility for substance misuse from the Minister for Social Justice and Local Government. Indeed, responsibility for the area has switched backwards and forwards between Ministers several times since devolution, perhaps reflecting some fundamental uncertainty about its most appropriate 'home'.

In addition to its policy development roles (discussed earlier), the Branch publishes formal three-year (or one-year) Implementation Plans, as well as more detailed annual Branch plans. It distributes Welsh Government funds to Community Safety Partnerships (and latterly Area Planning Boards) and oversees performance monitoring processes. It also commissions a number of centrally managed projects, as well as bidding for project funds from elsewhere (notably the European Social Fund). Finally, one of the critical elements of the implementation system is the work of the Substance Misuse Advisory Regional Teams (SMARTs), which act as intermediaries between the Substance Misuse Branch and local planners and commissioners (CSPs, SMATs and APBs).

The Strategy Implementation board
According to the Welsh Government website (accessed 21/6/12), the aims of the Strategy Implementation Board are (1) to oversee, at a national level, the delivery of the Strategy, (2) to ensure that the Strategy is reviewed and refreshed in light of emerging developments or changes in patterns of substance misuse, and (3) to ensure that links are established and maintained with relevant groups. Membership of the Board comprises WG senior officials as well as external stakeholders drawn from a wide variety of organisations.

APoSM
The Advisory Panel on Substance Misuse (APoSM) is primarily tasked with advising the Minister on the current state of knowledge and evidence about substance misuse issues. The Panel is comprised of people with a close interest in substance misuse and includes representatives from a diverse range of organisations including: police, prison, probation, health, voluntary sector agencies, statutory treatment services, pharmacists, nursing, youth services, social services, education, and public health. APoSM has developed four sub-groups each of which focus on a specific issue. At the current time there are sub-groups examining alcohol, opiate replacement treatments, psychoactive substances and the recovery agenda. Minutes from APoSM meetings (usually held four times each year) are published on the WG website along with any APoSM reports. At the time of writing, just three reports are available on the WG website, the last of which was published in March 2011. We understand that APoSM

has been without a Chair for some time and is in the process of recruiting a replacement.

Organisational structure of the Welsh Government Substance Misuse Branch (2012)
Figure A2.1

APPENDIX 3:

Analysis of the Substance Misuse Strategy for Wales

The first method of determining use of evidence was to search the strategy document (specifically Chapter 4) for the word 'evidence'. In the 33 pages presenting the four priority actions, the word 'evidence' was used 19 times. The word 'research' was used twice, 'findings' three times, and 'statistics' once. Hence, the main section of the document covering proposed interventions clearly considered the findings of research. However, the word counts do not show whether evidence was consulted to inform the choice of effective interventions or for some other purpose. To examine this, the sections of text in which the word 'evidence' was found was read to determine if research was being used to identify the nature of the problem (e.g. facts about drug misuse) or the nature of the solution (e.g. the most effective intervention to be implemented). We also looked at whether evidence was mentioned as something that *had* been addressed or something that *might be* addressed in the future.

The review showed that 12 of the 19 references referred to finding out something about the solution rather than collecting information about the nature of the problem. It also showed that 16 of the 19 references to evidence referred to research that *had* been consulted rather than *might be* consulted. Hence, on this basis alone, it could be argued that the strategy document drew upon research evidence. It should be acknowledged, however, that it provides only an indirect method of determining whether the strategy was evidence based.

To investigate this further, we also examined the references cited to determine the extent to which they included evaluations of intervention effectiveness. Overall, there were 64 citations to 58 references to the research literature in the 33 pages of Chapter Four. The distribution of references across the four priority action areas was somewhat uneven. The research was most frequently incorporated in the discussion on 'Support for substance misusers' and least frequently in the section on 'tackling availability'; with the first action area ('Preventing harm') containing 12 citations; 'Supporting substance misusers' having 30 citations; 'Supporting families' had 18; and 'Tackling availability' had four.

We also looked at whether the reference used concerned the nature of the problem (substance misuse) or the nature of the solution (interventions). The concept of evidence-based policy concerns mainly the use of evidence to determine solutions to problems. The analysis showed that almost three-quarters (72%) of the references concerned the nature of the solution (the effectiveness of interventions).

Accepting that the analysis was fairly brief in the time available, even these fairly indirect indicators of evidence-based policy suggest that research played some role in determining the strategy, and in the choice of particular interventions proposed. The role of evidence in relation to other aspects of the strategy and the extent to which programmes implemented matched the conclusions of broader-based literature reviews on effectiveness, is considered in Chapter 3.

Figure A3.1

Interventions included:

* named programmes
* types of programmes (e.g. harm-reduction, educational programmes. etc.)
* general, but tangible, interventions (e.g. 'support', 'guidance', 'information', etc.)
* programmes that might indirectly reduce substance misuse (e.g. health, relationships, employment, etc.)
* interventions that are current, but were implemented in a previous strategy.

Interventions excluded:

* statements of *aims* to tackle a problem without saying how
* general statements about improving services
* unspecified interventions
* general statements about improving access
* general statements about improving staff training
* proposed changes to organisational or administrative arrangements
* actions proposed at the UK level

Table A3.1: Priority Action Area 1: Preventing Harm

Strategy document page number	Action summary level 1	Action summary level 2	Action summary level 3
28	Diversion	Diversionary activities	Led by CYPPs, CSPs and YOTs should work together to ensure that appropriate diversionary activities and support systems are in place via joint commissioning or budget pooling arrangements where appropriate.
22	Education	Educational material	We need to ensure that information and education material are available in Welsh and ethnic minority languages to meet the needs of the local community.
22		Educational material	A core substance misuse education programme in 97 per cent of primary and secondary schools, backed by local initiatives.
25		Schools programmes	We have directly funded (jointly with the four police forces in Wales) the establishment of the 'All Wales School Liaison Core Programme' (AWSLCP) which is now delivered at key stages in 97 per cent of primary and secondary schools across Wales.
28		Non-schools programmes	Our NEET policies, which CSPs have been consulted on, include a range of actions aimed at re-engaging young people into education, employment or training opportunities. The Learning Pathways Programme for all 14-19 year olds and, in particular, its focus on tailored personal support will be crucial here.
22	Information	DAN 24/7	The Welsh Substance Misuse Helpline (DAN 24/7) providing easy access 24 hours a day to information and advice (including about where to access further support or treatment).

23	Media campaigns	[R]aise awareness through media campaigns at a national and local level.
23	Information	[Raise awareness] ... through sensible drinking information at the point of sale.
27	Information	For that reason, we will provide advice to parents about appropriate age-related alcohol consumption in young people.
27	Information	We want colleges and universities to develop policies to make sure that students are not drinking excessively because of misperceived social norms for drinking, an approach that has had success in universities in other countries.
28	Information	The new Welsh youth service strategy, launched in 2007, identifies improved health, fitness and well being as a strategic outcome. To support this, guidance 'Introducing Health to Youth Workers', which contains information on substance misuse, will be revised and re-issued to key partners and agencies in 2008.

Table A3.2: Priority Action Area 2: Supporting Substance Misusers

Strategy document page number	Action summary level 1	Action summary level 2	Action summary level 3
33	Brief interventions	Brief interventions	We will therefore be scoping the potential to pilot a brief intervention service to which GPs and others can refer those drinking alcohol at harmful levels but not requiring specialist treatment for addiction.
34	Detoxification	Detoxification services	Tackling the problem of access to inpatient detoxification and residential rehabilitation services in Wales. (Studies show that clients entering residential and inpatient programmes make substantial improvements in terms of abstinence from or reduction in illegal drug misuse, criminal activity, levels of injecting and psychological health. They are especially beneficial for substance misusers with severe problems, and evidence suggests that residential treatment may be more effective for tho
34	Drop-in services	Drop in and day services	Encouraging the development of drop-in and day services...
31		Drop-in services	Expanding outreach, drop in and other services aimed at identifying those in need of treatment and support and engaging them with services.
31	Harm reduction	Needle exchange	The services provided must include needle exchange, harm minimisation ...
31		Testing for BBVs	The services provided must include ...blood-borne virus testing and vaccination for hepatitis B
33	Information	Advice and information to users	Primary care settings are particularly important in offering advice and information to alcohol misusers and ensuring greater numbers are referred to and engage with services.
34		DAN 24/7	Promoting the Welsh Drug and Alcohol Helpline (DAN 24/7) as a route to access information and advice about substance misuse information and services in Wales and developing it to provide a source of easily accessible support for substance misusers.
40	Multi-agency services	Multi-agency care for pregnant substance-	Pregnant women with substance misuse problems should not be managed by GPs and midwives alone but with support from specialist services, to ensure co-ordinated multidisciplinary and multi-agency care. Close multidisciplinary and multi-agency care should be continued not only through pregnancy but also in to the postnatal period even if the infant is removed into the care of the local authority.
31	Outreach services	Outreach services	The services provided must include ... better provision via outreach services.
33		Outreach services	This will require more investment in youth and other outreach services ...

34	Prescribing	Heroin prescribing	In line with the latest evidence on effectiveness continuing to develop the capacity of substitute opiate prescribing across Wales (including supervised consumption), and the greater involvement of community pharmacists but ensuring that the effectiveness of such treatment is enhanced by the provision of Tier 2 support services.
34		Heroin treatment programmes	Considering the cost effectiveness of the introduction of the heroin treatment programmes for a very small number of individuals for whom alternative treatment has failed. This will include reviewing evaluations of the pilots running in England as soon as they are available. APoSM will be asked to provide expert advice on this matter once the evaluation material is available.
38		Monitoring prescribing	We will also take action aimed at ... encouraging more responsible prescribing.
38		Reducing use of abused drugs in primary care	Reducing inappropriately prescribed medicines such as benzodiazepines in primary care
33	Primary health care	General medical care	Individuals with substance misuse problems are often in poor general physical health and many are not registered with GPs. It is important that health service planners ensure that appropriate general medical health services (including sexual health and family planning) are available to this population.
34	Psychosocial interventions	Psychosocial interventions	Expanding psychosocial interventions and psychological therapies to motivate engage and retain substance misusers in treatment and support relapse prevention. This will also assist the expansion of treatment for those with alcohol or drug dependency (such as stimulants) where substitute medication is not an option.
36		Cognitive behaviour therapy	Service users who are trying to change their substance misusing behaviour need support to cope with situations that may lead to relapse. Cognitive behaviour therapy programmes which help individuals identify, anticipate and cope with pressures and problems should therefore be a key part of structured treatment programmes.
34	Self-help groups	Alcoholics Anonymous	Encouraging the development of ... self-help or mutual aid groups such as Alcoholics Anonymous
34		Narcotics Anonymous	Encouraging the development of ... self-help or mutual aid groups such as ...Narcotics Anonymous by ensuring service planners recognise their importance in supporting formal treatment
37	Skills training	Skills training and	The skills and employment strategy for Wales47, ‘Skills that Work for Wales’

		educational programmes	acknowledges the importance that training and skills programmes have in addressing deprivation and social exclusion, and preventing and reducing tthe harms caused to young people and families by substance misuse. We will work with partners to raise their awareness of the needs of substance misusers to improve their access to skills programmes and learning opportunities.
36	Support services	Support services	It is also essential to ensure that support services are in place to protect and support individuals from relapse after they leave structured treatment. Service planners should ensure that these important elements of the care pathway are available and seen as integral to service design and care planning.
31	Wrap around services	Wrap around services including support and care plans	Focusing on helping substance misusers to re-establish themselves in the community, both by providing wrap around services, and by providing support for the avoidance of relapse through the embedding of planning of these services in local substance misuse plans and individual care plans.
36		Wrap around services including support and care plans	For many substance misusers, it is the provision of wrap around services, alongside the appropriate treatment and aftercare services, that will be pivotal to reducing the harm caused by their substance misuse and to their ability to maintain or re-establish themselves in the community. If we are to help individuals sustain the benefits gained from treatment, then we must do more to provide effective wrap around services.
36		Wrap around services including support and care plans	In order to ensure these important elements of care are properly addressed, CSPs and their partners should consider wrap around services as a core component of treatment for all substance misusers.

Table A3.3: Priority Action Area 3: Supporting Families

Strategy document page number	Action summary level 1	Action summary level 2	Action summary level 3
46	Information	The Carers and Families module	We will be requiring the CSPs to implement the Carers and Families module of the SMTF. This will include ensuring there is well publicised advice available about local services and sources of information, including national agencies such as Families Anonymous and Adfam.
44	Prevention	On Track programme	The 'On Track' programme works with children and their families between the ages of four to twelve and provides a proactive, multi-disciplinary early prevention agenda for work with families, children and communities, combining area/community initiatives with targeted interventions.
44		Families First programme	'Families First' is a multi-agency collaboration to provide a child and family focused service in order to prevent and limit the potential for harm to children and young people of substance misusing parents. It works with both parents and children including direct work with children and young people to develop coping strategies and self esteem.
46-47		The domestic abuse strategy	We will work with the All Wales Domestic Abuse Working Group which is responsible for overseeing the Welsh Assembly Government's domestic abuse strategy and the network of Welsh domestic abuse co-ordinators to take forward, identify and co-ordinate actions which support jointly the delivery of the domestic abuse strategy and tackle substance misuse.
46	Psychosocial	Therapeutic communities	In addition, we will be piloting a therapeutic community family support service and issuing models of good practice to encourage the expansion of services that work with the families/carers of people who misuse substances offering them advice, guidance and counselling.
44	Support	Evaluated Early Parental Intervention Projects (EEPIP)	Evaluated Early Parental Intervention Projects (EEPIP) support parents where there are concerns about the impact of substance misuse on their parenting skills but which have not yet reached the threshold of activating child protection procedures. By working with the parents the intention is to achieve better welfare outcomes for their children. We are currently supporting five pilots and the evaluation and lessons learnt will be widely disseminated in October 2009.
44		Option 2 model	The 'Option 2' model offers a crisis intervention service for families where there are child protection concerns related to parental

		substance misuse. It is a time limited, intensive intervention. An evaluation of 'Option 2' commissioned by the Welsh Assembly Government has revealed promising results.
45	Caring about Carers strategy	Parental substance misuse can place a burden of responsibility for the care of siblings and parents onto children. In the case of illegal drugs, children can also be affected by stigma and the illegality of the activity.

Table A3.4: Priority Action Area 4: Tackling Availability

Page no.	Action summary level 1	Action summary level 2	Action summary level 3
53	Brief interventions	Brief interventions	In some areas, a similar approach is already being taken by police forces to offenders arrested for alcohol related crime. Under this strategy and, in line with the objectives in the Reducing Re-offending Plan for Wales, partnerships should work together to ensure that arrangements are in place to offer brief interventions, support or referral to alcohol treatment services to those arrested for alcohol related crimes.
53	Criminal Justice	Generic arrest referral workers	Partners should seek to develop generic substance misuse arrest referral workers, who are able to deal with both drug and alcohol misusing offenders in order to make the best use of workers in custody suites and better meet the needs of those who misuse both drugs and alcohol.
53		Better use of assess recovering procedures	When the police arrest individuals for drug supply it is imperative that they use asset recovery powers to remove the profits of the illegal drug trade. Funding from recovered assets should be used to fund further enforcement activity or community initiatives to divert young people from illegal drug use.
53		Better use of harm reduction in custody suites	Interventions in custody suites can be an effective means of offering support and harm minimisation advice to problematic drug users and directing them into other treatment services. Arrest referral workers, forming part of DIP teams, and the use of Drug Testing on Charge (DToC) in some areas is proving very successful in identifying and encouraging more people to engage in treatment.
53		Drug testing on arrest	A move to drug testing on arrest in some DIP areas in England has demonstrated further success in identifying and encouraging hard-to-reach individuals to engage in treatment79. Testing at the point of arrest also identifies individuals who misuse stimulants and other drugs that only stay in the system for a short time. We will support those areas in Wales operating DToC moving to testing on arrest as part of plans to encourage more individuals to enter treatment.
50	Enforcement	Better use of Licensing Act and Violent Crime Reduction Act	We are concerned that partners are not yet making best use of the Licensing Act and Violent Crime Reduction Act to reduce the harms to individuals and communities from excessive drinking. CSPs and Health bodies must do more to share data and information and work together on the preparation of the

			local substance misuse action plans to tackle alcohol related harm.
50		Target traders who sell alcohol to children	Work with local trading standards departments to tackle traders who persistently sell or supply alcohol to children, and make it easier for responsible traders to identify those who may be underage.
50		Enforce public drinking laws	Make the best use of current powers and legislation at a partnership level, and ensure that the full range of sanctions are brought to bear against the individuals who drink irresponsibly and become involved in crime and anti-social behaviour, and the licensees who continue to serve them regardless of their state of intoxication.
50		Licensing	Licensing
50		Test purchasing	Test purchasing
50		Under-age drinking	Under-age drinking
51		Impose licensing authority standards	Initiatives should be undertaken on a local and regional level to encourage the licensing industry to meet standards which will impact positively upon their business and the wider community.
50	Environmental	Environmental design and management	Look beyond licensees to take a holistic approach to the management of our towns and cities during the evening and night time so that everyone is able to visit them without the fear of alcohol related crime and disorder.
51		Transport	Transport
51		Environmental factors	Environmental factors such as toilet facilities
51		Lighting	Lighting
51		Street cleaning	Street cleaning
51		CCTV	CCTV
51		Night time economy	We will work with local partners to implement an evening and night-time economy framework across Wales through provision of a web-based tool providing up to date guidance and best practice for local areas to develop plans for managing the evening and night-time economy.
52	Policing	Neighbourhood policing	Neighbourhood Policing Teams are now established in each area of Wales under the current National Policing Plan. These teams should work to empower individuals and communities to engage with local policing in our communities.
53		Neighbourhood policing	Neighbourhood policing units should distribute leaflets informing the community of the action taking place and the agencies in place to support drug users requiring access to treatment.
52-53		Tarian	Tarian engages with the local policing teams and partnerships to ensure a co-ordinated approach is taken when the arrest phase of an

			operation is implemented. We will continue to support this initiative and encourage all partners to develop stronger links between drug enforcement activity at a local and regional level, both in terms of intelligence gathering and assistance with local initiatives.
53		Street level policing project	We will be supporting an initiative aimed at tackling street level dealing and the impact upon the visible anti-social effects of drug dealing in our communities.
50	Prevention	Proof of age cards	We also believe that the availability of alcohol and other age restricted products could be reduced by the wider use of approved Proof of Age cards. We will consider a national Proof of Age card scheme in Wales which is secure and has a Proof of Age Standards Scheme (PASS) hologram making it easier to identify a legitimate card.
50		Working with the licensed trade	Working with the licensed trade

APPENDIX 4:

Focused review of the literature: methods and additional tables

The search method used for the Cochrane database was to select initially *all* reviews published in the Cochrane Drugs and Alcohol Group. This is a separate collection of reviews relating to interventions concerning substance misuse. A similar procedure was adopted in relation to the Campbell library of criminal justice systematic reviews. As this collection was relatively small, it was possible to select them all initially with the view of finding relevant publications at the second stage of the review. The ASSIA database was more extensive and required using a traditional search expression to reduce the number of initially relevant publications. The search terms used are shown below.

Figure A4.1

Prevention - ab(systematic review AND (prevent*) AND (drug* OR substance* OR alcohol))

Treatment - ab(systematic review AND (treat* OR interven*) AND (drug* OR substance* OR alcohol))

Harm reduction - ab(systematic review AND (harm reduc* OR harm minim*) AND (drug* OR substance* OR alcohol))

Enforcement - ab(systematic review AND (enforce* OR policing) AND (drug* OR substance* OR alcohol))

The first search resulted in 361 studies that fitted our search criteria (see Figure A3.1). The title and abstracts were obtained for all 361 studies. These were then checked against our eligibility criteria to determine if they were suitable for analysis. The initial eligibility criteria were that the document must comprise a systematic review (e.g. not an evaluation or a systematic review of systematic reviews), it must be based on determining the effect of an intervention using an experimental design (e.g. randomised controlled trials, double blind experiments, quasi-experiments), it must be easy to obtain (bearing in mind the time and resource constraints of the review), and it must not duplicate a systematic review already identified. This resulted in 104 eligible items with 257 items rejected. We then attempted to obtain copies of all eligible publications. Seven were unobtainable, which left a total of 97 reviews. Each review was then read and checked against a final round of eligibility criteria. The main criteria were that the systematic review must contain a summary outcome measure relating to substance misuse. We excluded studies that focused solely on completion rates, outcomes relating to knowledge gained or skills developed, and outcomes relating to criminal behaviour. Forty-two studies were excluded, which left a total of 55 systematic reviews suitable for analysis covering 1,874 evaluations.

Table A4.1 Systematic Reviews of Pharmaceutical and Psychosocial Interventions

	Approach	Database	Reference	Substance	Outcome
1.	Pharmaceutical	Cochrane	Rösner S, Hackl-Herrwerth A, Leucht S, Lehert P, Vecchi S, Soyka M. Acamprosate for alcohol dependence. *Cochrane Database of Systematic Reviews* 2010, Issue 9. Art. No.: CD004332. DOI: 10.1002/14651858.CD004332.pub2.	Alcohol	Positive
2.	Pharmaceutical	Cochrane	Mattick RP, Kimber J, BreenC,DavoliM. Buprenorphinemaintenance versus placebo ormethadonemaintenance for opioid dependence. *Cochrane Database of Systematic Reviews* 2008, Issue 2. Art.No.: CD002207. DOI: 10.1002/14651858.CD002207.pub3.	Drugs	Positive
3.	Pharmaceutical	Cochrane	Ferri M, Davoli M, Perucci CA. Heroin maintenance for chronic heroin-dependent individuals. *Cochrane Database of Systematic Reviews* 2011, Issue 12. Art. No.: CD003410. DOI: 10.1002/14651858.CD003410.pub4.	Drugs	Positive
4.	Pharmaceutical	Cochrane	Clark NC, Lintzeris N, Gijsbers A, Whelan G, Dunlop A, Ritter A, Ling WW. LAAM maintenance vs methadone maintenance for heroin dependence. *Cochrane Database of Systematic Reviews* 2002, Issue 2. Art. No.: CD002210. DOI: 10.1002/14651858.CD002210.	Drugs	Positive
5.	Pharmaceutical	Cochrane	Minozzi S, Amato L, Davoli M. Maintenance treatments for opiate dependent adolescent. *Cochrane Database of Systematic Reviews* 2009, Issue 2. Art. No.: CD007210. DOI: 10.1002/14651858.CD007210.pub2.	Drugs	Positive
6.	Pharmaceutical	Cochrane	Faggiano F, Vigna-Taglianti F, Versino E, Lemma P. Methadone maintenance at different dosages for opioid dependence. *Cochrane Database of Systematic Reviews* 2003, Issue 3. Art. No.: CD002208. DOI: 10.1002/14651858.CD002208.	Drugs	Positive
7.	Pharmaceutical	Cochrane	Mattick RP, Breen C, Kimber J,DavoliM.Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database of Systematic Reviews* 2009, Issue 3. Art.No.: CD002209. DOI: 10.1002/14651858.CD002209.pub2.	Drugs	Positive
8.	Pharmaceutical	Cochrane	Rösner S, Hackl-Herrwerth A, Leucht S, Vecchi S, Srisurapanont M, SoykaM. Opioid antagonists for alcohol dependence. *Cochrane Database of Systematic Reviews* 2010, Issue 12. Art. No.: CD001867. DOI: 10.1002/14651858.CD001867.pub3.	Alcohol	Positive
9.	Pharmaceutical	ASSIA	Angeles, Muñoz Ana & Amate José María (2004) Efficacy and safety of naltrexone and acamprosate in the treatment of alcohol dependence: a systematic review Bouza Carmen, Magro. *Addiction,* 99 , 811–828	Alcohol	Positive
10.	Pharmaceutical	ASSIA	C. Streeton and G. Whelan (2001) Naltrexone, A Relapse Prevention Maintenance Treatment of Alcohol Dependence: A Meta-Analysis of Randomized Controlled Trials Alcohol and Alcoholism (2001) 36 (6): 544-552. doi: 10.1093/alcalc/36.6.544	Alcohol	Positive
11.	Pharmaceutical	Cochrane	Gowing L, Farrell MF, Bornemann R, Sullivan LE, Ali R. Oral substitution treatment of injecting opioid users for prevention of HIV infection. *Cochrane Database of Systematic Reviews* 2011, Issue 8. Art. No.: CD004145. DOI: 10.1002/14651858.CD004145.pub4.	Drugs	Positive
12.	Pharmaceutical	Cochrane	Pani PP, Trogu E, Vacca R, Amato L, Vecchi S, Davoli M. Disulfiram for the treatment of cocaine dependence. Cochrane Database of Systematic Reviews 2010, Issue 1. Art. No.: CD007024. DOI: 10.1002/14651858.CD007024.pub2	Drugs	Positive
13.	Pharmaceutical	ASSIA	Yolanda Alvarez, (M.D.), Magí Farré, (M.D., Ph.D.), Francina Fonseca, (M.D.), Marta Torrens, (M.D., Ph.D.) (2010) Anticonvulsant drugs in cocaine dependence: A systematic review and meta-analysis. Journal of Substance Abuse Treatment 38 (2010) 66–73.	Drugs	Positive

	Approach	Database	Reference	Substance	Outcome
14.	Pharmaceutical	ASSIA	Anita Srivastava, Meldon Kahan, Sue Ross (2008) The effect of methadone maintenance treatment on alcohol consumption: A systematic review. Journal of Substance Abuse Treatment 34 215– 223.	Alcohol	Mixed
15.	Pharmaceutical	Cochrane	Minozzi S, Amato L, Vecchi S, DavoliM.Maintenance agonist treatments for opiate dependent pregnant women. *Cochrane Database of Systematic Reviews* 2008, Issue 2. Art. No.: CD006318. DOI: 10.1002/14651858.CD006318.pub2.	Drugs	Mixed
16.	Pharmaceutical	Cochrane	Leone MA, Vigna-Taglianti F, Avanzi G, Brambilla R, Faggiano F. Gamma-hydroxybutyrate (GHB) for treatment of alcohol withdrawal and prevention of relapses. Cochrane Database of Systematic Reviews 2010, Issue 2. Art. No.: CD006266. DOI: 10.1002/14651858.CD006266.pub2.	Alcohol	Uncertain
17.	Pharmaceutical	Cochrane	Day E, Ison J, Strang J. Inpatient versus other settings for detoxification for opioid dependence. *Cochrane Database of Systematic Reviews* 2005, Issue 2. Art. No.: CD004580. DOI: 10.1002/14651858.CD004580.pub2.	Drugs	Uncertain
18.	Pharmaceutical	Cochrane	Pani PP, Trogu E, Vecchi S, Amato L. Antidepressants for cocaine dependence and problematic cocaine use. *Cochrane Database of Systematic Reviews* 2011, Issue 12. Art. No.: CD002950. DOI: 10.1002/14651858.CD002950.pub3.	Drugs	No effect
19.	Pharmaceutical	Cochrane	Amato L,Minozzi S, Pani PP, DavoliM. Antipsychotic medications for cocaine dependence. *Cochrane Database of Systematic Reviews* 2007, Issue 3. Art. No.: CD006306. DOI: 10.1002/14651858.CD006306.pub2.	Drugs	No effect
20.	Pharmaceutical	Cochrane	Minozzi S, Amato L, DavoliM. Detoxification treatments for opiate dependent adolescents. *Cochrane Database of Systematic Reviews* 2009, Issue 2. Art. No.: CD006749. DOI: 10.1002/14651858.CD006749.pub2.	Drugs	No effect
21.	Pharmaceutical	Cochrane	Amato L, Minozzi S, Pani PP, Solimini R, Vecchi S, Zuccaro P, Davoli M. Dopamine agonists for the treatment of cocaine dependence.CochraneDatabase of SystematicReviews 2011, Issue 12.Art.No.:CD003352.DOI: 10.1002/14651858.CD003352.pub3.	Drugs	No effect
22.	Pharmaceutical	Cochrane	Castells X, Casas M, Pérez-Mañá C, Roncero C, Vidal X, Capellà D. Efficacy of Psychostimulant Drugs for Cocaine Dependence. *CochraneDatabase of Systematic Reviews* 2010, Issue 2. Art.No.:CD007380. DOI: 10.1002/14651858.CD007380.pub3.	Drugs	No effect
23.	Pharmaceutical	Cochrane	Minozzi S, Amato L, Vecchi S, Davoli M, Kirchmayer U, Verster A. Oral naltrexone maintenance treatment for opioid dependence. *Cochrane Database of Systematic Reviews* 2011, Issue 4. Art.No.: CD001333. DOI: 10.1002/14651858.CD001333.pub4.	Drugs	No effect
24.	Psychosocial	Cochrane	Thomas RE, Lorenzetti D, Spragins W. Mentoring adolescents to prevent drug and alcohol use. Cochrane Database of Systematic Reviews 2011, Issue 11. Art. No.: CD007381. DOI: 10.1002/14651858.CD007381.pub2	Alcohol and drugs	Positive
25.	Psychosocial	Cochrane	Foxcroft DR, Tsertsvadze A. Universal multi-component prevention programs for alcohol misuse in young people. Cochrane Database of Systematic Reviews 2011, Issue 9. Art. No.: CD009307. DOI: 10.1002/14651858.CD009307.	Alcohol	Positive
26.	Psychosocial	ASSIA	Riper, Heleen; van Straten, Annemieke; Keuken, Max; Smit, Filip; Schippers, Gerard; et al. (2009) Curbing Problem Drinking with Personalized-Feedback Interventions A Meta-Analysis..American Journal of Preventive Medicine. 36, 3, 247-255.	Alcohol	Positive
27.	Psychosocial	Cochrane	McQueen J, Howe TE, Allan L, Mains D, Hardy V. Brief interventions for heavy alcohol users admitted to general hospital wards. *Cochrane Database of Systematic Reviews* 2011, Issue 8. Art. No.: CD005191. DOI: 10.1002/14651858.CD005191.pub3.	Alcohol	Positive

	Approach	Database	Reference	Substance	Outcome
28.	Psychosocial	Cochrane	Kaner EF, Dickinson HO, Beyer FR, Campbell F, Schlesinger C, Heather N, Saunders JB, Burnand B, Pienaar ED. Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database of Systematic Reviews 2007, Issue 2. Art. No.: CD004148. DOI: 10.1002/14651858.CD004148.pub3.	Alcohol	Positive
29.	Psychosocial	Cochrane	Amato L, Minozzi S, Davoli M, Vecchi S. Psychosocial and pharmacological treatments versus pharmacological treatments for opioid detoxification. *Cochrane Database of Systematic Reviews* 2011, Issue 9. Art. No.: CD005031. DOI: 10.1002/14651858.CD005031.pub4.	Drugs	Positive
30.	Psychosocial	Cochrane	Mayet S, FarrellM, FerriM, Amato L,DavoliM. Psychosocial treatment for opiate abuse and dependence. *CochraneDatabase of Systematic Reviews* 2004, Issue 4. Art. No.: CD004330. DOI: 10.1002/14651858.CD004330.pub2.	Drugs	Positive
31.	Psychosocial	Cochrane	DenisC, Lavie E, FatseasM, AuriacombeM. Psychotherapeutic interventions for cannabis abuse and/or dependence in outpatient settings. *CochraneDatabase of Systematic Reviews* 2006, Issue 3. Art.No.:CD005336. DOI: 10.1002/14651858.CD005336.pub2.	Drugs	Positive
32.	Psychosocial	Cochrane	Smith LA, Gates S, Foxcroft D. Therapeutic communities for substance related disorder. *Cochrane Database of Systematic Reviews* 2006, Issue 1. Art. No.: CD005338. DOI: 10.1002/14651858.CD005338.pub2.	Substances	Positive
33.	Psychosocial	Campbell	Smedslund G, Berg RC, Hammerstrøm KT, Steiro A, Leiknes KA, Dahl HM, Karlsen K. Motivational interviewing for substance abuse. Campbell Systematic Reviews 2011:6 DOI: 10.4073/csr.2011.6	Substances	Positive
34.	Psychosocial	ASSIA	Evelien Smit, Jacqueline Verdurmen, Karin Monshouwer, Filip Smit (2008) Family interventions and their effect on adolescent alcohol use in general populations; a meta-analysis of randomized controlled trials. Drug and Alcohol Dependence 97 195–206.	Alcohol	Positive
35.	Psychosocial	ASSIA	Nicole K. Lee & Richard A. Rawson (2008) A systematic review of cognitive and behavioural therapies for methamphetamine dependence. Drug and Alcohol Review 27, 309 – 317 .	Drugs	Positive
36.	Psychosocial	Cochrane	Foxcroft DR, Tsertsvadze A. Universal family-based prevention programs for alcohol misuse in young people. Cochrane Database of Systematic Reviews 2011, Issue 9. Art. No.: CD009308. DOI: 10.1002/14651858.CD009308..	Alcohol	Positive
37.	Psychosocial	ASSIA	Petrie, Jane; Bunn, Frances; Byrne, Geraldine. (2007) Parenting programmes for preventing tobacco, alcohol or drugs misuse in children. Health Education Research 22. 2. 177-191.	Drugs	Positive
38.	Psychosocial	ASSIA	White, D; Pitts, M. (1998) Educating young people about drugs: a systematic review. Addiction 93. 10. 1475-1487.	Drugs	Positive
39.	Psychosocial	ASSIA	Maria J Emmen, Gerard M Schippers, Gijs Bleijenberg, Hub Wollersheim (2004) (published 16 January 2004) Effectiveness of opportunistic brief interventions for problem drinking in a general hospital setting: systematic review BMJ, doi:10.1136/bmj.37956.562130.EE	Alcohol	Mixed
40.	Psychosocial	Cochrane	Moreira MT, Smith LA, Foxcroft D. Social norms interventions to reduce alcohol misuse in University or College students. *Cochrane Database of Systematic Reviews* 2009, Issue 3. Art. No.: CD006748. DOI: 10.1002/14651858.CD006748.pub2.	Alcohol	Mixed
41.	Psychosocial	Cochrane	Smedslund G, Berg RC, Hammerstrøm KT, Steiro A, Leiknes KA, Dahl HM, Karlsen K.Motivational interviewing for substance abuse. *CochraneDatabase of Systematic Reviews* 2011, Issue 5. Art.No.:CD008063. DOI: 10.1002/14651858.CD008063.pub2.	Substances	Mixed
42.	Psychosocial	ASSIA	Ritter A, Cameron J. (2006) A review of the efficacy and effectiveness of harm reduction strategies for alcohol, tobacco and illicit drugs. Drug Alcohol Rev. 25: 611 – 624	Substances	Mixed

	Approach	Database	Reference	Substance	Outcome
43.	Psychosocial	Cochrane	Gates S, McCambridge J, Smith LA, Foxcroft D. Interventions for prevention of drug use by young people delivered in non-school settings. *Cochrane Database of Systematic Reviews* 2006, Issue 1. Art. No.: CD005030. DOI: 10.1002/14651858.CD005030.pub2	Drugs	Uncertain
44.	Psychosocial	Cochrane	Ferri M, Amato L, Davoli M. Alcoholics Anonymous and other 12-step programmes for alcohol dependence. *Cochrane Database of Systematic Reviews* 2006, Issue 3. Art. No.: CD005032. DOI: 10.1002/14651858.CD005032.pub2	Alcohol	No effect
45.	Psychosocial	Cochrane	Hesse M, VanderplasschenW, Rapp R, Broekaert E, Fridell M. Case management for persons with substance use disorders. *Cochrane Database of Systematic Reviews* 2007, Issue 4. Art. No.: CD006265. DOI: 10.1002/14651858.CD006265.pub2.	Substances	No effect
46.	Psychosocial	Cochrane	Amato L, Minozzi S, Davoli M, Vecchi S. Psychosocial combined with agonist maintenance treatments versus agonist maintenance treatments alone for treatment of opioid dependence. *Cochrane Database of Systematic Reviews* 2011, Issue 10. Art. No.: CD004147. DOI: 10.1002/14651858.CD004147.pub4.	Drugs	No effect
47.	Psychosocial	Cochrane	Knapp WP, Soares B, Farrell M, Silva de Lima M. Psychosocial interventions for cocaine and psychostimulant amphetamines related disorders. *Cochrane Database of Systematic Reviews* 2007, Issue 3. Art. No.: CD003023. DOI: 10.1002/14651858.CD003023.pub2.	Drugs	No effect
48.	Psychosocial	Cochrane	Terplan M, Lui S. Psychosocial interventions for pregnant women in outpatient illicit drug treatment programs compared to other interventions. *Cochrane Database of Systematic Reviews* 2007, Issue 4. Art. No.: CD006037. DOI: 10.1002/14651858.CD006037.pub2.	Drugs	No effect

Table A4.2 Systematic Reviews of Schools-based Interventions

	Approach	Database	Reference	Substance	Outcome
1.	Schools-based	Cochrane	Faggiano F, Vigna-Taglianti F, Versino E, Zambon A, Borraccino A, Lemma P. School-based prevention for illicit drugs' use. Cochrane Database of Systematic Reviews 2005, Issue 2. Art. No.: CD003020. DOI: 10.1002/14651858.CD003020.pub2.	Drugs	Positive
2.	Schools-based	Cochrane	Foxcroft DR, Tsertsvadze A. Universal school-based prevention programs for alcohol misuse in young people. Cochrane Database of Systematic Reviews 2011, Issue 5. Art. No.: CD009113. DOI: 10.1002/14651858.CD009113.	Alcohol	Positive
3.	Schools-based	ASSIA	Fletcher, Adam; Bonell, Chris; Hargreaves, James. (2008) School Effects on Young People's Drug Use: A Systematic Review of Intervention and Observational Studies . Journal of Adolescent Health. 42, 3, 209-220.	Drugs	Positive

Specific types of intervention for which there is good quality evidence of effectiveness

Schools-based prevention
A good example of a well evaluated schools-based prevention programme is the Life Skills Training in Schools programme in the United States which is focused on reducing excessive alcohol use (Foxcroft and Tsertsvadze, 2011).

The intervention

> In school settings, universal prevention typically takes the form of alcohol awareness education, social and peer resistance skills, normative feedback, or development of behavioural norms and positive peer affiliations. Prevention programs can be either specific curricula delivered as school lessons, or classroom behaviour management programs, and can be educational, psychosocial, or a combination. Psychosocial interventions aim to develop psychological and social skills (e.g. peer resistance) through modelling, understanding, norm-setting and social skill practice, so that young people are less likely to misuse alcohol. Educational interventions aim to raise awareness of the potential dangers of alcohol misuse (e.g. increased knowledge) so that young people are less likely to misuse alcohol.

Foxcroft DR, Tsertsvadze A. Universal school-based prevention programs for alcohol misuse in young people. Cochrane Database of Systematic Reviews 2011, Issue 5. Art. No.: CD009113. DOI: 10.1002/14651858.CD009113.

The results

> In two trials, the single intervention program - Life Skills Training (LST) was delivered through formal teacher, older students, or video training. In the first trial, the peer-led program significantly reduced frequency of drunkenness and the amount of consumption per occasion compared to the teacher-led program or standard curriculum at four months of follow-up. In the second trial, the LST program delivered either through teacher or video training was significantly more effective in reducing the mean number of drunkenness episodes in the last month compared to standard curriculum at 6 months of follow-up. In the same trial, post-intervention alcohol use (monthly or weekly) and the frequency of three or more drinks per occasion did not significantly differ between the intervention programs and the control group. In another trial that evaluated the LST program, the program was significantly more effective in reducing binge drinking (> 5 drinks per occasion) at one year and two years of follow-up.

Family-based prevention
A common psychosocial intervention used to prevent substance misuse are family-based programmes. These cover a wide range of activities including developing parenting skills, providing parental support, social and peer-resistance skills training, and positive peer affiliations. Several evaluations of these programmes were included in the systematic review. One of these reviews, by the same authors of the previous review, summarised the results of 12 evaluations of universal family-based prevention programmes. The following is a description of this kind of programme and the evaluation results obtained.

The intervention

> Universal prevention strategies address the entire population within a particular setting (schools, colleges, families, community). The aim of universal prevention is to deter or to delay the onset of a disorder or problem by providing all individuals the information and skills necessary to prevent the problem. Universal prevention programs are delivered to large groups without any prior screening for risk factors, so all members of the population share the same general risk, although the risk may vary greatly among individuals and sub-groups. In family settings, universal prevention typically takes the form of supporting the development of parenting skills including parental support, nurturing behaviours, establishing clear boundaries or rules, and parental monitoring. Social and peer resistance skills, the development of behavioural norms and positive peer affiliations can also be addressed with a universal family-based preventive program.

Foxcroft DR, Tsertsvadze A. Universal multi-component prevention programs for alcohol misuse in young people. Cochrane Database of Systematic Reviews 2011, Issue 9. Art. No.: CD009307. DOI: 10.1002/14651858.CD009307

The results

Nine of the 12 evaluations examined in the review showed significantly greater reductions in alcohol use among family-based intervention groups than in the control groups. Examples of two of the nine family-based interventions are shown below.

> In one long-term trial (Spoth 1999a), the effectiveness of two family-based intervention programs (Iowa Strengthening Families Program and Preparing for the Drug-Free Years Program) were compared to the control intervention (4 mailed leaflets) through a 10-year follow-up for different alcohol use measures (e.g., lifetime use, past year use, past month use, lifetime drunkenness, past month frequency of drinking, alcohol use composite index, or alcohol use initiation growth curve parameters). The long-term results of this trial indicated that both family-based interventions significantly reduced the proportion of new alcohol users, past month mean frequency of drinking, and alcohol use composite index. In general, the positive effect of the Iowa Strengthening Families Program (ISFP) relative to the control intervention was more pronounced than that of the Preparing for the Drug-Free Years Program (PDFY) for reducing several alcohol use outcome measures (e.g., lifetime use, past year use, past month use, lifetime drunkenness, ever drinking alcohol, and growth curves for lifetime alcohol use, lifetime drunkenness, and initiation of drunkenness).

Pharmaceutical approaches

The main pharmaceutical methods used in the treatment of substance misuse are broadly ‘agonist treatment’, which mimic the effect of the substance being misused, (the most common is substitute prescribing), and ‘antagonist treatment’, which blocks the effect of the misused substance (the most common of which is Naltrexone treatment). A third method is various forms of adjunct drug treatment to modify the effects of withdrawal or to control related disorders (e.g. use of anti-depressants and anti-psychotics).

The most common and widely known pharmaceutical intervention is methadone treatment. This is a form of substitute prescribing which aims to replace the drug of addiction (usually heroin) with another drug (oral or injectable methadone). It can be

administered on a reducing or maintenance basis. There have been many evaluations of the effectiveness of methadone maintenance. One of the earliest and most frequently cited are the various studies by Gluber et al. in the United State based on random allocation designs.

The intervention

> The therapy comprised 6 months of methadone maintenance with standard counselling. Participants were transferred from 21-day methadone detoxification to the 6-month methadone maintenance program, and were guaranteed methadone maintenance for 6 months (60–90 mg) followed by a 6-week taper. Participants in this treatment condition received their therapy in directly observed doses at their daily methadone clinic visits.

Gruber VA, Delucchi KL, Kielstein A, Batki SL. (2008) A randomised trial of 6-month methadone maintenance with standard or minimal counselling versus 21-day methadone detoxification.. Drug and Alcohol Dependence 94:199–206.

The results

> Compared to 21-day methadone detoxification, 6-month methadone maintenance with minimal counselling resulted in a greater decrease from baseline in opiate positive urine tests (65–85%) and self-reported heroin use (mean = 5.8–8.1 days per month) during months 1–6.

Psychosocial approaches

Psychosocial approaches are used in treatment to provide information (e.g. educational programmes such as skills training and family-based interventions) and to aid motivation (such as motivational interviewing and cognitive behavioural therapy). The example chosen describes an intervention that is used widely in the United States.

The intervention

> Reinforcement-based intensive outpatient treatment (RBT) is a relatively newly developed therapy based on the community reinforcement approach (CRA). Reinforcement-based outpatient treatment (RBT) has been based on CRA with monetary-based incentives. It has been tailored to inner-city heroin abusers who may not be eligible or do not want methadone maintenance. This is implemented as aftercare from a rapid (3-day) inpatient detoxification. Abstinence-contingent financial support for practical needs such as housing, travel, lunch and recreational activities is also included. A brief version of RBT includes a three-month treatment schedule was implemented with intensive daily attendance in the first two-week phase, followed by a less intensive three weekly sessions offered for six weeks, then twice-weekly sessions offered for the last four weeks. During attendance, individual sessions could incorporate cognitive behavioural methods, addressing individual needs of the patient.

Mayet S, Farrell M, Ferri M, Amato L, Davoli M. (2004) Psychosocial treatment for opiate abuse and dependence. Cochrane Database of Systematic Reviews. Issue 4. Art. No.: CD004330. DOI: 10.1002/14651858.CD004330.pub2.

The results

Reinforcement-Based Intensive Outpatient Treatment (RBT) versus Standard Community Treatment Resources. Relapse to heroin use by urinalysis suggested that the RBT group had a significantly better prevention at one-month follow up. However at three months follow up, this effect was not significant. Self-report of heroin and cocaine use was less likely with the RBT group as compared to the standard group at discharge, at one week follow up and at one month follow up. Being in employment was significantly more likely by the RBT groups at one month, but not at three months.

APPENDIX 5:

Analysis of projects and services implemented

To determine if what had been implemented in practice matched the proposals listed in the Strategy, our approach was to identify all interventions implemented from the main funding sources. These included: CSP (Community Safety Partnership) funding allocations, the WG (Welsh Government) central budget funding, Health Budget funding, as well as ESF (European Social Fund), Lottery funding, and funding from other charities. As a result of various difficulties in obtaining the data, (e.g. there is no clear list of projects funded out of the Health Budget) we limited our analysis to CSP funded projects and activities published in the annual reports of the Implementation Board. The CSP funded project analysis was conducted by coding the interventions into Excel and analysing the results in SPSS. The results enabled us to see if the Strategy plans had been put into practice.

Table A5.1 Total projects and activities recorded in the 2011-2012 CSP funding allocations showing the third and fourth level of breakdown

Third breakdown	n	Fourth breakdown	n
1. Education	15	Parenting	1
		Public	4
		Users	3
		Various	2
		Web site	5
2. Prevention	16	Prevention	16
3. Diversionary activities	4	Diversionary activities	2
		Activities youth	2
4. Harm reduction	11	Harm reduction	11
5. Needle exchange	4	Needle exchange	4
6. Brief interventions (Prescribing)	1	Brief interventions (Prescribing)	1
7. Detox.	10	Detox.	10
8. GPs Shared Care	7	GPs Shared Care	7
9. Prescribing	18	Prescribing	18
10. Alcohol services	17	Adults	11
		Education	1
		Harms	1
		Support	1
		Treatment	2
		Various	1
11. Brief interventions (Psychosocial)	7	Alcohol	3
		Substance	1
		Various	3
12. Treatment	8	General	3
		Mental illness	1
		Psychosocial	3
		Youth	1
13. Aftercare	1	Aftercare	1
14. Residential	17	Residential	17
15. Counselling	15	Counselling	15
16. Drop-in	2	Drop-in	2
17. Outreach	7	Alcohol	2
		Drugs	1
		General	2

		Users	1
		Youth	1
18. Service user groups	4	Service user groups	4
19. Support services	67	Abstinence	1
		Adults	3
		Children	2
		Day Care	3
		Families	16
		Housing	3
		Multiple	1
		Users	17
		Women	1
		Workshops	2
		Youth	18
20. Enforcement	2	Enforcement	2
21. Arrest referral	2	Arrest referral	2
22. Offending	2	Offending	2
23. Domestic violence	2	Domestic violence	2
24. Drug testing	2	Drug testing	2
25. Youth offending	3	Youth offending	3
	244		**244**

Table A5.2 Total cost activities recorded in the 2011-2012 CSP funding allocations by Local Authority

Local Authority	n	Mean	Sum	% all
Anglesey	17	31,055	527,944	3
Blaenau Gwent	15	23,179	347,689	2
Bridgend	9	66,349	597,145	3
Caerphilly	20	59,635	1,192,716	6
Cardiff	19	121,394	2,306,503	12
Carmarthenshire	28	45,000	1,260,021	7
Ceredigion	24	27,840	668,171	4
Conwy	17	41,083	698,424	4
Denbighshire	18	37,433	673,807	4
Flintshire	18	44,748	805,466	4
Gwynedd	24	31,847	764,345	4
Merthyr	17	35,614	605,442	3
Monmouthshire	10	58,727	587,277	3
Neath Port Talbot	25	38,540	963,521	5
Pembrokeshire	19	39,355	747,746	4
RCT	20	107,748	2,154,968	12
Swansea	23	72,737	1,672,959	9
Torfaen	12	50,748	608,986	3

Vale	10	53,427	534,279	3
Wrexham	26	33,782	878,339	5
Total	371	50,123	18,595,748	100

Note: There were no returns from two local authorities.

APPENDIX 6:

Evaluations commissioned by the WG since 2008

Table A6.1 Evaluations commissioned by the WG since 2008

No.	Title	Source of information	Year
1.	Evaluation of the Take Home Naloxone Demonstration Project	WG website (SM research section)	2011
2.	Evaluation of the All Wales School Liaison Core Programme (AWSLCP)	WG website (SM research section)	2011
3.	Evaluation of the Transitional Support Scheme (TSS)	WG website (SM research section)	2010
4.	Evaluation of Early Parental Intervention Pilot Projects	WG website (SM research section)	2010
5.	Evaluation of the include Programme	WG website (SM research section)	2009
6.	Helping people off benzodiazepines. An evaluation of a pilot initiative run by the prescribed medication support service in Conwy	WG website (SM research section)	2008
7.	Evaluation of Option 2	WG website (SM research section)	Undated
8.	Evaluation of the ESF Peer Mentoring Project	WG website (SM research section)	Ongoing
9.	Informing and modernising care in a substance misuse treatment community: linking policy, strategy, management and practice (Evaluation of the PARIS system)	WG website (SM research section)	2011
10.	Guidance to reduce unplanned drop out from, and promote re-engagement with, substance misuse treatment services – both sides of the story	WG website (SM research section)	2009
11.	The nature and scope of benzodiazepine and 'z' drug prescribing in Wales	WG website (SM research section)	2010
12.	A scoping exercise to identify the requirements for and current provision of, counselling across substance misuse services in Wales	WG website (SM research section)	2009
13.	Drug-related deaths in Wales – 2010 – Annual report of the systematic review of drug-related deaths in Wales	WG website (SM research section)	Undated
14.	Evaluation of the CRAFT pilot project	WG website (Social Research section)	2011
15.	A pilot study of alcohol policy and social norms in Welsh Universities	Specification document	Ongoing
16.	Evaluation of the Strengthening Families programme	Key stakeholder	Ongoing
17.	Evaluation of alcohol brief interventions	Key stakeholder	Ongoing

18.	National overdose study	Personal knowledge	Ongoing

Table A6.2 Methodological details of evaluations commissioned by the WG

No.	Title	Evaluators	Research design	Key outcomes
1.	Evaluation of the Take Home Naloxone Demonstration Project	University of Glamorgan	Pre and post-test, no comparison Post-test only, with non-matched comparison	Knowledge Survival
2.	Evaluation of the All Wales School Liaison Core Programme (AWSLCP)	University of Edinburgh and University of Wales, Cardiff	Post-test only, no comparison	Substance misuse
3.	Evaluation of the Transitional Support Scheme (TSS)	University of Glamorgan and ARCS (UK) Ltd	Post-test only, with non-matched comparison	Reconviction
4.	Evaluation of Early Parental Intervention Pilot Projects	Swansea University, University of Salford and ARCS (UK) Ltd	Qualitative only	Problems
5.	Evaluation of the include Programme	Swansea University and ARCS (UK) Ltd	Pre and post-test, no comparison	Substance misuse and offending
6.	Helping people off benzodiazepines. An evaluation of a pilot initiative run by the prescribed medication support service in Conwy	Catrin Williams PMSS	Pre and post-test, with non-matched comparison	Prescribing levels and use of benzodiazepines
7.	Evaluation of Option 2	University of Bedfordshire, Brunel University, University of Birmingham, University of Wisconsin	Pre and post-test, with comparison	Entering care, length of stay in care
8.	Evaluation of the ESF Peer Mentoring Project	University of Glamorgan, Aberystwyth University and ARCS (UK) Ltd	Unknown	Ongoing
9.	Informing and modernising care in a substance misuse treatment community: linking policy, strategy,	Swansea University, Concinnitas	Pre and post-test, with no comparison	Number of organisiations Number of

No.	Title	Evaluators	Research design	Key outcomes
	management and practice (Evaluation of the PARIS system)	and ARCS (UK) Ltd		interactions
10.	Guidance to reduce unplanned drop out from, and promote re-engagement with, substance misuse treatment services – both sides of the story	National Public Health Service for Wales with Liverpool John Moores University	Cross-sectional survey	Factors associated with unplanned drop-out
11.	The nature and scope of benzodiazepine and 'z' drug prescribing in Wales	Welsh Medicines Partnership	A longitudinal, comparative study	Prescribing levels
12.	A scoping exercise to identify the requirements for and current provision of, counselling across substance misuse services in Wales	The PIER Group	Cross-sectional survey	Provision of and characteristics of counselling services
13.	Drug-related deaths in Wales – 2010 – Annual report of the systematic review of drug-related deaths in Wales	Drug-Related Death Panel	Random sample of case files and questionnaire survey	
14.	Evaluation of the CRAFT pilot project	Swansea University and ARCS (UK) Ltd	Cross-sectional survey	Quality of life Substance misuse Treatment entry
15.	A pilot study of alcohol policy and social norms in Welsh Universities	Cardiff University	Cluster, randomised controlled trial	Alcohol consumption Problems
16.	Evaluation of the Strengthening Families programme	Cardiff University	Randomised controlled trial	Public health benefits
17.	Evaluation of alcohol brief interventions	Unknown	Unknown	Unknown
18.	National overdose study	University of Glamorgan	Cross-sectional survey	Non-fatal overdoses

Summaries of evaluations commissioned by the WG since 2008

Evaluation of the Take-Home Naloxone demonstration project

The Take-Home Naloxone demonstration project grew out of the WG's substance misuse strategy which stated a commitment to take actions to reduce the number of drug-related deaths and near-fatal drug poisonings. The project was launched in September 2009 in selected areas across Wales. It involved training drug users and their family and friends in the administration of naloxone (an opioid antagonist which

blocks the actions of opioid medicines such as heroin) and other life-saving actions following the discovery of an overdose event. THN kits were then issued to opiate users who completed the training. The evaluation comprised a process evaluation and an outcome evaluation of the project during its first year of operation. The findings indicate that the THN training sessions were effective in improving knowledge and skills across a range of measures. However, the absence of a long-term follow-up means that it is not clear whether these improvements were maintained over time. In terms of lives saved, no difference was found in the survival rates of overdose events in the THN sites and a non-matched comparison site in which THN was not distributed.

Evaluation of the All Wales School Liaison Core Programme

The All Wales School Liaison Core Programme (AWSLCP) was developed "in recognition of the role that schools and education can play in tackling anti-social behaviour, substance misuse and in improving personal safety" (p.15). The programme became fully operational in September 2004 and by 2008/09 98% of schools in Wales had signed up to it. In practice the AWSLCP involves school community police officers delivering formal lessons to children in Key Stages 1-4 on substance misuse, social behaviour, community and personal safety. The evaluation comprised both a process and outcome evaluation. The use of a questionnaire survey showed that after participating in the AWSLCP 83% of primary pupils, 57% of Year 8 pupils and 37% of Year 11 pupils 'now' thought about what would happen if they used illegal drugs. A similar pattern of results was found for alcohol. Results from focus groups also indicated that there were changes in attitude towards substance misuse though the authors recognise that the picture is a 'complex one' (p. 65). The evaluation also examined changes in behaviour regarding substance misuse. The authors explain that although fewer in number than other examples given, "they nonetheless suggest the lessons were having an impact in this area." (p. 9) Overall, the evaluation provides some fairly weak evidence to support the effectiveness of the programme. The absence of pre-test measures means that changes following the programme have not been properly assessed and the absence of a control group means that any effects cannot be attributed to the programme with any certainty.

Evaluation of the Transitional Support Scheme

The Transitional Support Scheme (TSS) is one of the largest and longest established mentoring schemes for ex-prisoners in the UK. Its main aim is to reduce re-offending. The scheme was developed to help with the resettlement of short-term prisoners who, unlike their long-term counterparts, are not subject to statutory supervision on release. The evaluation examined both the effectiveness of the scheme's organisational processes and its impact on the client group using a combination of quantitative and qualitative methods. Using data from the Police National Computer, the two-year reconviction rates of all male TSS participants over 21 were compared with those of a sample of similar prisoners who did not participate in TSS. No significant difference in reconviction rates was found between TSS participants as a whole and the comparison group. However, reconviction rates were found to be considerably lower among participants who had maintained contact with their mentors post-release (71%) than among both the comparison group (77%) and those who had not maintained contact (83%). Other statistical data collected to measure the 'distance travelled' by TSS participants in terms of addressing

criminogenic needs such as employment, housing and substance abuse, indicated that substantial proportions of participants made progress in these areas. The results provide relatively strong evidence of the effectiveness of TSS in reducing crime. However, the use of a post-test only design without random allocation into experimental and comparison conditions, weakens the strength of this evidence.

Evaluation of the Early Parental Intervention Pilot Programme

The Early Parental Intervention Pilot programme (EPIP) was developed as part of the WG's policy objective of reducing harm caused to children by parental substance misuse. In April 2007, five pilot projects were commissioned in different locations across Wales. Each project aimed to reduce the effect of substance misuse on parenting capacity and to enable substance misusing adults to develop positive and effective parenting skills. The evaluation included both a process and impact evaluation. The effectiveness of the EPIP was assessed on a largely qualitative basis due to the lack of quantitative data available to the evaluation team. The researchers explain that the evaluation was commissioned 10 months into a 24-month pilot after data collections systems, focusing on outputs rather than outcomes, had already been implemented. Despite developing a bespoke database to enhance the recording of outcomes, the data were either not entered or not complete enough to support any robust outcome analyses. Nevertheless, the qualitative data collected showed that despite a short implementation period, four of the five projects 'helped to alleviate the problems caused by substance misuse within the families that they worked with' (p. 33). Given the absence of any robust quantitative data, the evaluation provides only limited evidence of the effectiveness of the EPIP.

Evaluation of the 'include' Programme

The 'include' programme was established in 2003 in three areas of South Wales. It aims to provide intensive support to young people who have been involved in significant substance use and offending behaviour. The programme runs on a rolling basis over an 11-week period and involves young people (in groups of no more than eight) participating in 25 hours of activities per week. The evaluation was conducted over a six-month period from January to July 2008 and investigated the delivery, impact and effectiveness of the programme. Effectiveness, on a range of outcomes including, substance use and offending, was measured using data from the 'include' database and through qualitative interviews with participants. Project involvement was found to be associated with a significant positive increase in behaviour scores across all aspects of measured behaviour on exit from treatment. Interviews with participants on completion of treatment (and again three months post-exit) provided further evidence to support the positive impact of the project on participants. However, the absence of a comparison group and the short-term measure of changes makes it difficult to know precisely what impact the project has on participants and if any impact is maintained post-completion.

Evaluation of the Prescribed Medication Support Service in Conwy

The development of a Prescribed Medication Support Service in Conwy was initiated and funded by Conwy Local Health Board to tackle high levels of benzodiazepine prescribing. The main aim of the project was to address inequalities in health care provision across Conwy and to increase the quality of life of long-term benzodiazepine users. The project ran from the end of May 2006 for a 12-month period. It involved a Support Worker (RGN and Psychotherapist) and a team of

volunteer counsellors, working closely with the five GP Practices that had the highest levels of benzodiazepine prescribing. It should be noted that the evaluation report presents findings relating to a period prior to the implementation of the 2008 strategy. Nevertheless, its inclusion on the WG website and its coverage of an issue highlighted in the 2008 strategy means that it is relevant to include in this review. The evaluation is brief and focuses on effectiveness by measuring the level of GP prescribing and the numbers and percentages of people reducing or stopping their use of benzodiazepines. Over the duration of the project the average reduction in prescribing was nearly three times greater among the five practices taking part than among those practices not taking part. Furthermore, 33% of clients reduced their medication and 12% stopped taking their medication altogether. When interviewed about their experiences of the service, clients rated their experiences very highly. Overall, the evaluation provides fairly strong evidence to support the service. However, the small sample sizes, the short-term follow-up and the inability to control for information reaching the comparison group means that caution must be taken when interpreting the findings.

Evaluation of Option 2

Option 2 provides brief and intensive interventions for families where social workers have identified a risk that a child may either enter care or be placed on the Child Protection Register. The programme is based on the Homebuilders model (from the US) and is designed for families in which there is known parental substance misuse. The intervention is short (4-6 weeks) and intensive. Workers are available 24 hours a day and use a combination of techniques including motivational interviewing, solution-focused counselling and other therapeutic and practical interventions. The evaluation focused on impacts rather than processes and benefited from the use of a 'broadly valid' comparison group and a long follow-up period (3.5 years). To assess impact, children accepted by the Option 2 service between 2000 and 2006 (including 16% who did not receive the service) were compared with children who were referred but not accepted as the service was full (the comparison group). While Option 2 did not reduce the proportion of children who entered care, it was found to significantly reduce the time children spent in care. Furthermore, cost analyses demonstrated that Option 2, on average, saved the local authority in one area more than £1,000 per child. While the evaluation is relatively strong in its design, it is weakened by several factors including the unmatched nature of the comparison group, the lack of knowledge about what services the comparison group received, and the failure to measure impact on a wider array of measures (e.g. substance misuse, offending, education, health).

Evaluation of the ESF Peer Mentoring Programme

The Peer Mentoring Programme is a national scheme funded by the European Structural Fund (ESF) covering all ESF convergence and competitiveness areas in Wales. It is implemented by six providers across nine sites. The project aims to give substance misusers a pathway out of a substance misuse lifestyle, by providing mentoring support to enter employment, gain qualifications, enter further learning and achieve other positive outcomes. The evaluation of the programme is ongoing and includes both a process and an impact evaluation. The unusually lengthy evaluation was commissioned in August 2010 for a three and a half-year period. To date, no reports have been published from which information about research design and results can be extracted. However, from our own knowledge of the evaluation

we know that it will examine the impact of the programme on a range of outcome measures using both quantitative and qualitative methods. To ensure that effectiveness is measured robustly, it would be useful for the evaluation to include a comparison group so that any programme effects can be clearly identified.

Informing and modernising care in a substance misuse treatment community (Evaluation of the PARIS system)

In June 2010, the WG commissioned an evaluation of the impact of a new client record capture system (PARIS) in Swansea. The research examined the implications of the PARIS system for the delivery, management, commissioning and effectiveness of substance use treatment services. The PARIS system was launched in the Swansea SMAT commissioning area in September 2010. The aim was to establish a single comprehensive assessment and case management system, enhance information sharing between agencies, and increase the efficiency and effectiveness of service delivery to improve the quality and volume of treatment provision. Statistical analyses comparing pre and post-PARIS data for the client sample showed that the number of organisations and individuals that clients engaged with increased post-PARIS. It also showed that the number of interactions with agencies was higher among the post-PARIS group than the pre-PARIS group. The results of this evaluation point to substantial improvements in service provision post-PARIS. However, the short follow-up period and the lack of information about the selection of the detailed case studies (which formed the basis of the evaluation) means that the longer-term impact of the system across the full range of clients is not known.

Guidance to reduce unplanned drop out from, and promote re-engagement with, substance misuse treatment services

As part of the 2008 strategy the WG commissioned the National Public Health Service for Wales to investigate the range of factors that influence unplanned drop-out from, and re-engagement with, substance misuse treatment services in Wales. The project is therefore unlike most of the other studies reviewed in this section in that it did not evaluate a particular intervention or system. Rather, it investigated a particular problem common to all substance misuse services. To identify the relevant factors that influence retention in treatment, a cross-sectional survey design was used and postal questionnaires were distributed to 78 substance misuse services in Wales that routinely submitted data to the WNDSM. In addition, a structured mixed-method questionnaire was completed by 559 current and ex-service users from across Wales who had experienced unplanned drop-out from services in the last two years. A myriad of factors were found to be related to early departures from treatment including issues relating to operational practice, resources, service design, and the culture of substance misuse services and their commissioning bodies. While the sample sizes used in this study are fairly large, the opportunistic sampling strategy employed to recruit current and ex-service users may mean that the sample is not entirely representative of the whole population of treatment drop-outs. Nevertheless, it is useful that the researchers designed a sampling framework which would ensure that both primary drug and primary alcohol users were equally represented in the sample.

The Nature and Scope of Benzodiazepine and 'z' Drug Prescribing in Wales

In December 2009 the WG commissioned the Welsh Medicines Partnership (WMP) to investigate the prescribing of benzodiazepine and 'z' drugs in Wales. The need for this study emerged out of growing concerns regarding the high volume of anxiolytic and hypnotic prescribing in Wales and the subsequent call for a reduction of such prescribing in the 2008 substance misuse strategy. The study was conducted in four phases. In Phase 1 raw prescribing data was analysed to identify changes in prescribing practices between 04/05 and 08/09. In Phase 2 comparisons were made with data from England. In Phase 3 areas of good practice were identified through interviews with Heads of Pharmacy and Medicines Management in each of the 22 Local Health Boards. In Phase 4 analyses of demographic data were undertaken. The results showed that over the study period rates of benzodiazepine prescribing did not increase in any of the LHBs and actually decreased in many areas (ranging from a decrease of 3% to 46%). However, rates of 'z' drug prescribing increased in eight of the LHBs (ranging from an increase of 1% to 20%). The study also found that hypnotics and anxiolytics are prescribed more frequently in Wales than in England, even when compared with a demographically equivalent area in the North East of England. The study is comprehensive and detailed and appears to be a useful source of data on prescribing practices in Wales.

A Scoping Exercise to Identify the Requirements for, and Current Provision of, Counselling across Substance Misuse Services in Wales

Over the last twenty years support has grown for the use of evidence-based structured counselling in the substance misuse field. This scoping exercise was commissioned by the WG to help inform the expansion of counselling services in Wales that was called for in the 2008 strategy. The research aimed to investigate a range of issues including what counselling services are currently being delivered in Wales, who delivers them, where they are delivered, as well as the need for and effectiveness of them. Qualitative, semi-structured telephone interviews were conducted with 16 commissioners (80% response rate) and 65 providers of services (100% response rate). The results showed that there is a lack of structured counselling provision in substance misuse services across Wales, leading to long waiting lists and clients not receiving referrals to appropriate interventions. Furthermore, problems with evaluating the effectiveness of these services were identified as no single outcome measure was found to be used consistently across them. Overall, on the basis of fairly comprehensive qualitative data, the study demonstrated a clear need for structured counselling in substance misuse services in Wales.

Annual Report of the Systematic Review of Drug Related Deaths in Wales 2010

In 2005 the WG published guidance on developing local confidential reviews into drug-related deaths. Since then, four panels, comprising addiction specialists, clinicians and treatment providers, have been developed and they now meet regularly to analyse drug-related deaths. This report examines drug-related deaths from 2010 and compares them with deaths from 2008 and 2009 (inclusive). The data were collected from a random sample of post-inquest files and from questionnaires distributed to treatment providers thought to have had contact with the deceased. The report provides information on key demographic themes, geographical distribution, substance of harm, treatment issues, co-occurring substance misuse and mental health, first aid, prison release and near fatal poisonings attending

emergency care settings. While it is laudable that the annual report of the drug-related death panel has been put in the public domain, it is disappointing that the report presents only limited information. First, it is unclear why data from 2010 (a one-year period) have been compared with data from 2008-2009 (a two-year period). Second, while it is stated that 114 cases were reviewed in relation to 2008 to 2009, it is unclear how many were from 2008 and how many from 2009. Any changes may therefore be related more to one year than the other. Third, only limited information on sampling is provided. For example, it is not known whether the sample was selected randomly by year or randomly from across all years. Last, the report is weak in its presentation of results. The lack of charts and tables makes it difficult for the reader to note any changes over time. Given that the need to reduce drug-related deaths is a priority listed in the strategy, it is important that high quality information about such deaths is used to monitor the nature of the problem and guide future developments to tackle the problem.

Evaluation of the CRAFT Pilot Project

Community Reinforcement and Family Training (CRAFT) is a programme designed for families and carers (Concerned Significant Others, CSOs) of substance misusers (loved ones). The programme has three main aims: (1) to help the CSO to improve the quality of their own lives, (2) to minimise the loved ones' consumption of substances, and (3) to encourage the loved ones into treatment. A CRAFT service has been operating in Cardiff since 2007 when it was funded as part of the Drug Interventions Programme. In July 2008 the programme moved under the management of the Cardiff Alcohol and Drug Team (CADT) and became funded by the WG. Subsequently, in 2010 the WG commissioned a process and outcome evaluation of the CRAFT programme to be completed over a short three-month period (January to March 2010). The evaluation team note that 'the data collection necessary to support a robust outcome evaluation had not been planned for at the start of the CRAFT project' (p. 17). The impact of the CRAFT programme was therefore measured in a largely qualitative way using feedback forms completed by CSOs and interviews with therapists and a small number of CSOs (n=7). The research found that CRAFT has a range of positive effects on the psychological health and well-being of the CSO. In terms of impact on loved ones' substance misuse, just under two-thirds of participating CSOs reported a reduction in their loved one's substance misuse. However, the role of CRAFT in achieving this reduction is difficult to measure given that three-quarters of those who experienced a reduction were already in treatment when contact with CRAFT was made. Overall, this study provides only weak evidence of the effectiveness of CRAFT in achieving its aims.

A Pilot Study of Alcohol Policy and Social Norms in Welsh Universities

In recent years, particularly in the US, there has been increasing interest in the social norm approach to reduce drinking among students. The approach is based on the assumption that students are influenced by their perception of what their peers are doing (e.g. drinking large quantities of alcohol). In reality, however, these perceptions are often wrong. The social norms approach therefore aims to correct inaccurate perceptions and thereby influence behaviour. The pilot study used a cluster randomised control trial whereby first year students living in halls of residence in four Welsh Universities were randomly selected to receive the social norms materials (e.g. drinking mats, posters and mirror stickers). Students were asked to

complete an anonymous web-based or paper questionnaire describing their alcohol consumption and related consequences and were offered entry into a £100 prize draw as an incentive for participation. The results of this study have not yet been published and it is therefore not possible to comment on them here. However, if the study is to measure impact reliably, it will need to be careful to ensure that materials given to the experimental group are not leaked to the comparison group thereby confounding any programme effects. Of note is the fact that there is some doubt about who funded this study. Documentation on the internet suggests that the study is funded by Alcohol Research UK. Communication with the Substance Misuse division at the WG suggests that the study is funded by the WG. Perhaps it is a combination of the two.

Evaluation of the Strengthening Families Programme

The Strengthening Families Programme aims to prevent young people from using drugs or alcohol by strengthening the protective factors and reducing the risk factors associated with substance misuse. The SFP has been operating in Cardiff since 2005 and is managed by Cardiff Alcohol and Drugs Team. The programme includes seven weekly sessions covering a range of issues including family functioning, strengthening parental skills and helping young people to learn how to resist peer pressure. The SFP was evaluated in 2008 and is now in the process of being evaluated again. Full details of the evaluation are not in the public domain, but the WG website does state that the SFP is currently participating in a randomised control trial funded by the National Prevention Research Initiative. The trial will examine the long term public health benefits of the Strengthening Families Programme in relation to preventing alcohol, tobacco and drug use and anti-social behaviour in young people. To what extent the WG are involved in funding the study is unclear.

Evaluation of Alcohol Brief Interventions

Alcohol Brief Intervention (ABI) is a short (around five minutes) structured conversation about alcohol consumption with patients. The aim of the intervention is to motivate and support the individual to think about reducing their alcohol consumption. Evidence suggests that ABI is most effective when used in primary care settings and in trauma settings when delivered by nurses. However, if ABI is only delivered in such settings then a large proportion of those who are drinking at harmful levels will not be reached. As a result, Public Health Wales has developed a training model for all 'Allied Health and Social Care professionals' to provide ABI more widely. We understand from colleagues in Public Health Wales that the current roll-out of the ABI is in the process of being evaluated. No further details are known about the evaluation at this time.

National Overdose Study

As part of the WG's commitment to reduce drug-related death (as stated in the 2008 strategy), the WG have recently funded researchers to conduct a national survey to find out the proportion of injecting opiate users who overdose in any year. The aim is is to generate a national estimate of the scale of the problem, with the view of taking action if necessary to reduce harm and save lives. The survey will run during the month of September 2012 and will involve drug workers in all agency needle exchange programmes collecting information on client overdose. The information will be collected using a single-page questionnaire containing eight questions that will take no more than one minute to complete. It is hoped that this method will

ensure a high response rate and therefore generate reliable results. The survey will also include a qualitative component, whereby clients who completed the questionnaire will be asked if they are willing to speak to a member of the research team in more detail about overdose events. On the face of it, this study appears to have been designed in such a way to enable a national estimate to be generated. However, the usefulness of this study hinges on it achieving a high enough response rate.